REPORT ON EXAMINATION

OF

COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY

AS OF

DECEMBER 31, 2006

DATE OF REPORT	MAY 30, 2008
EXAMINER	ROY ZABALA

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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 30, 2008

Honorable Eric R. Dinallo
Superintendent of Insurance
New York, NY 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and in compliance with the instructions in Appointment Number 22618, dated May 1, 2007 annexed hereto, I have made an examination into the condition and affairs of Commercial Travelers Mutual Insurance Company, a domestic accident and health insurer, as of December 31, 2006 and submit the following report thereon.

The examination was conducted at the Company's home office located at 70 Genesee Street, Utica, NY 13502.

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

1. SCOPE OF EXAMINATION

The Company was previously examined as of December 31, 2002. This examination covered the four year period from January 1, 2003 through December 31, 2006. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a verification of assets and liabilities as of December 31, 2006, in accordance with statutory accounting principles, as adopted by the New York Insurance Department, a review of income and disbursements deemed necessary to accomplish such verification and, to the extent considered appropriate, utilized work performed by the Company’s independent certified public accountants. A review or audit was also made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners:

History of the Company
Management and control
Corporate records
Fidelity bonds and other insurance
Territory and plan of operation
Growth of Company
Business in force
Reinsurance
Loss experience
Accounts and records
Market conduct

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

This report on examination is confined to financial statements and comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require explanation or description.

2. EXECUTIVE SUMMARY

The examination revealed certain operational deficiencies during the examination period. The following are the examination findings:

- The Company did not comply with its conflict of interest statement policy by failing to record an approval or authorization by the Board of Directors of the Company or its Executive Committee regarding a business relationship with three board members. (See item 3F of this report)

- Premium checks received by the Employers Group Department were not stored in a secure location. (See item 3G of this report)

- The Company's allocation of its total amounts of reserves and liabilities between amounts for reserves and amounts for liabilities differ from the usual practices utilized by actuaries. (See item 5 of this report)

- A review of the Company's claims adjudication process revealed 12 financial errors and 31 procedural errors. (See item 6A of this report)

- The Company failed to pay claims within the 45 day limitation as prescribed by Section 3224-a(a) of the New York Insurance Law and failed to request additional information or make proper denial of benefits within the 30 day time frame prescribed by Section 3224-a(b) of the New York Insurance Law. (See item 6B of this report.)

- The Company failed to comply with the requirements of Section 3234(b)(5) of the New York Insurance Law relative to the information contained in its explanation of benefits statements. (See item 6C of this report)

- The Company reported third party administrative fee invoices as part of its reported claims expenses in its general ledger and filed annual statement. Such third party administrative fees should instead be reported as claim adjustment expenses. (See item 6D of this report)

3. DESCRIPTION OF COMPANY

The Company was incorporated as "Commercial Travelers Mutual Accident Association of America," a cooperative assessment health, under the Laws of New York and 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 under the 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 Company name was adopted. The Company is licensed under Article 42 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. Commercial Travelers Mutual Insurance Company was the surviving corporation.

A. Management

Pursuant to the Company's charter and by-laws, management of the Company is to be vested in a board of directors consisting of thirteen (13) members. As of the examination date, the Board of Directors was comprised of thirteen (13) members. The board meets at least four times each calendar year. The Board members as of December 31, 2006 were as follows:

Name and residence	Principal business affiliation
Joan W. Compson Clinton, New York	Chief Financial Officer, Carbone Auto Group
Richard R. Griffith Utica, New York	President, Sturges Manufacturing Company, Inc.
Frederick H. Hager Clinton, New York	Principal, Strategic Planning Advisors, LLC
Harrison J. Hummel III Mohawk, New York	President and Chief Executive Officer, Hummel's Office Plus
Kevin M. Kelly New Hartford, New York	Retired President, Consultant Jay-K Independent Lumber Corporation
Jeremiah O. McCarthy Barneveld, New York	President and Chief Executive Officer, Oneida County Rural Telephone and Northland Communications
Cathy M. Newell New Hartford, New York	President, Mohawk Ltd.
Earle C. Reed Utica, New York	Supervisor, Town of New Hartford
Gary D. Scalzo New Hartford, New York	President, Scalzo, Zogby & Wittig, Inc.
Robert N. Sheldon Utica, New York	President, Reid-Sheldon and Company
Herbert E. Trevvett Poland, New York	Consultant, Retired President and CEO, Commercial Travelers Mutual Insurance Company
Paul H. Trevvett Cold Brook, New York	President and CEO, Commercial Travelers Mutual Insurance Company
Dwight E. Vicks, Jr. Utica, New York	President, Vicks Lithograph and Printing Corp.

The Board is required to meet once for an annual meeting, and three additional regular meetings during each calendar year, but may hold special meetings as desired. The Board of Directors of Commercial met seventeen (17) times during the period of January 1, 2003 through December 31, 2006. A review of the minutes of the Board of Directors' meetings indicated that board meetings were generally well attended.

The principal officers of Commercial as of December 31, 2006 are as follows:

Name	Title
Paul H. Trevvett	President and Chief Executive Officer
Sharon P. DeCarr	Vice President
William G. Holbrook	Vice President
Richard A. Lang	Vice President
Lynn J. Macrina	Vice President
David R. Milner	Secretary and General Counsel
Thomas P. Moore	Vice President
Alan L. Shulman	Vice President and Actuary
Brian T. Stalder	Vice President
James D. Trevvett	Treasurer

B. Territory and plan of operation

Commercial Travelers Mutual Insurance Company is a mutual accident and health insurer licensed under the provisions of Article 42 of the New York Insurance Law. As of December 31, 2006, the Company was licensed to write in 49 states and the District of Columbia.

The Company's primary lines of business include college student medical expense, K–12 student accident only medical expense, and disability income for small

employers. Other lines of business include special risk group accident and medical expense, which provides medical expense coverage for non-student youth sports and youth/adult special activities.

Based upon the line of business, for which the Company is licensed, the Company is required to maintain a minimum surplus in the amount of $150,000 pursuant to Article 42 of the New York Insurance Law.

The following is a schedule for the examination period of direct premiums written in New York compared to premiums written nation wide:

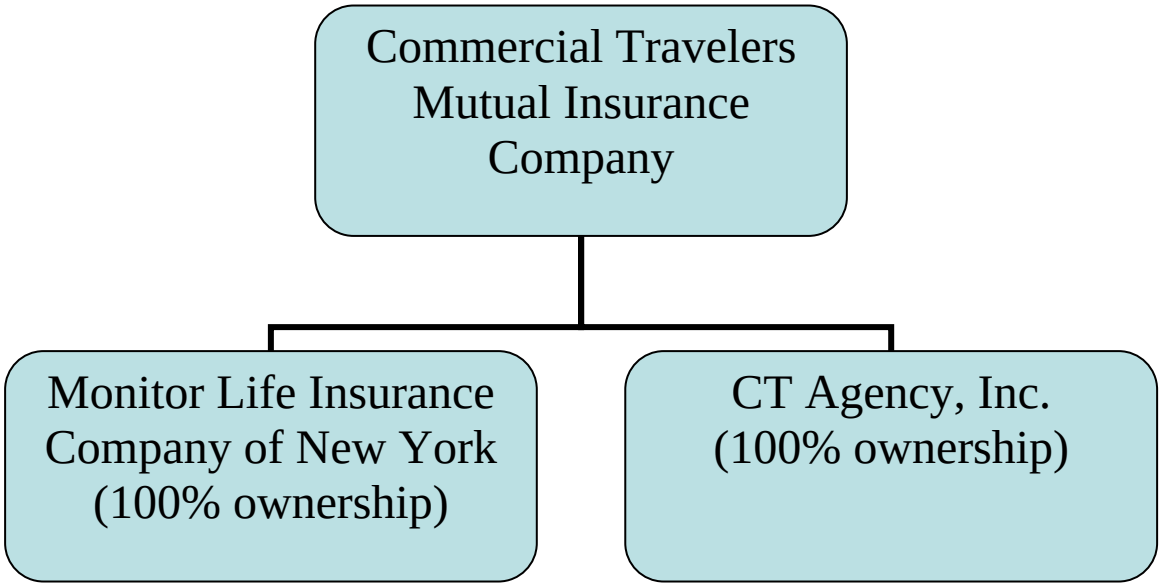
	2003	2004	2005	2006
New York	$ 3,172,366	$ 2,306,404	$ 1,832,064	$ 1,736,050
Nationwide	$17,050,294	$20,720,416	$20,776,785	$20,912,416
% of premiums written in New York	18.6%	11.1%	8.8%	8.3%

The decrease in premiums written in New York during the period of examination was primarily due to some New York schools requiring insurance companies to be rated “A” by A.M. Best Company (“AM Best”) to underwrite their school insurance policies. AM Best is a Nationally Recognized Statistical Rating Organization (NRSRO) that rates the financial stability of insurance companies. Based on AM Best’s opinion of Commercial’s financial strength, the Company was assigned a rating of “B.” As a result of its AM Best rating, the Company’s direct school plan business in New York decreased during the examination period. Subsequent to the examination period, the Company’s

AM Best financial strength rating has been increased to “B+”. Additionally, in 2004, the increase in premiums written throughout the country was due to writing some new accounts primarily in Ohio, which totaled approximately $3.5M of new business.

C. Holding company system

The following chart depicts the Company and its relationship to its affiliates as of December 31, 2006:



Monitor Life Insurance Company of New York

The Company owns 100% of the issued and outstanding stock of Monitor Life Insurance Company of New York (“Monitor”), a domestic life insurer licensed to write life and accident and health insurance in twenty-six states, including New York.

A Service Agreement went into effect on April 1, 1979 between Commercial and Monitor. Under the agreement, Commercial is reimbursed for marketing, underwriting, claim, investment and other services it performs for Monitor. The Service Agreement was approved by the New York Insurance Department on May 8, 1979.

Furthermore, effective in 1982 and with the approval of this Department, the Company and Monitor entered into an agreement which provides for reciprocal lines of credit between the companies. According to the terms of the agreement, the maximum amount of borrowings made at any time is limited to the lesser of $500,000 or 5% of the lending company's admitted assets as of the previous year-end. At December 31, 2006, there were no borrowings outstanding under this agreement.

CT Agency, Inc.

On January 30, 1991, the Department approved the Company's organization and acquisition of CT Agency, Inc. The purpose of CT Agency, Inc. is to serve as an insurance agency to aid the Company in placing business for policyholders that the Company cannot accommodate according to its underwriting guidelines. CT Agency, Inc. also places risks for other outside companies.

The Company entered into a service agreement with CT Agency, Inc. on March 13, 1991. Under the agreement, the Company pays CT Agency, Inc. a commission on premiums earned for business placed with the Company.

Tax allocation agreement

The Company entered into a consolidated Tax Allocation Agreement with an effective date of February 23, 2000 with its subsidiaries. This agreement was found to be consistent with the guidelines contained in Circular Letter No. 33 (1979), and was approved by the Department on May 12, 2000.

D. Reinsurance

During the examination period and continuing thereafter, the Company acted as a managing underwriter on a "pooled basis" arrangement with Security Mutual Life Insurance Company of New York ("Security") in which all school insurance policies and a small amount of special risks business are pooled by the participants.

Pursuant to the terms of this agreement, the Company and Security share in premiums, losses and expenses of the pooled business in accordance with each Company's percentage of participation. However, Commercial incurs all the costs for administering such business and Security pays a fee to Commercial for administrative services based on a percentage of net premiums written.

As of December 31, 2006, the insurers included in this pooling agreement and their proportions of participation were as follows:

Name	Percentage of Participation
Commercial Travelers Mutual Insurance Company	100%
Security Mutual Life Insurance Company	0%*

* Security has an option to recapture 10% of the business.

Ceded Reinsurance

Commercial Travelers Mutual Insurance Company has several reinsurance agreements in effect, which limit its net exposure. In addition to its pooling arrangement, Commercial has quota share, excess of loss and catastrophe agreements to protect itself against excessive exposure. The examiner reviewed all ceded reinsurance agreements effective during the examination period. All agreements contained the required standard clauses including insolvency clauses, meeting the requirements of Section 1308 of the New York Insurance Law.

A general outline of the reinsurance agreements in effect at December 31, 2006, is as follows:

Type of Contract	**Coverage**	**Cession**
Excess of loss	School Plans	5% of excess of $100,000 up to $250,000
Excess of loss	School Plans	85% of excess of $100,000 up to $250,000
Excess of loss	School Plans – Catastrophic	In excess of $100,000 per incident up to $3,000,000
Excess of loss	Accidental death and dismemberment	$900,000 excess of $100,000 per life
Quota Share	Long term disability	90% is automatically ceded to the reinsurer

E. Significant operating ratios

The underwriting ratios presented below are on an earned-incurred basis and encompass the period covered by this examination:

	Amounts	**Ratios**
Claims incurred	$ 86,856,345	62%
Commissions on premium	23,292,928	17%
General administrative expenses	29,629,308	21%
Net underwriting gain	279,610	0%
Premiums earned	$ 140,058,191	100%

F. Conflict of interest

Commercial's "Statement of Policy" regarding its principles established to avoid conflicts of interest detrimental to the Company and its policyholders states in part:

> *"The Company shall not contract or otherwise enter into any transaction with a director, officer or key employee, or a partnership or corporation in which a director, officer or key employee has directly or indirectly, a proprietary interest in excess of 5%, unless the interest of such director, officer or key employee is fully disclosed to the Board of Directors of the Company or its Executive Committee and thereafter such Board or Committee approves and authorizes the contract or transaction by a vote sufficient for the purpose without counting the vote of such interested person. All such actions by the Executive Committee shall be reported to the next meeting of the Board of Directors."*

A review of Commercial's conflict of interest statements revealed that three board members did have potential conflicts of interest. Although they were disclosed and reviewed by the Board of Directors, it was noted that no written documentation was maintained in the Board of Directors' minutes that such business relationships with the

three board members were approved or authorized by the Board of Directors of the Company or its Executive Committee.

It is recommended that the Company comply with its "Statement of Policy," and record any approvals or authorizations by the Board of Directors of the Company or its Executive Committee regarding any business relationships with a director, officer or key employee of Commercial within the Company's Board of Directors' minutes.

G. Internal controls

Effective internal controls are the foundation of safe and sound operation of an entity. A properly designed and consistently enforced system of operational and financial internal control helps an entity's Board of Directors and management safeguard the entity's resources, produce reliable financial reports, and comply with laws and regulations.

The following internal control weakness was identified:

- Premium checks are received by the Company's Employers Group Department on a daily basis. At times, these checks are stored in a small safe-box and deposited the next day. It was noted that the safe-box was located in an unsecured area, and on some days it may contain checks in excess of $10,000.

It is recommended that the Company safeguard the premiums checks received by the Company's Employers Group Department in a more secure environment.

4. FINANCIAL STATEMENTS

A. Balance sheet

The following shows the assets, liabilities, and capital and surplus as determined by this examination as of December 31, 2006. This statement is the same as the balance sheet filed by the Company.

Assets

Bonds	$ 15,232,017
Preferred stocks	500,000
Common stocks	6,105,038
Real estate – properties occupied by the company	286,322
Cash, cash equivalents and short-term investments	11,672,979
Investment income due and accrued	183,819
Uncollected premiums and agent's balance in the course of collection	(117,609)
Amounts recoverable from reinsurers	158,603
Amounts receivable relating to uninsured plans	46,076
Net deferred tax asset	945,259
Guaranty funds receivable or on deposit	25,379
Aggregated write-ins for other than invested assets	513,171
Total Assets	$ 35,551,054

Liabilities

Aggregate reserve for accident and health contracts	$ 15,793,475
Accident and health claims	6,151,865
Premium and annuity considerations for life and accident and health contracts received in advance less	209,614
Commissions to agents due or accrued – accident and health	285,384
General expenses due and accrued	604,603
Taxes, licenses and fees due or accrued, excluding federal income taxes	56,216
Amounts withheld or retained by company as agent or trustee	3,093
Remittances and items not allocated	11,764
Liability for benefits for employees and agents if not included above	460,334
Payable to parent, subsidiaries and affiliates	35,646
Aggregate write-ins for liabilities	22,203
Total liabilities	$ 23,634,198

Surplus

Unassigned funds	$ 11,916,856
Total surplus	11,916,856
Total liabilities and surplus	$ 35,551,054

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Company through tax year 2006. The examiner is unaware of any potential exposure of the Company to any tax assessments and no liability has been established herein relative to such contingency.

B. Underwriting and investment exhibit

Capital and surplus increased $6,608,200 during the period January 1, 2003 through December 31, 2006, detailed as follows:

Revenue		
Premiums	$ 140,058,191	
Net investment income	2,991,563	
Commissions and expense allowances on reinsurance ceded	(166,510)	
Miscellaneous	130,556	
Total Revenue		$ 143,013,800
Expenses		
Disability benefits and benefits under accident and health Contracts (including increase in aggregate reserves)	$86,856,345	
Commissions on premiums	12,432,151	
Commissions and expense allowances on reinsurance assumed	10,860,777	
General insurance expenses	26,813,127	
Insurance taxes, licenses and fees excluding federal income taxes	2,816,181	
Total Deductions		$ 139,778,581
Net income from operations before federal income taxes		3,235,219
Federal and foreign income taxes (tax benefit)		(371,222)
Net income from operations after federal income taxes		$ 3,606,441
Net realized capital gains		151,491
Net income		$ 3,757,932

Capital and surplus account

Capital and surplus per report on examination as of December 31, 2002			$ 5,308,660
	Gains in Surplus	Losses in Surplus	
Net income	$ 3,757,932		
Change in net unrealized capital gains (losses)	826,364		
Change in net unrealized foreign exchange capital gain (loss)		$ (1,803)	
Change in net deferred income tax		(1,254,970)	
Change in not-admitted assets	3,280,678		
Total gains and losses	$ 7,864,973	$ 1,256,773	
Net change in capital and surplus			6,608,200
Surplus as of December 31, 2006			$ 11,916,860

5. CLAIMS UNPAID

The examination liability of $21,945,340 is the same as that reported by the Company in its filed annual statement as of December 31, 2006.

The examination analysis of the unpaid claims reserve was conducted in accordance with generally accepted actuarial principles and practices, and was based on statistical information contained in the Company's internal records and in its filed annual statements as verified during the examination. Based upon such analysis, it was noted that the allocations of the total reserves and liabilities were not consistent with the usual actuarial practices. However, the discrepancies noted were not material enough to make an examination financial change. Descriptions of such discrepancies are as follows:

Reserves and liabilities for long term disability – incurred and unreported ("IBNR")

A review of the Company's claims unpaid revealed that Commercial's reserves and liabilities for direct claims (long term disability claims unpaid – incurred and unreported) were understated by approximately 50%, due to the Company's methodology of the development of its reserves and liabilities on long term disability – incurred and unreported. The Company's methodology is based on expected loss ratios at 65% along with an IBNR factor of 15%.

The Department's review of the Company's long term disability IBNR reserves and liabilities utilized a tabulation of the direct reported claims by month of disability and by qualifying period developed for the last six months of 2006. Such tabulation method tends to produce more reliable estimates than the methodology used by the Company.

It is recommended that the Company review its methodology relative to the loss ratio and the IBNR factor used in the Company's development of its long term disability IBNR reserves and liabilities. In this regard, it is recommended that the Company adopt a tabulation methodology relative to the establishment of its direct claims long term disability IBNR reserves and liabilities.

It was noted that the Company's reserves and liabilities for ceded claims (long term disability claims unpaid – incurred and unreported) were established at 45% of direct claims. The acceptable allocation should be at 90% of direct claims, since the Company cedes 90% of its long term disability plans.

It is recommended that the Company set its reserves and liabilities for ceded claims at 90% of direct claims (long term disability claims unpaid – incurred and unreported).

It was noted that the allocation of the total amounts of long term disability claims unpaid – (incurred and unreported) between reserves and liabilities by the Company was 60% to reserves and 40% to liabilities on the direct claims. On the ceded claims, the

allocation was 54% on reserves and 46% on liabilities. It is customary for actuaries to allocate 100% of long term disability direct and ceded claims to liabilities and 0% to reserves.

It is recommended that the Company allocate 100% of its total amount of long term disability claims unpaid (IBNR) to liabilities and 0% to reserves in future annual and quarterly statements to this Department.

Subsequent to the actuarial review portion of the examination, the Company indicated that the recommended allocations of long term disability claims unpaid between reserves and liabilities will appear on the annual statement on a going forward basis.

Reserves and liabilities for long term disability – present values of amounts not yet due

It was noted that the allocation of the total amounts of long term disability – (present values of amounts not yet due) between reserves and liabilities are 60% to reserves and 40% to liabilities on the direct claims. On the ceded claims, the allocation is 54% on reserves and 46% on liabilities. It is customary for actuaries to allocate 0% of these claims to liabilities and 100% to reserves.

It is recommended that, in the future, the Company allocate its total amount of long term disability – (present values of amounts not yet due) between reserves and liabilities for ceded and direct claims to 0% to liabilities and 100% to reserves, which is the general actuarial practice.

Subsequent to the actuarial review portion of the examination, the Company indicated that the recommended allocations between the reserves and liabilities will appear on the annual statement on a going forward basis.

Reserves and liabilities for short term disability

It was noted that the reserves and liabilities for short term disability established by the Company were understated by about 35%, due to its failure to include an estimate for incurred but not reported (IBNR) reserves and liabilities. In addition, the Company failed to properly allocate its short term reserves and liabilities to the appropriate components within such short term reserves and liabilities. Typically, 100% of its total IBNR claims in course of settlement and claims due and unpaid are classified as liabilities, while 100% of the present value of the amounts not yet due are classified as reserves. The above is the general practice of actuaries.

It is recommended that, in the future, Commercial establish appropriate IBNR reserves and liabilities for short term disability claims. Furthermore, it is recommended that the Company review its allocation methodology relative to the components of short term disability reserves and liabilities.

Subsequent to the actuarial review portion of the examination, Commercial developed a method to establish its reserves and liabilities for short term disability. Commercial also stated that the recommended allocation between the reserves and liabilities will appear on the annual statement on a going forward basis.

6. MARKET CONDUCT

In the course of this examination, a review was made of the manner in which the Company conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the generally more precise scope of a market conduct investigation.

The general review was directed at practices of the Company in the following major areas:

A. Claims processing
B. Claims prompt payment
C. Explanation of benefits
D. Claims adjustment expenses
E. Sales and advertising

A. Claims processing

A review of the Company's claims practices and procedures was performed by using a statistical sample covering claims adjudicated during the period of January 1, 2006 through December 31, 2006, in order to evaluate the overall accuracy and compliance environment of its claims processing. The examiner selected a sample of 167 claims for review.

This statistical random sampling process, which was performed using the computer software program ACL, was utilized to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually or on a combined basis. For example, if ten attributes were being tested, conclusions about each attribute individually, or on a collective basis, could be concluded for each item in the sample.

For the purpose of this report, a "claim" as defined by the Company is the total number of bills submitted by all providers for an insured's injury or sickness. This claim may consist of various lines, procedures or service dates. 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 Commercial for the period January 1, 2006 through December 31, 2006, and included in its annual statement filed with the Department for calendar year 2006.

The examination review revealed that the overall claims processing financial accuracy level was 92.81% and the overall claims processing procedural accuracy level was 81.44%. 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 was processed in accordance with Commercial's claim processing guidelines and/or New York Insurance Laws and Regulations. An error in processing accuracy may or may not affect the financial accuracy. However, a financial error is caused by a

procedural error and as such, it is counted both as a financial error and a procedural error. In summary, of the 167 claims reviewed, there were 12 financial errors and 31 procedural errors.

The following represents various errors noted by the examiners:

- In one instance, the Company failed to pay the Health Care Reform Act (HCRA) surcharge.
- Commercial issued payments without proper approval or authorization by a unit manager for "high dollar" claims (payments over $2,000). The Company is in violation of its claims payment policy.
- It was noted that several claims had an incorrect received date.
- In some instances, the Company requested additional information when all the information to process the claim was available.
- The Company's policy is to process a claim only after receipt of Explanation of Benefit from a primary insurer, when Commercial is a secondary insurer. However, it was noted that the Company processed and paid several claims without receipt of an EOB from the primary insurer.
- A system error was noted in that claims were not sequentially numbered.
- On several claims, there was no indication in the system that a deductible had been taken.

It is recommended that Commercial take proactive steps to identify and correct errors that may be occurring on an ongoing basis and that Commercial address the causes of the errors.

The following tables summarize the claims processing errors:

Summary of Financial Accuracy

Population	24,785
Sample Size	167
Number of claims with errors	12
Calculated Error Rate	7.19%
Calculated Accuracy Rate	92.81%
Upper error limit	11.10%
Lower error limit	3.27%
Upper limit claims in error	2,752
Lower limit claims in error	810

Note: The upper and lower error limits represent the range of potential error (e.g. if 100 sample items were selected the rate of error would fall between these limits 95 times.)

Summary of Procedural Accuracy

Population	24,785
Sample Size	167
Number of claims with errors	31
Calculated Error Rate	18.56%
Calculated Accuracy Rate	81.44%
Upper error limit	24.46%
Lower error limit	12.67%
Upper limit claims in error	6,062
Lower limit claims in error	3,139

Note: The upper and lower error limits represent the range of potential error (e.g. if 100 sample items were selected the rate of error would fall between these limits 95 times.)

B. Claims prompt payment

§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" ("Prompt Pay"), requires all insurers to pay undisputed claims within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

§ 3224-a(a) of the New York Insurance Law states,

> *"Except in a case where the obligation of an insurer… to pay a claim submitted by a policyholder or person covered under such policy 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 forty-five days of receipt of a claim or bill for services rendered."*

§3224-a(b) of the New York Insurance Law states,

> *"In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to …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 pursuant to article forty-three of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section."*

The examination included statistical samples for Commercial to determine whether or not interest was appropriately paid pursuant to §3224-a(c) of the New York Insurance Law to those claimants not receiving payment or denials within the timeframes required by §3224-a(a) and (b) of the New York Insurance Law. Accordingly, all claims that were not paid within 45 days during the period, January 1, 2006 through December 31, 2006 were segregated from the population. During this 12 month period 5,819 claims were paid more than 45 days after the date of receipt. A statistical sample of this population was then selected to determine whether the claims paid were in accordance with §3224-a of the New York Insurance Law.

The following charts illustrate the Plan's non-compliance with New York Insurance Law §3224-a, as determined by this examination.

New York Insurance Law §3224-a(a)

	Commercial Travelers Mutual Insurance Company
Total Population	24,785
Eligible Population	5,819
Sample Size	167
Part (a) violations	10
Calculated Error Rate	5.99%
Upper Error Limit	**9.59%**
Lower Error Limit	**2.39%**
Upper Limit Claims in Error	**558**
Lower Limit Claims in Error	**139**

New York Insurance Law §3224-a(b)

	Commercial Travelers Mutual Insurance Company
Total Population	24,785
Eligible Population	5,819
Sample Size	167
Part (b) violations	17
Calculated Error Rate	10.18%
Upper Error Limit	**14.77%**
Lower Error Limit	**5.59%**
Upper Limit Claims in Error	**859**
Lower Limit Claims in Error	**325**

It is recommended that the Company improve its internal claim procedures to ensure full compliance with Section 3224-a (a) and (b) of the New York Insurance Law. A similar recommendation was made in the prior report on examination.

C. Explanation of benefits

As part of the review of the Company's claims practices and procedures, an analysis of the explanation of benefits statements (“EOB”) sent to subscribers and/or providers by the Company was performed. An EOB is an important link between the subscriber, the provider, and the Company. It should clearly communicate to the subscriber and/or provider that the Company has processed a claim and how that claim was processed. It should clearly describe the charges submitted, the date the claim was received, the amount allowed for the services rendered, and show any balance owed to the provider. It should also serve as the documentation to recover any money from coordination of benefits with other carriers.

The sample selected for analyzing EOBs was the same as used for the claims processing review noted in 6A above.

§3234(b)(5) of the New York Insurance Law states:

"(b) The explanation of benefits form must include at least the following:

(5) The amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed."

It was noted that several explanation of benefits issued by the Company contained inaccurate and insufficient information. Details of these inconsistencies are as follows:

- Many of the EOBS reviewed contained inaccurate amounts in the "discount" and "allowable charges" column, primarily when Commercial is the secondary insurer.
- Several EOBs did not explain the difference between the fee charged and the allowable charges, while other EOBs had explanations.
- Denial code 091, which states "This expense does not appear to be related to the accident or injury," was frequently used as an explanation for denial of a claim. This is ambiguous and does not fully explain the subscriber's responsibility.

It is recommended that the Company comply with the requirements of §3234(b)(5) of the New York Insurance Law to ensure its explanation of benefits are consistent, complete and accurately describe all reductions from the billed amounts and the subscribers responsibilities. A similar recommendation was made in the prior report on examination.

D. Claim adjustment expenses

Claim numbers were assigned to bills received from the Company's third party claims administrators, Multiplan, Medavant and Beechstreet for their services. The services were reported as claim expenses in the general ledger and annual statement. These expenses should be treated as claim adjustment expenses, instead of being treated as claims expenses.

It is recommended that the Company discontinue the practice of assigning a claim number to third party administrative fee invoices. Such fees should be reported as claim adjustment expenses.

E. Sales and advertising

A review was made of the Company's sales and advertising activity to appraise the representations made to the public and to determine compliance with the requirements of Department Regulation 34 (11 NYCRR 215). No unfair practices were noted.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination contained fourteen (14) comments and recommendations as follows (page numbers refer to the prior report):

ITEM		PAGE NO.
A.	It is recommended that the Company amend its by-laws or add another director to the Executive Committee, in order to comply with the requirement of Article VI, Section 1 of the Company's by-laws. The Company has complied with this recommendation.	5
B.	It is recommended that members of the Finance Committee who are unable to attend at least 50% of its meetings should resign or be removed from the Committee by the Board of Directors. The Company should take into consideration the attendance of its directors at sub-committee meetings, when electing directors to serve on sub-committees. The Company has complied with this recommendation.	6
C.	It is recommended that, in the future, the Company maintain written and signed reinsurance agreements pertaining to its reinsurance business. The Company has complied with this recommendation.	10
D.	It is recommended that the custodian agreements between the Company and HSBC Bank be revised to include all of the protective covenants and provisions outlined, in order to meet the minimum custodial guidelines established by the New York State Insurance Department for the contents of such agreements. The Company has complied with this recommendation.	15
E.	It is recommended that the Company comply with the requirements of Section 4209(c) of the New York Insurance Law and include a clear statement in its policies as to whether or not the holder of such policy is subject to a liability for assessment. The Company has complied with this recommendation.	21

F. It is recommended that the Company comply with the requirement of Section 3201(b)(1) of the New York Insurance Law and submit the two endorsements of mandated benefits to the New York Insurance Department for approval. It is further recommended that the Company, in the future, submit all endorsements to the Department for approval prior to the issuance of such endorsements. 22

The Company has complied with this recommendation.

G. It is recommended that the Company establish a claims processing manual and appropriately train all persons responsible for the supervision, processing and settlement of claims. 24

The Company has complied with this recommendation.

H. It is recommended that the Company comply with New York Insurance Department Regulation No. 64 (11 NYCRR 216.0(e)(6)) and distribute a copy of Regulation No. 64 to every person directly responsible for the supervision, handling and settlement of claims subject to such regulation. It is further recommended that the Company satisfy itself that all such personnel are thoroughly conversant with, and are complying with Regulation No. 64. 24

The Company has complied with this recommendation.

I. It is recommended that the Company adopt procedures to separate properly the duties of its claim department personnel. 25

The Company has complied with this recommendation.

J. It is recommended that the Company establish appropriate guidelines and procedures, including the definition of reported charges, for its claims examiners to follow relative to the entry of claims data into the Company's claims system. 26

The Company has complied with this recommendation.

K. It is recommended that the Company adopt procedures to complete the adjudication of all claims, within 12 months from the date the claim is received, except in certain situations where additional time is warranted. 27

It is recommended that the Company deny claims for which information necessary to process the claim was requested, but not

received, and issue an EOB to the subscriber in compliance with Section 3234 of the New York Insurance Law.

The Company has complied with this recommendation.

L. It is recommended that the Company discontinue the practice of administrative deletion for duplicate claims. It is recommended that the Company enter the duplicate claims data into its claims system and properly deny such duplicate claims. 27

The Company has complied with this recommendation.

M. It is recommended that the Company issue EOBs that include all of the requisite information required by Section 3234(a) and (b) of the New York Insurance Law. Accordingly, subscribers will be properly informed of their appeal rights and how their claims are processed. 29

A similar recommendation is contained in this report.

N. It is recommended that the Company improve its internal claim processing procedures in order to ensure full compliance with Subsections 3224-a(a), (b) and (c) of the New York Insurance Law. 32

A similar recommendation is contained in this report.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
	Conflict of interest	
A.	It is recommended that the Company comply with its "Statement of Policy" and record any approvals or authorizations by the Board of Directors of the Company or its Executive Committee regarding any business relationships with a director, officer or key employee of Commercial within the Company's board of directors' minutes.	13
	Internal controls	
B.	It is recommended that the Company safeguard the premiums checks received by the Company's Employers Group Department in a more secure environment.	13
	Claims unpaid	
C.	It is recommended that the Company review its methodology relative to the loss ratio and the IBNR factor used in the Company's establishment of its long term disability IBNR reserves and liabilities. In this regard, it is recommended that the Company adopt a tabulation methodology relative to the establishment of its direct claims long term disability IBNR reserves and liabilities.	18
	It is recommended that the Company set its reserves and liabilities for ceded claims at 90% of direct claims (long term disability claims unpaid – incurred and unreported).	18
	It is recommended that the Company allocate 100% of its total amount of long term disability claims unpaid (IBNR) to liabilities and 0% to reserves in future annual and quarterly statements to this Department.	19

Appointment No. ***22618***

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **Eric R. Dinallo** , Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Roy Zabala
as a proper person to examine into the affairs of the

Commercial Travelers Mutual Insurance Company

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

Company

with such information as he shall deem requisite.

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

this 1st day of May 2007

Eric R. Dinallo
Superintendent of Insurance