

MARKET CONDUCT EXAMINATION

OF

COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY

AS OF

SEPTEMBER 30, 2013

DATE OF REPORT

MAY 7, 2015

EXAMINER

PEARSON GRIFFITH

TABLE OF CONTENTS

<u>ITEM NO.</u>		<u>PAGE NO.</u>
1.	Scope of the examination	3
2.	Description of the Company	4
3.	Agents' commissions	5
4.	Adoption of Procedure Manuals –Circular Letter No. 9 (1999)	6
5.	Policy forms	7
6.	Disclosure of information	8
7.	Privacy notices	8
8.	Record retention	9
9.	Claims attribute review	10
10.	Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services (“Prompt Payment Law”)	12
11.	Compliance with prior comments and recommendations	16
12.	Summary of comments and recommendations	19



NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsby
Superintendent

March 7, 2015

Honorable Benjamin M. Lawsby
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 30951, dated March 6, 2013, attached hereto, I have made an examination into the affairs of Commercial Travelers Mutual Insurance Company, an accident and health insurer licensed pursuant to the provisions of Article 42 of the New York Insurance Law, as of September 30, 2013. The following report is respectfully submitted thereon.

The examination was conducted at the home office of Commercial Travelers Mutual Insurance Company located at 70 Genesee Street, Utica, New York and the home office of National Guardian Life Insurance Company located at 2 East Gilman Street, Madison, Wisconsin.

Wherever the designations “CTMIC” or the “Company” appear herein, without qualification, they should be understood to indicate Commercial Travelers Mutual Insurance Company.

Wherever the designation “NGLIC” appears herein, without qualification, it should be

understood to indicate the National Guardian Life Insurance Company.

Wherever the designation the “Department” appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

The previous market conduct examination of CTMIC was conducted as of December 31, 2009. This examination covers the period January 1, 2010 to September 30, 2013 and was performed to review the manner in which CTMIC conducted its business practices and fulfilled its contractual obligations to policyholders and claimants. Transactions subsequent to this period were reviewed where deemed appropriate by the examiner.

This report on examination contains significant findings of the examination and is confined to comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require explanation or description.

A review was also made to ascertain what actions were taken by the Company with regard to comments and recommendations made in the prior market conduct report on examination.

A concurrent examination regarding the financial condition of CTMIC was conducted by the Department as of September 30, 2013, and a separate report on examination has been issued thereon and filed February 27, 2015.

2. **DESCRIPTION OF THE COMPANY**

The Company was incorporated under the Laws of the State of New York as a cooperative assessment health plan under the name “Commercial Travelers Mutual Accident Association of America.” It commenced business on March 30, 1883. The Company’s name was shortened to “The Commercial Travelers Mutual Accident Association” on May 22, 1953. Operations were conducted as a cooperative assessment plan until February 16, 1970. On that date, the Company re-incorporated to become a mutual accident and health insurance company. Concurrent with this change, the present name was adopted. The Company is licensed under Article 42 of the New York Insurance Law to write accident and health insurance, as defined in Section 1113(a)(3) of the New York Insurance Law.

On May 6, 1988, a merger was effected between the Company and InterAmerica Consolidated Mutual Insurance Company of La Grange, Illinois, whereby the assets of the two entities were accounted for as a pooling of interest. Commercial Travelers Mutual Insurance Company was the surviving corporation.

On April 20, 2012, CTMIC entered into an affiliation agreement with NGLIC, a Wisconsin-domiciled mutual life insurer. Under the terms of the affiliation agreement, NGLIC representatives hold a majority of the positions on CTMIC’s board of directors. The agreement was non-disapproved by the New York State Department of Financial Services and was approved by the Wisconsin Office of the Commissioner of Insurance. CTMIC and NGLIC agreed that NGLIC will exercise “control” over CTMIC, as that term is defined by Section 1501(a)(2) of the New York Insurance Law. In addition, CTMIC and NGLIC agreed, pursuant to commitments signed on behalf of both companies that any direct or indirect transaction

involving the companies, or between CTMIC and any member(s) of NGLIC's holding company system, shall be governed by Section 1505 of the New York Insurance Law.

3. AGENTS' COMMISSIONS

A review was performed of CTMIC's sales distribution system during the period covered by the examination. Specifically, the examiner reviewed commissions paid to Morgan-White Administrators, Inc. ("Morgan-White"), one of the Company's Third Party Administrators (TPA).

CTMIC has a Claim and Policy Servicing Agreement with Morgan-White under which Morgan-White performs underwriting, premium billing and collection, commissions, policy issuance, and policy servicing functions on behalf of CTMIC for its disability insurance business.

The examiner selected a sample of commissions paid to five Morgan-White agents on business produced for six employer groups for review, to determine the accuracy of commissions Morgan-White paid to the agents. The review determined that Morgan-White incorrectly calculated the commissions paid for five of the employer groups. This condition was brought to management's attention who advised that the commission inaccuracies were due to Morgan-White's clerical errors. In addition, the examiner determined that the Company failed to conduct internal audits of Morgan-White's commission payment processes during the examination period, as permitted by the terms of the Claims and Policy Servicing Agreement.

These omissions are indicative of a lack of sufficient internal control procedures over the third-party relationship.

It is recommended that the Company implement internal control procedures over Morgan-White's calculation of agent commissions, as permitted by the terms of the Claims and Policy Servicing Agreement.

4. ADOPTION OF PROCEDURE MANUALS – CIRCULAR LETTER NO. 9 (1999)

Circular Letter No. 9 (1999), dated May 25, 1999, "Adoption of Procedure Manuals," was issued to Article 43 Corporations, Public Health Law Article 44 Health Maintenance Organizations, and insurers licensed to write health insurance in New York State. Circular Letter No. 9 (1999) states in part:

"...Of equal importance is the adoption of written procedures to enable the board to assure itself that the company's operations in other key areas are being conducted in accordance with applicable statutes, rules and regulations. Examples of additional key areas include: implementation of the Managed Care Bill of Rights (e.g. information dissemination, accessing prompt quality care, grievance/appeal process); underwriting and rating; external appeals; and the accurate and timely reporting of all financial statement schedules and exhibits..."

The previously recommended annual certification to the board regarding implementation of the adopted procedures and the board's need to oversee outside parties under contract with the company also extends to these additional areas..."

During the review of the Company's underwriting manuals, the examiner noted that there had been few documented changes to the Short-Term and Intermediate Disability manuals since they were implemented in 1998. In addition, the examiner noted that the Company failed to provide the board of directors with certifications of changes to the adopted procedures, in

accordance with the guidelines contained in Circular Letter No. 9 (1999). When this was brought to management's attention, the examiner was provided a document dated February 25, 2014 that listed the changes to these manuals since implementation.

It is recommended that the Company comply with Circular Letter No. 9 (1999) and provide annual certifications to its board of directors to assure the board that all key operational areas are being managed in accordance with applicable statutes, rules and regulations.

5. POLICY FORMS

Section 3201(b)(1) of the New York Insurance Law states, in part:

“No policy form shall be delivered or issued for delivery in this state unless it has been filed with and approved by the superintendent as conforming to the requirements of this chapter and not inconsistent with law...”

The examiner reviewed a sample of policy forms issued during the examination period and noted that on August 23, 2012, the Company issued indemnity forms CT-HIP-300 (AMB), CT-HIP-300 (AD&D), and IP-APP-1 (NY) which had not received the Superintendent's approval to three colleges with a total of 4,911 enrollees. The examiner determined that CTMIC failed to respond in a timely manner to a Department request for information, and the policy forms were non-approved by Department on January 9, 2013. The Company advised the examiner that these policies were non-renewed in 2013.

It is recommended that CTMIC comply with the provisions of Section 3201(b)(1) of the New York Insurance Law by obtaining the Superintendent's approval prior to issuance of policy forms.

DISCLOSURE OF INFORMATION

Section 3217-a(a) of the New York Insurance Law, states in part:

“Each insurer subject to this article shall supply each insured, and upon request, each prospective insured prior to enrollment, written disclosure information, which may be incorporated into the insurance contract or certificate, containing at least the information set forth below...

The information to be disclosed shall include at least the following...

(7) a description of the grievance procedures to be used to resolve disputes between an insurer and an insured, including: the right to file a grievance regarding any dispute between an insured and an insurer; the right to file a grievance orally when the dispute is about referrals or covered benefits...”

The examiner reviewed the group disability brochures and certificate booklets provided to agents and noted that a description of the procedures on how to file a grievance/appeal verbally was not included.

It is recommended that the Company comply with the provisions of Section 3217-a(a) of the New York Insurance Law by including in the written disclosure information, a notice of the insured’s right and procedures on how to file a grievance verbally, when the dispute concerns covered benefits.

7. PRIVACY NOTICES

Part 420.1(a) of Insurance Regulation No. 169 (11 NYCRR 420.1(a)) states in part:

(a) Purpose. This Part governs the treatment of nonpublic personal information about individuals (defined in this Part as consumers or customers) in this State by all licensees of the Department of Financial Services. This Part:

(1) Requires a licensee to provide notice to individuals about its privacy policies and practices;

- (2) Describes the conditions under which a licensee may disclose nonpublic personal health information and nonpublic personal financial information about individuals to nonaffiliated third parties;
- (3) Provides methods for individuals to prevent a licensee from disclosing that information; and
- (4) Provides a method for individuals to prevent a licensee from disclosing nonpublic personal health information by not affirmatively consenting to such disclosure, subject to the exceptions in section 420.17(b) of this Part.

The examiner reviewed a sample of accident-only policies and noted that privacy notices were not distributed to accident-only policyholders.

It is recommended that the Company comply with the requirements of Part 420.1(a) of Insurance Regulation No. 169 (11 NYCRR 420.1(a)) and issue privacy notices to all policyholders.

8. RECORD RETENTION

Insurance Regulation No. 152 (11 NYCRR 243.2(b)(6)) states:

- “(b) Except as otherwise required by law or regulation, an insurer shall maintain:
 - (6) A complaint record required to be maintained under Chapter IX of this Title for six calendar years after all elements of the complaint are resolved and the file is closed.”

The examiner conducted a review of eleven CTMIC complaint files to ascertain whether complaints were responded to in a timely manner and whether the issues were fully addressed. The examiner noted that seven files did not contain appeal/response letters and three letters had received/response dates different from what was noted in the complaint log.

It is recommended that CTMIC comply with Part 243.2(b)(6) of Insurance Regulation No. 152 by maintaining a record of each complaint for six calendar years after the date the policy is no longer in force, or until after all elements of the complaint are resolved and the file is closed.

9. CLAIMS ATTRIBUTE REVIEW

A review of CTMIC's claims practices and procedures was performed covering claims adjudicated during the period of January 1, 2012 through December 31, 2012, in order to evaluate the overall accuracy and compliance environment of its claims processing. A random sample was drawn from the Company's adjudicated claims population to test for verification of compliance with certain specified areas, including: eligibility, payment adherence to appropriate fee schedules, co-payments, deductibles, treatment plan authorization, denied claims and explanation of benefits statements ("EOBs").

Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times a claim transaction was processed in accordance with CTMIC's guidelines and/or Department statutes/regulations. An error in processing accuracy may or may not affect the financial accuracy. A financial error is also considered a procedural error. To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the paid claims data reported by CTMIC for the period January 1, 2012 through December 31, 2012.

The following represents errors identified by the examiner during the abovementioned claims review:

- In two instances, the Company failed to accurately apply co-payments and deductibles in accordance with contractual provisions, and to comply with its own policies and procedures. These claims were deemed to be financial and procedural errors.
- The Company failed to issue full payment on one claim, although there was an additional amount owed, as detailed from the adjudication process. This claim was deemed to be a financial and procedural error.
- The Company failed to comply with its own policies and procedures when it adjudicated and paid two claims for which it was the secondary insurer, based on the providers' balance-due statements. Instead, the Company should have used the primary insurers' explanation of benefits statements. As a result, these claims were overpaid. These claims were deemed to be financial and procedural errors.

It is recommended that the Company comply with policy provisions and its own policies and procedures by properly applying co-payments and deductibles.

It is recommended that the Company reprocess and issue full payment on claims, when support for such payment is submitted during the adjudication process, in accordance with contractual provisions and its own policies and procedures.

It is recommended that, when the Company is the secondary insurer, it complies with its own policies and procedures by adjudicating and paying claims based on the primary insurers' explanation of benefits statements.

10. STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENT OF CLAIMS FOR HEALTH CARE AND PAYMENTS FOR HEALTH CARE SERVICES (“PROMPT PAY LAW”)

Section 3224-a(a) of the New York Insurance Law states:

“(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy (“covered person”) or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile.”

In addition, Section 3224-a(b) of the New York Insurance Law states:

“(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:”

(1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or

(2) to request all additional information needed to determine liability to pay the claim or make the health care payment. Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section.

Furthermore, Section 3224-a(c) of the New York Insurance Law states:

“(c) (1) Except as provided in paragraph two of this subsection, each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less than two dollars, and insurer or organization or corporation shall not be required to pay interest on such claim.

(2) Where a violation of this section is determined by the superintendent as a result of the superintendent's own investigation, examination, audit or inquiry, an insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall not be subject to a civil penalty prescribed in paragraph one of this subsection, if the superintendent determines that the insurer or organization or corporation has otherwise processed at least ninety-eight percent of the claims submitted in a calendar year in compliance with this section; provided, however, nothing in this paragraph shall limit, preclude or exempt an insurer or organization or corporation from payment of a claim and payment of interest pursuant to this section. This paragraph shall not apply to violations of this section determined by the superintendent resulting from individual complaints submitted to the superintendent by health care providers or policyholders.”

Section 3224-a of the New York Insurance Law, “Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services” (the “Prompt Pay Law”), requires all insurers to pay undisputed paper or facsimile claims within forty-five days of receipt. If such undisputed claims are not paid within the designated timeframe, interest may be payable. It is noted that all of CTMIC’s claims are filed on paper.

A “claim” is defined by CTMIC as the total number of items submitted on a single claim form to which CTMIC assigns a unique “claim number.”

A review of CTMIC's claims practices and procedures was performed for claims adjudicated during the period January 1, 2012 through December 31, 2012, in order to determine whether the claims were processed within the timeframe requirements of Sections 3224-a(a) and (b) of the New York Insurance Law, and if interest was required and paid pursuant to Section 3224-a(c), where applicable.

In conducting the review, the examiner selected a sample of 25 claims in order to establish compliance with the aforementioned law. The results of that testing were presented to Company representatives, who acknowledged that the examiner's analyses were consistent with their own internal analyses. During this discussion, the Company acknowledged that there was a prompt pay issue at CTMIC prior to NGLIC's takeover of management of CTMIC. Furthermore, NGLIC indicated that since the takeover, the accuracy and compliance environment of CTMIC's claims processing had improved. Based on this discussion, in an effort to expedite the Prompt Pay analysis, the Company agreed with the examiner's decision to forego a selection/extrapolation of a statistically valid sample size and to utilize the smaller sample size of 25 claims to verify and draw conclusions and make recommendations and/or comments based on the examiner's preliminary analyses.

The examiner's analysis of CTMIC's claim data indicated that 5,405 claims of the population of 17,009 claims, or 32%, were paid more than forty-five (45) days after the eligible for payment date ("EFPDATE") and were therefore in violation of the provisions of Section 3224-a(a) of the New York Insurance Law.

Furthermore, the examiner's analysis of denied claims indicated that there were 312 claims from the population of 1,330 rejected claims where CTMIC requested additional

information more than 30 days from the date of receipt, in violation of Section 3224-a(b) of the New York Insurance Law.

The examiner then utilized the 5,405 claims that were violative of Section 3224-a(a) of the New York Insurance Law, as described above, to test for the payment of interest as required by Section 3224-a(c) of the New York Insurance Law. An extrapolation of the testing results revealed that 730 claims, or 13.5% of the aforementioned 5,405 claims that were paid more than 45 days from the EFPDATE were also eligible for interest payments in accordance with Section 3224-a(c) of the New York Insurance Law. The examiner's testing revealed that in each of these cases, interest was properly calculated and paid.

It is recommended that CTMIC comply with the requirements of Section 3224-a(a) of the New York Insurance Law by making appropriate payment of all claims within the designated timeframes mandated by the aforementioned section of the Insurance Law.

It is recommended that CTMIC comply with the requirements of Section 3224-a(b) of the New York Insurance Law by making appropriate denials of all claims within the designated timeframe provided by the aforementioned section of the Insurance Law.

11. COMPLIANCE WITH PRIOR COMMENTS AND RECOMMENDATIONS

The prior market conduct report on examination contained ten comments and recommendations, detailed as follows (page numbers refer to the prior report on examination):

<u>ITEM NO.</u>	<u>PAGE NO.</u>	
<u>Claims Adjudication Testing</u>		
1.	<p>It is recommended that the Company comply with the requirements of Section 3234(b)(3) of the New York Insurance Law and include all of the required information within its Explanation of Benefits statements.</p> <p><i>The Company has complied with this recommendation.</i></p>	30
2.	<p>It is recommended that the Company comply with the requirements of Section 3221(a)(6) of the New York Insurance Law and deliver consistent contract language within all documents distributed to parties covered under the Company's insured contracts.</p> <p><i>The Company has complied with this recommendation.</i></p>	31
3.	<p>It is recommended that the Company cease the practice of limiting its claim liability through the use of payment of claims by means of a usual and customary fee schedule in instances where the contract indicates that the Company's liability is based upon "Expense Incurred" or "Charges Incurred."</p> <p><i>The Company has complied with this recommendation.</i></p>	31
4.	<p>It is also recommended that the Company re-adjudicate and pay any additional amounts due relative to any claims paid during the examination period that utilized a usual and customary fee as the limit of the Company's liability, where the group contract did not specifically reference and permit the use of a usual and customary fee cap.</p> <p><i>The Company has complied with this recommendation.</i></p>	32

<u>ITEM NO.</u>		<u>PAGE NO.</u>
5.	It is recommended that the Company ensure that all of its School Group contracts clearly define the Company's liability when the Company is not the primary insurer. <i>The Company has complied with this recommendation.</i>	32
	<u>Prompt Payment of Claims</u>	
6.	It is recommended that the Company's electronic claim records accurately reflect the date that the Company's claim payments are mailed. <i>The Company has complied with this recommendation.</i>	34
7.	It is recommended that the Company take the necessary steps to comply with Sections 3224-a(a), 3224-a(b) and 3224-a(c) of the New York Insurance Law. <i>The Company has complied with this recommendation.</i>	36
	<u>Disclosure of Information</u>	
8.	It is recommended that the Company's disclosure of information material include a notice of the insured's right to file a grievance orally when the dispute concerns covered benefits. <i>The Company has not complied with this recommendation. A similar recommendation is included within this report on examination.</i>	37
	<u>Record Retention</u>	
9.	It is recommended that the Company comply with Part 243.2(b)(8) of Department Regulation No. 152 and retain appropriate records at all times. <i>The Company has complied with this recommendation.</i>	38

ITEM NO.**PAGE NO.**Privacy

10. It is recommended that the Company comply with Part 421.3 of Department Regulation No. 173 and Part 45 USC 164.502 and 160.103 of the U.S. Health Insurance Portability and Accountability Act and ensure the security and confidentiality of its members' Protected Health Information. 40

The Company has complied with this recommendation.

12. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
<p>A. <u>Agents' Commissions</u></p> <p>It is recommended that the Company implement internal control procedures over Morgan-White's calculation of agent commissions, as permitted by the terms of the Claims and Policy Servicing Agreement.</p>	<p>6</p>
<p>B. <u>Adoption of Procedure Manuals – Department Circular Letter No. 9 (1999)</u></p> <p>It is recommended that the Company comply with Circular Letter No. 9 (1999) and provide annual certifications to its board of directors to assure the board that all key operational areas are being managed in accordance with applicable statutes, rules and regulations.</p>	<p>7</p>
<p>C. <u>Policy Forms</u></p> <p>It is recommended that CTMIC comply with the provisions of Section 3201(b)(1) of the New York Insurance Law by obtaining the Superintendent's approval prior to issuance of policy forms.</p>	<p>7</p>
<p>D. <u>Disclosure of Information</u></p> <p>It is recommended that the Company comply with the provisions of Section 3217-a(a) of the New York Insurance Law by including in the written disclosure information, a notice of the insured's right and procedures on how to file a grievance verbally, when the dispute concerns covered benefits.</p>	<p>8</p>
<p>E. <u>Privacy Notices</u></p> <p>It is recommended that the Company comply with the requirements of Part 420.1(a) of Insurance Regulation No. 169 (11 NYCRR 420.1(a)) and issue privacy notices to all policyholders.</p>	<p>9</p>

<u>ITEM</u>	<u>PAGE NO.</u>
F. <u>Record Retention</u>	
It is recommended that CTMIC comply with Part 243.2(b)(6) of Insurance Regulation No. 152 by maintaining a record of each complaint for six calendar years after the date the policy is no longer in force, or until after all elements of the complaint are resolved and the file is closed.	10
G. <u>Claim Attribute Review</u>	
i. It is recommended that the Company comply with policy provisions and its own policies and procedures by properly applying co-payments and deductibles.	11
ii. It is recommended that the Company reprocess and issue full payment on claims, when support for such payment is submitted during the adjudication process, in accordance with contractual provisions and its own policies and procedures.	11
iii. It is recommended that, when the Company is the secondary insurer, it complies with its own policies and procedures by adjudicating and paying claims based on the primary insurers' explanation of benefits statements.	11
H. <u>Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services ("Prompt Payment Law")</u>	
i. It is recommended that CTMIC comply with the requirements of Section 3224-a(a) of the New York Insurance Law by making appropriate payment of all claims within the designated timeframes mandated by the aforementioned section of the Insurance Law.	15
ii. It is recommended that CTMIC comply with the requirements of Section 3224-a(b) of the New York Insurance Law by making appropriate denials of all claims within the designated timeframe provided by the aforementioned section of the Insurance Law.	15

APPOINTMENT NO. 30951

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, **BENJAMIN M. LAWSKY**, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:

Pearson Griffith

as a proper person to examine the affairs of the

Commercial Travelers Mutual Insurance Company

and to make a report to me in writing of the condition of said

Company

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed my name
and affixed the official Seal of the Department
at the City of New York

this 6th day of March, 2013

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By:

Steph J. Wiest

Stephen J. Wiest
Deputy Bureau Chief
Health Bureau

