Arizona Department of Insurance

Department's process to prioritize fraud referrals for investigation lacks important components and practices for managing conflicts of interest increase risk of nondisclosure

Performance Audit and Sunset Review

September 2019
Report 19-110

A Report to the Arizona Legislature

Lindsey A. Perry
Auditor General

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Audit Staff

Dale Chapman, Director
Rosa Ellis, Manager

Amir Mach, Team Leader
Gina Alvarado
Jennifer Dagna
James Danielson
Liam VanPelt

Contact Information

Arizona Office of the Auditor General
2910 N. 44th St., Ste. 410
Phoenix, AZ 85018-7271

(602) 553-0333

contact@azauditor.gov

www.azauditor.gov

MELANIE M. CHESNEY
DEPUTY AUDITOR GENERAL

ARIZONA AUDITOR GENERAL
LINDSEY A. PERRY

JOSEPH D. MOORE
DEPUTY AUDITOR GENERAL

September 19, 2019

Members of the Arizona Legislature

The Honorable Doug Ducey, Governor

Mr. Keith Schraad, Director
Arizona Department of Insurance

Transmitted herewith is the Auditor General's report, *A Performance Audit and Sunset Review of the Arizona Department of Insurance*. This report is in response to a September 14, 2016, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes §41-2951 et seq. I am also transmitting within this report a copy of the Report Highlights to provide a quick summary for your convenience.

As outlined in its response, the Arizona Department of Insurance agrees with all of the findings and plans to implement or implement in a different manner all of the recommendations.

My staff and I will be pleased to discuss or clarify items in the report.

Sincerely,

Lindsey Perry, CPA, CFE
Auditor General


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Performance Audit and Sunset Review
Report Highlights
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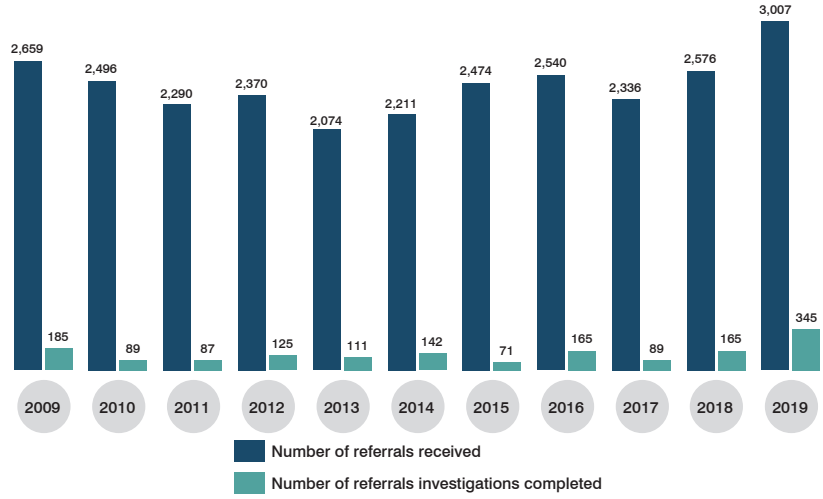
Arizona Department of Insurance

CONCLUSION: The Arizona Department of Insurance (Department) regulates and monitors insurance companies and professionals operating in Arizona to protect the public and help ensure that these entities comply with State and federal laws. Key Department functions include licensing qualified insurance professionals and companies, investigating consumer complaints and suspected fraud, overseeing insurance companies' financial solvency, and reviewing insurance policies, rates, and products to protect the public from excessive, inadequate, or unfairly discriminatory rates. According to Department data, as of July 2019, there were 1,691 insurance companies licensed to operate in Arizona. We found that the Department's fraud-referral prioritization process lacks components to ensure it investigates high-priority referrals. Additionally, we identified deficiencies with the Department's conflict-of-interest process. Finally, the Department should improve its management and administration of long-term care insurance rate reviews and information technology (IT) security.

Department's new fraud-referral prioritization process lacks components to ensure it investigates high-priority referrals

Investigating insurance fraud is critical for identifying and convicting wrongdoers, obtaining restitution, and helping to deter future fraud. The Department investigates suspected cases of insurance fraud against insurance companies referred by these companies. According to Department data, in fiscal year 2019, it received more than 3,000 fraud referrals and completed 345 investigations using its 6 investigators. Similar to other states, the Department does not investigate all of the fraud referrals it receives. For those referrals it does not investigate, the Department either closes the referral because it lacks merit or closes the referral and sends a notice to the insurance company indicating that the referral has merit but is determined to be a lower priority and cannot be investigated at that time due to a lack of investigative resources.

Number of insurance fraud referrals received and number of referral investigations completed



In August 2018, the Department began piloting a new prioritization process to ensure it effectively uses its investigative resources on high-priority referrals. However, the Department's prioritization process lacks important components to help ensure its effectiveness. For example, we found that other states we contacted require insurance companies' fraud referrals to include specific, standardized information to help ensure that these states have complete and accurate information to inform their prioritization efforts and focus on high-priority fraud referrals. These other states also use fraud referral data to identify fraud trends and then use this information to assist with prioritization efforts. Finally, we found that the Department has not established a risk-based supervisory review process to help ensure referrals are correctly prioritized and has yet to evaluate whether its new prioritization process effectively focuses the Department's investigative resources on high-priority fraud referrals.

Recommendations

The Department should:

- Take several steps to strengthen its fraud-referral prioritization process, including developing and implementing a fraud referral template, a process for using available fraud referral data to help identify fraud trends and prioritize fraud referrals, and a risk-based supervisory process; and then evaluate the effectiveness of this process and determine and implement any changes needed to continue to improve its prioritization process.
- Once it has taken these actions, assess its fraud investigative staffing needs to help ensure it investigates all of the high-priority fraud referrals it receives.

Department's practices for managing conflicts of interest increases risk of nondisclosure

Arizona law requires public officers and employees to avoid conflicts of interest that might influence or affect their official conduct and outlines several requirements for doing so. We found that the Department lacks a formal conflict-of-interest policy, did not require its employees or members of the boards it supports to annually disclose interests, and uses a disclosure form that did not address all required conflict-of-interest components. During the audit, the Department directed all employees to complete a conflict-of-interest disclosure form by March 1, 2019. However, as of April 2019, only 43 of its then 72.5 filled FTEs had completed a disclosure form that was available in the Department's special disclosure file, as required by statute.

Recommendation

The Department should develop and implement conflict-of-interest policies that require its employees and board members to annually complete disclosure forms, define a process for managing disclosed conflicts, and ensure that disclosure forms are maintained in a special disclosure file for public inspection.

Other Department improvements needed

As reported in the Sunset Factors section, we identified additional areas where the Department should improve. These include the following:

Reviewing long-term care insurance rates in a timely manner—The Department is statutorily responsible for approving long-term care insurance rates before they go into effect. However, the Department does not review long-term care insurance rates in a timely manner and lacks a formal process for notifying insurance companies when the review time frame will not be met. Absent a formal process, the Department is at risk for not notifying insurance companies, and thereby, not extending its review time frame, which could result in rate filings being automatically deemed approved.

Complying with Arizona Strategic Enterprise Technology (ASET) requirements, conducting IT risk assessments, and documenting IT services and support—Arizona State agencies are required to develop IT security-specific policies and procedures consistent with ASET's State-wide policies. The Department has begun drafting policies for 9 ASET-required areas; however, it has not yet finalized these draft policies or developed detailed procedures to implement these policies. Additionally, the Department has not conducted a formal IT risk assessment to identify IT system risks, such as weak security practices or outdated systems, which is recommended by credible industry standards. Finally, although the Department has an interagency service agreement with ASET to obtain IT security services and support, it does not have assurance that the services it expects to obtain from ASET are being provided.

Recommendations

The Department should:

- Research an appropriate time frame and then provide information to the Legislature regarding the need to revise the statutory time frame for reviewing long-term care insurance rates and establish and implement a formal process for notifying insurance companies to waive the time frame requirement.
- Conduct a risk assessment to evaluate, document, and prioritize the areas in the Department's IT systems with the highest security risks; use the results of its risk assessment to guide its efforts to develop and implement all required IT security program policies and procedures; train its employees on these policies and procedures; and work with ASET to define and document the scope of IT security services provided by ASET.

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INTRODUCTION

The Office of the Auditor General has completed a performance audit and sunset review of the Arizona Department of Insurance (Department). This report addresses the Department's process for prioritizing referrals of suspected insurance fraud it receives from insurance companies for further investigation, its practices for managing conflicts of interest, and provides responses to the statutory sunset factors.

History and mission

The State Constitution established the regulation of insurance within the Arizona Corporation Commission in 1912. The Department was established as a separate State agency by a constitutional amendment in 1968 to regulate and monitor insurance companies and professionals operating in Arizona to protect the public and help ensure that these entities follow State and federal laws. Its mission is to protect Arizona citizens and businesses by promoting a safe, strong, innovative, and competitive insurance marketplace. Laws 2019, Ch. 252, §1, consolidated the Arizona Department of Financial Institutions and the Automobile Theft Authority as divisions within the Department. The Department was also renamed the Arizona Department of Insurance and Financial Institutions, effective July 1, 2020.

Key terms

Claim—A request made to an insurer to pay for a loss that is covered under an insurance policy.

Claims adjuster—A person who is paid to adjust, investigate, or negotiate insurance claims.

Domicile—The state where an insurance company was incorporated or formed.

Policy—A contract between an insurance company and the policyholder regarding insurance coverage.

Premium—Money charged for insurance coverage.

Producer—A licensed person who sells, solicits, or negotiates insurance policies.

Rate—The amount of money the insurance company determines is necessary to cover the cost of insurance, including projected losses, hazards, expenses, and profit to the insurance company.

Source: Auditor General staff review of Arizona Revised Statutes (A.R.S.) Title 20, Department-provided information, and National Association of Insurance Commissioners (NAIC). (n.d.) *Glossary of insurance terms*. Washington, DC. Retrieved 5/22/2019 from www.naic.org/consumer_glossary.htm.

Department responsible for regulating insurance companies and professionals

Federal law requires states to regulate insurance, and the National Association of Insurance Commissioners (NAIC)—in partnership with state insurance regulatory agencies—has established regulatory standards and model regulations.[1] Because some insurance companies and professionals operate in multiple states, the NAIC's standards guide the consistent regulation of the insurance industry across the country. Specifically, the Department—similar to other states—uses the following standards and methods to regulate insurance companies operating in the State:

- **Financial solvency standards are used to monitor the financial conditions of insurance companies—** The NAIC provides a Financial Analysis Handbook and a Financial Condition Examiners Handbook that the Department uses for guidance to monitor insurance companies' financial health. For example, the Financial

[1] The NAIC is a standard-setting and regulatory support professional organization created and governed by insurance regulators from the 50 states, the District of Columbia, and 5 U.S. territories.

Analysis Handbook directs Department analysts to review insurance companies' Financial Profile Reports, which provide short summaries of insurance companies' quarterly or annual financial statements.

- **Market conduct standards are used to monitor insurance companies' compliance with various regulatory requirements—**The NAIC provides a Product Filing Review Handbook that the Department uses for guidance to ensure that appropriately priced, compliant insurance rates and policies are available to consumers. Additionally, Department staff reported using NAIC guidance to conduct Market Conduct Examinations, which involve audits of information, such as historical claims payments and rate calculations used to determine premiums, to decide if insurance companies need to take any corrective action to comply with federal and State insurance laws.

- **Uniform reciprocal licensing—**The National Insurance Producer Registry (NIPR), an independent, nonprofit affiliate of the NAIC, established an electronic national repository system that receives data from all 50 states, the District of Columbia, and Puerto Rico to streamline the licensing process for insurance professionals. Applicants use the NIPR system to apply for reciprocal licensure in any state and pay any required, state-specific licensing fees. The Department—similar to other states—receives notification through the system when a license application is complete and the fee has been paid. The Department then processes the application. In fiscal year 2018, approximately 258,000 insurance producers were licensed to operate in Arizona.

According to Department data, as of July 2019, 1,691 insurance companies were licensed to operate in Arizona. In calendar year 2018, insurance companies collected approximately $34 billion in total premiums from Arizona policyholders. Additionally, the insurance industry offers several types of insurance that have various compliance standards or requirements that the Department must regulate (see textbox for examples of the types of insurance that the Department regulates).

The NAIC has also established accreditation standards for state insurance regulatory agencies, and as of April 2019, all 50 states, the District of Columbia, and Puerto Rico's insurance regulatory agencies were accredited NAIC members. The purpose of the NAIC accreditation process is to promote regulatory uniformity between states by creating minimum regulatory standards for insurance. This national accreditation process is designed to allow state insurance regulatory agencies to rely on one another's licensing of insurance professionals, and licensing and financial solvency monitoring of insurance companies to ensure they are operating legally and appropriately. During an accreditation review, the NAIC assesses the performance of the Department's financial analysis and financial examination functions and the Department's licensure of insurance companies. The Department was reaccredited for 5 years by the NAIC in April 2019.

Example insurance types

Long-term care insurance—Insurance that covers therapeutic, rehabilitative, or custodial care services, including services for chronically ill individuals or those with severe cognitive impairment provided in a setting other than an acute care unit of a hospital.

Property insurance—Insurance that covers personal property against damage or loss from any or all hazard or cause.

Vehicle insurance—Insurance that covers a land vehicle or aircraft against damage or loss from any hazard or cause, and against any loss, liability, or expense resulting from ownership, maintenance, or use—together with accidental injury or accidental death insurance—while in, entering, alighting from, adjusting, repairing, cranking, or caused by being struck by a vehicle or aircraft.

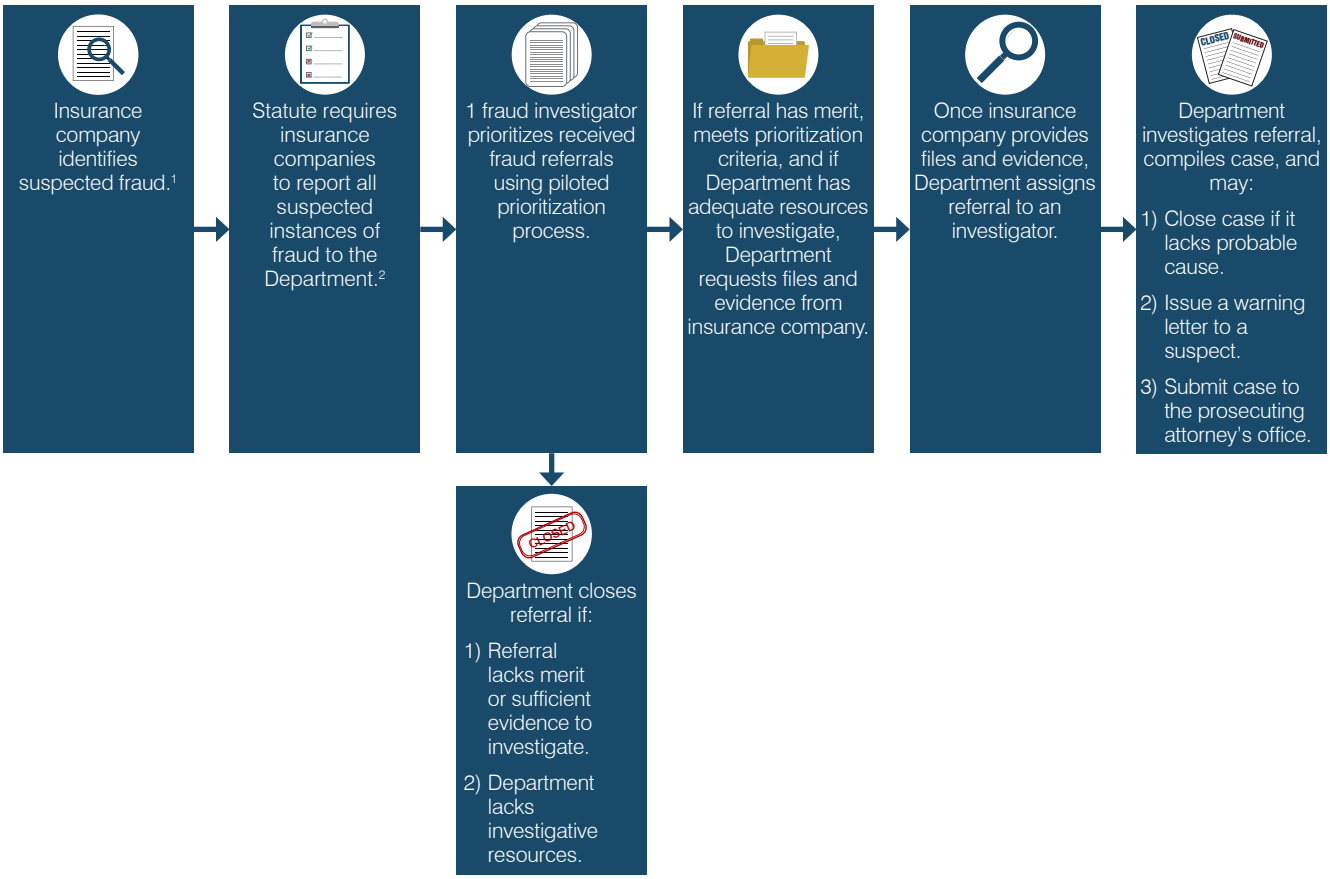
Workers' compensation insurance—Insurance that covers an employer's liability for injuries, disability, or death to persons in their employment, without regard to fault and prescribed by state or federal laws.

Source: Auditor General staff review of A.R.S. §§20-1691, 20-256, 20-259, and NAIC, n.d.

Department responsible for investigating suspected instances of insurance fraud

The Department receives reports of suspected instances of insurance fraud from insurance companies, known as referrals.[2] The Department is statutorily responsible for determining which fraud referrals warrant further investigation and, as of August 2018, began piloting a process to prioritize referrals for investigation based on the monetary impact and the number of people potentially impacted by the suspected fraud.[3] Figure 1 shows the Department's pilot process for receiving, prioritizing, assigning, and investigating prioritized referrals. According to Department data, in fiscal year 2019, it received more than 3,000 fraud referrals, completed 345 investigations, and submitted 221 cases to the Attorney General or county attorneys for prosecution, who obtained convictions or civil judgements in 14 of these cases.[4] See Finding 1 (pages 7 through 12) for more information on the number of fraud referrals the Department investigates, the disposition of fraud referrals it does not investigate, and our findings and recommendations related to the Department's fraud-referral prioritization process.

Figure 1
Department's suspected fraud referral receipt, prioritization, and investigation process



[1] Insurance companies can identify instances of suspected fraud through internal investigations, which may include claims reviews, obtaining photo or video evidence, and reviewing law enforcement reports.

[2] See A.R.S. §20-466(G).

Source: Auditor General staff review of A.R.S. §20-466, interviews and observations with Department staff, and review of Department procedures.

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[2] The Department also receives and processes fraud-related complaints from the public and may refer these complaints to its insurance fraud division for further investigation, if necessary.

[3] See A.R.S. §20-466(G).

[4] Referral investigations were not always completed in the same fiscal year that the referral was received because referrals can be received at any point during the fiscal year and fraud investigations take time to complete.

Organization, staffing, and key responsibilities

As shown in Table 1, Department staff are organized into several divisions with various responsibilities. According to Department data, as of August 2019, the Department had 70.5 filled full-time equivalent (FTE) positions and 10 vacant FTEs.

Table 1
Department divisions, filled and vacant FTEs, and key responsibilities
As of August 2019

Division	Filled FTEs	Vacant FTEs	Key responsibilities
Financial Affairs	19.5	1	Licenses and oversees the financial solvency of insurance companies that are domiciled in Arizona, using NAIC standards. This includes examining insurance companies' financial statements and reviewing and approving license applications submitted by insurance companies.
Consumer Protection	17	2	Licenses qualified insurance professionals and investigates consumer complaints about insurance companies and licensed individuals. See Sunset Factor 6, pages 23 through 24, for more information about the Department's complaint-handling process.
Insurance Fraud	7	2	Coordinates with law enforcement agencies and State and federal attorneys to investigate and prosecute insurance fraud. In fiscal year 2019, the Department received 3,007 referrals of suspected insurance fraud and completed 345 investigations. See Finding 1, pages 7 through 12, for our findings and recommendations related to the Department's process for prioritizing insurance fraud referrals.
Market Oversight	14	0	Monitors insurance companies licensed to operate in Arizona by completing Market Conduct Examinations using NAIC standards, evaluating insurance policies, and reviewing and approving certain types of insurance rates, such as long-term care insurance and workers' compensation insurance, to help ensure that the policies and rates comply with the statutory requirements that they are not excessive, inadequate, or unfairly discriminatory. See Sunset Factor 2, pages 18 through 19 and 21, for our findings and recommendations related to the Department's long-term care insurance rate review process.
Office of the Insurance Guaranty Funds	2	2	Oversees and administers 2 insurance guaranty funds that are responsible for processing and paying policyholders' claims when their insurance company becomes insolvent and cannot cover claims.[1] Each fund is managed by a Department-supported board (see page 5 for a description of these funds' advisory boards). See Sunset Factor 2, pages 20 through 21, for our findings and recommendations related to the guaranty funds.
Administrative Services	6	3	Provides the resources necessary for the Department to perform its duties, including accounting, procurement, human resources, IT support, and facilitating insurance companies' remittances of insurance premium taxes (see Table 2, page 6, for more information about premium taxes). See Sunset Factor 2, pages 20 through 22, for our findings and recommendations related to the Department's IT security program and related policies and procedures.
Office of the Director	5	0	Provides leadership, establishes Department policies and procedures, and supports the Department in protecting Arizona citizens and businesses by developing, recommending, implementing, and enforcing insurance-related legislation and rules, and managing insolvent insurance companies that have gone into receivership.

[1] The Workers' Compensation Special Fund (Fund) was created in 1969 with the purpose of providing workers' compensation benefits to uninsured claimants, partial coverage to second injury claims, vocational rehabilitation benefits, and benefits to claimants of insolvent insurance companies. Laws 2014, Ch. 186, effective July 2015, transferred the Fund from the Arizona Industrial Commission to the Department, renamed it the Workers' Compensation Insurance Account within the Arizona Property and Casualty Insurance Guaranty Fund, and transferred the responsibility of paying eligible workers' compensation claims for insolvent insurance companies to the Arizona Property and Casualty Insurance Guaranty Fund.

Source: Auditor General staff review of statute, Department information, and NAIC information.

Boards and committees established within Department

Statute has established the following boards and committees within the Department:[5]

- **Arizona Life and Disability Insurance Guaranty Fund Board and the Arizona Property and Casualty Insurance Guaranty Fund Board—**These 2 boards are responsible for overseeing the State's 2 insurance guaranty funds, which pay policyholders' claims if their insurance company becomes insolvent and cannot pay claims.[6] The Arizona Life and Disability Insurance Guaranty Fund pays eligible claims on disability, life, and annuity insurance policies, and the Arizona Property and Casualty Insurance Guaranty Fund pays eligible claims on automobile, workers' compensation, and homeowners' insurance policies. The boards associated with these funds are responsible for (1) verifying that an insolvent insurance company is a member insurer of the guaranty fund; (2) verifying that the claimants affected by the insolvency are Arizona residents who hold a valid policy with the insolvent insurance company; (3) estimating whether the fund can cover the liabilities owed as a result of the insolvency; and (4) levying assessments on solvent member insurance companies, as necessary, to pay claims of the insolvent companies.

- **Arizona Workers' Compensation Appeals Board—**This board is responsible for hearing appeals from individuals and employers claiming that an insurance company's rating system was not correctly applied to the employer by the insurance company. An insurance company's rating system comprises classification codes that specify categories of work and the employer's claims history, as compared to similar businesses. Employers and individuals may appeal to the Board if they dispute the classification codes or claims history comparison applied by the insurance company.

- **Insurance Consumer Advisory Board—**Although this board was intended to provide advice and counsel to the director on matters relating to certain types of insurance, such as commercial property and casualty insurance, the Department reported that it never established this board despite being required to do so since 1987. See Sunset Factor 2, pages 19 and 21, for our finding and recommendation regarding the Insurance Consumer Advisory Board.

- **Continuing Education Review Committee—**The NAIC sets the standards for continuing education hours for licensed insurance professionals, and state insurance regulatory agencies are responsible for reviewing and approving the continuing education credit hours submitted by insurance professionals operating in their state. Although this Committee is responsible for establishing minimum performance standards for continuing education providers and approved courses used by insurance professionals operating in Arizona, it has not met since 2005. See Sunset Factor 2, pages 19 and 21, for our finding and recommendation regarding the Continuing Education Review Committee.

Revenues and expenditures

As shown in Table 2 on page 6, the Department receives State General Fund appropriations and collects revenue from insurance premium taxes, license fees, examination fees, filing fees, other charges for goods and services, and penalties. The insurance premium tax is a tax on the premiums collected by insurance companies and entities that the Arizona Health Care Cost Containment System (AHCCCS) contracts with to provide Medicaid services. In fiscal year 2019, the Department collected nearly $600 million in premium taxes from insurance companies and AHCCCS contractors, most of which it remitted to the State General Fund, as required by statute. The Department's expenditures include payroll and related benefits, professional and outside services, travel, other operating costs, and equipment.

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[5] Statute also established the Uniform Employee Health Status Questionnaire Committee (Committee), which was responsible for developing a questionnaire to simplify the insurance application process for small groups required by accountable health plans to complete questionnaires about their health history when applying for health insurance. The Committee completed the required questionnaire, and the Department reported it has not needed to convene the Committee since that time.

[6] The monies in the Arizona Life and Disability Insurance Guaranty Fund and the Arizona Property and Casualty Insurance Guaranty Fund come from the insolvent insurance companies' assets; assessments paid by insurance companies that write life, disability, annuity, property, and casualty insurance in Arizona; and investment income. The State is not responsible for liabilities associated with the guaranty funds if the annual assessments do not cover these liabilities in a given year.

Table 2
Schedule of revenues, expenditures, and changes in fund balance[1]
Fiscal years 2017 through 2019
(Unaudited)

	2017 (Actual)	2018 (Actual)	2019 (Actual)
Revenues			
Insurance premium taxes[2]	$550,907,738	$552,834,429	$596,654,797
Licensing and related fees	12,877,150	13,985,356	14,501,204
State General Fund appropriations	5,104,933	5,475,582	5,100,969
Examination fees, filing fees, and other charges for goods and services	4,018,154	2,817,167	2,982,180
Fines, forfeits, and penalties	1,204,419	756,655	296,921
Reimbursements[3]	513,223	493,721	494,767
Federal grants	208,549	149,431	68,935
Other	7,846	66,557	69,637
Total gross revenues	574,842,012	576,578,898	620,169,410
Credit card fees	(8,990)	(11,361)	(2,175)
Remittances to the State General Fund[4]	(529,981,654)	(526,387,751)	(567,148,682)
Total net revenues	**44,851,368**	**50,179,786**	**53,018,553**
Expenditures and transfers			
Payroll and related benefits	6,014,926	6,155,315	6,138,544
Professional and outside services	3,376,670	2,257,311	2,339,883
Travel	60,341	56,314	54,457
Other operating	976,749	857,510	830,191
Furniture, equipment, and software	48,161	68,518	56,795
Total expenditures	10,476,847	9,394,968	9,419,870
Transfers to the State General Fund[5]	391,299	347,549	311,727
Transfers to other State agencies[6]	2,600	208,688	24,892
Transfers to the Firefighters' Relief and Pension Fund and Public Safety Personnel Retirement System[7]	37,429,207	40,399,551	43,757,419
Total expenditures and transfers	**48,299,953**	**50,350,756**	**53,513,908**
Net change in fund balance	(3,448,585)	(170,970)	(495,355)
Fund balance, beginning of year	6,099,718	2,651,133	2,480,163
Fund balance, end of year	**$2,651,133**	**$2,480,163**	**$1,984,808**

1 The table includes only the financial activity of the Arizona Property and Casualty Insurance Guaranty Fund and the Arizona Life and Disability Insurance Guaranty Fund pertaining to the administration of those programs. The assets the State holds on behalf of others for these funds are not included. As of December 31, 2018, these funds had ending fund balances of approximately $220 million and $20 million, respectively.

2 Insurance premium taxes are paid by insurers on net premiums and AHCCCS contractors based on rates charged for medical services provided to AHCCCS-eligible patients, including long-term care, as required by A.R.S. §§20-224, 20-224.01, 36-2905, and 36-2944.01. The taxes are intended to help defray the cost of State government and to lessen the tax burden upon tangible property. As indicated in footnotes 4 and 7, these taxes are remitted to the State General Fund, the Firefighters' Relief and Pension Fund, and the Public Safety Personnel Retirement System, in accordance with statute.

3 Reimbursements are from the 2 insurance guaranty funds to pay for operating these programs.

4 As required by A.R.S. §20-227, the Department remits insurance premium taxes, except those transferred to other entities as indicated in footnote 7, and all revenues not specifically excluded in statute to the State General Fund.

5 Transfers to the State General Fund are monies from one of the Department's funds that A.R.S. §20-1098.18 requires the Department to revert to the State General Fund because the unencumbered balances at year-end exceeded the fund's statutorily established balance.

6 Transfers to other State agencies in fiscal year 2018 were primarily transfers to the Arizona Department of Administration for relocation costs.

7 Transfers to the Firefighters' Relief and Pension Fund and the Public Safety Personnel Retirement System consists of insurance premium taxes collected from fire insurance policies and a portion of vehicle insurance policies transferred to other entities, as required by A.R.S. §§9-952 and 20-224.01. Specifically, fire insurance premiums were transferred to qualified municipal fire departments, legally organized fire districts, and public agencies who hire private fire protection services. In addition, a portion of vehicle premium taxes were transferred to the Highway Patrol Account at the Public Safety Personnel Retirement System.

Source: Auditor General staff analysis of the Arizona Financial Information System *Accounting Event Transaction File* for fiscal years 2017 through 2019, and the State of Arizona *Annual Financial Report* for fiscal years 2017 and 2018.

Department's new fraud-referral prioritization process lacks components to ensure it investigates high-priority referrals

Investigating insurance fraud is critical to protecting Arizona citizens

Effective insurance fraud investigations are critical for identifying and convicting wrongdoers, obtaining restitution, and helping deter future fraud. According to the Coalition Against Insurance Fraud, over $80 billion is lost annually because of insurance fraud nation-wide (see textbox for definition of insurance fraud).[7] Further, according to the Federal Bureau of Investigation, non-healthcare-related insurance fraud results in an estimated premium increase of $400 to $700 annually for families nation-wide.[8] According to a representative from the Coalition Against Insurance Fraud, Arizona is at a high risk for insurance fraud because of its large retiree population, who are more likely to be victimized by insurance fraud.

Insurance fraud

Insurance fraud occurs when an insurance company, agent, adjuster, or consumer commits a deliberate deception in order to obtain an illegitimate gain. It can occur during the process of buying, using, selling, or underwriting insurance. Insurance fraud may fall into different categories from individuals committing fraud against consumers to individuals committing fraud against insurance companies.

The Department's Insurance Fraud Division investigates suspected cases of insurance fraud against insurance companies. For example, the Department investigated a suspected case of insurance fraud in fiscal year 2018 where an individual fraudulently billed insurance companies for medical treatments using another person's medical credentials. It was alleged that this individual submitted more than $190,000 in fraudulent medical claims for providing medical treatment to approximately 80 victims.

Source: National Association of Insurance Commissioners (NAIC). (2019). *Insurance fraud*. Retrieved 6/27/2019 from https://www.naic.org/cipr_topics/topic_insurance_fraud.htm and Auditor General staff review of Department information.

Department does not investigate the majority of fraud referrals it receives

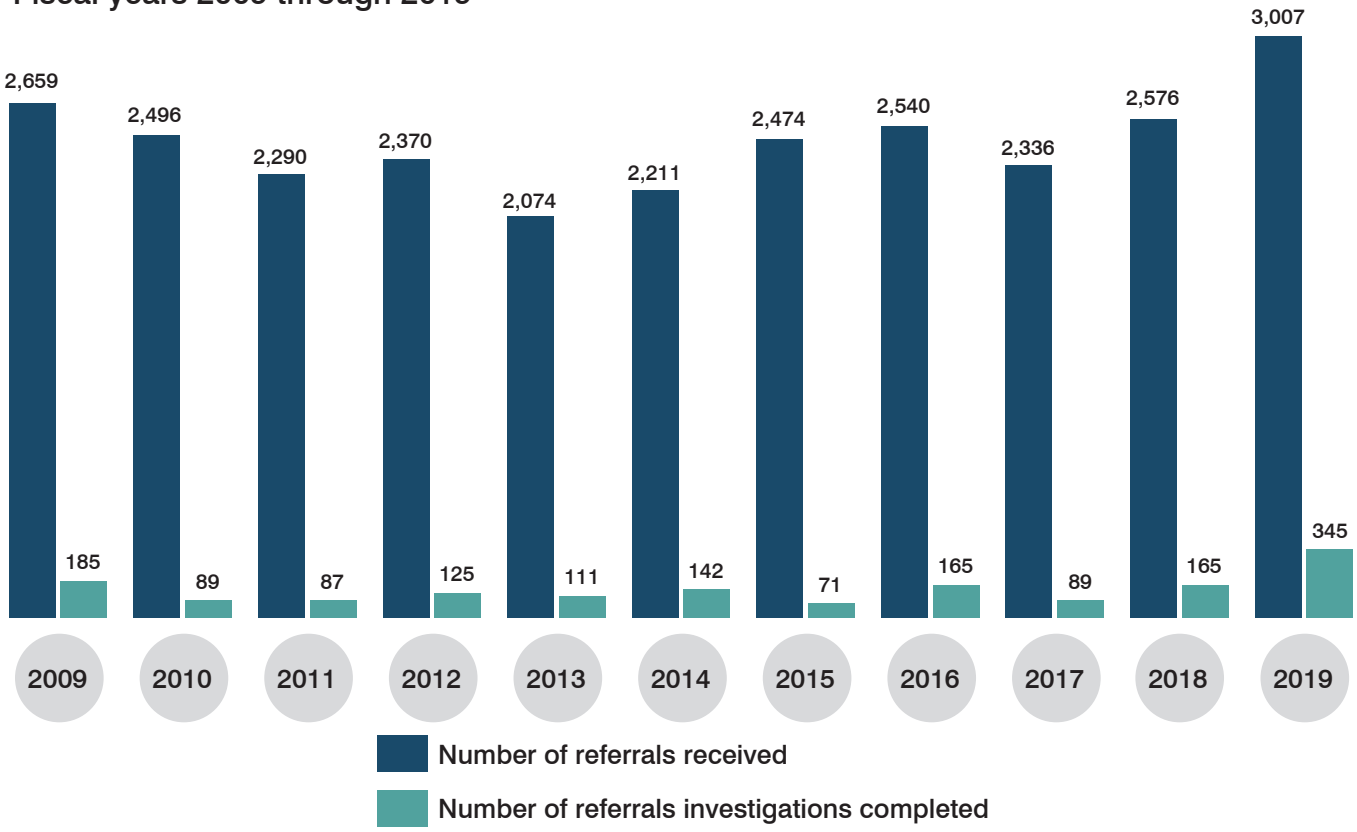
As shown in Figure 2 on page 8, the Department receives more referrals every year than it investigates. Specifically, according to Department data, in fiscal year 2019, it received more than 3,000 fraud referrals and completed 345 investigations using its 6 investigators. For those referrals it does not investigate, the Department either closes the referral because it lacks merit or closes the referral and sends a notice to the insurance company indicating that the referral has merit but is determined to be a lower priority and cannot be investigated at that time due to lack of resources (see Figure 3, page 8, for Department actions taken on fraud referrals in fiscal years 2018 and 2019).[9] The Department does not require the insurance company to take any further action on referrals for which it sends a notice to the insurance company. We reviewed a random

[7] The Coalition Against Insurance Fraud is an anti-fraud organization composed of different government agencies, insurance companies, consumer protection advocacy groups, academic institutions, and businesses from across the country.

[8] Federal Bureau of Investigation (FBI). (n.d.) *Insurance fraud*. Washington, DC. Retrieved 3/27/2019 from https://www.fbi.gov/stats-services/publications/insurance-fraud.

[9] Department staff reported that an insurance company may request a notice in order to administratively close the referral in its own records.

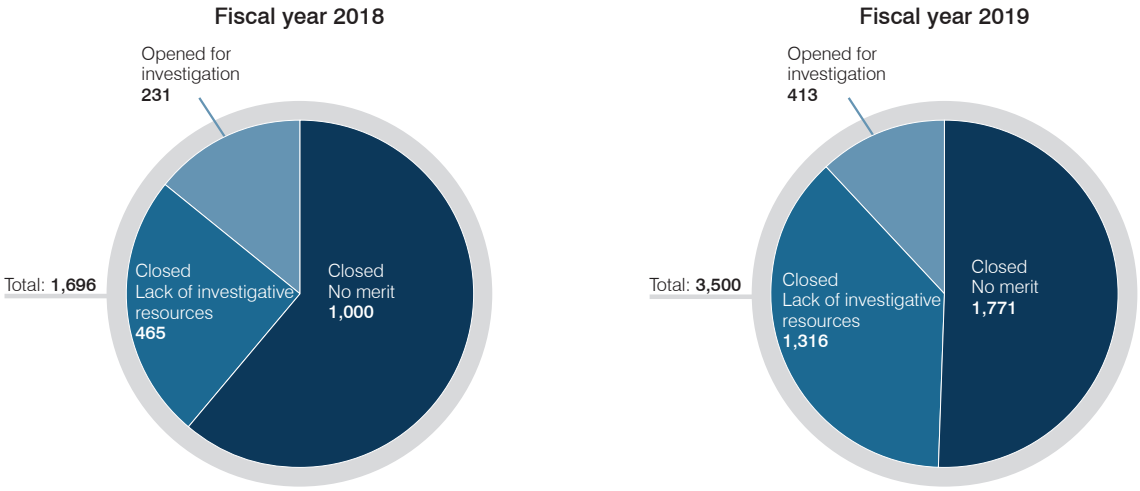
Figure 2
Number of insurance fraud referrals received and number of referral investigations completed by Department[1]
Fiscal years 2009 through 2019



[1] Fraud investigations were not always completed in the same fiscal year that the fraud referral was received because these referrals can be received at any point during the fiscal year and fraud investigations take time to complete.

Source: Auditor General staff review of Department information for fiscal years 2009 through 2019.

Figure 3
Actions taken on referrals (which may have been received in prior fiscal years)
Fiscal years 2018 and 2019



Source: Auditor General staff review of Department information for fiscal years 2018 and 2019.

sample of 20 of the 2,178 fraud referrals the Department received between July 1, 2018 and March 31, 2019, and for 7 of the 20 fraud referrals, the Department sent a notice to the insurance company. For example, 1 referral alleged that an individual may have attempted to commit fraud involving a deceased relative's life insurance policy. Based on this allegation, the Department determined that the referral had merit but was lower in priority, and the Department lacked the resources to conduct an investigation at that time.

Other states we contacted also receive more referrals than they investigate but have more fraud investigators

Similar to the Department, other states we contacted receive more referrals than they investigate. We contacted 4 states—California, Florida, Pennsylvania, and Utah—and found that in fiscal year 2018, these states did not investigate all of the referrals they received.[10] For example, as shown in the textbox, California received 25,159 referrals and conducted 1,226 investigations. Further, Utah received 972 referrals and conducted 334 investigations. We also found that compared to these other states, Arizona received more referrals per fraud investigator in fiscal year 2018. As shown in Figure 4, Pennsylvania received about 76 fraud referrals per investigator while Arizona received about 429 fraud referrals per investigator.

Number of insurance fraud referrals received and number of referrals opened for investigation by state in fiscal year 2018[1]

State	Referrals received	Referrals opened for investigation
Utah	972	334
Pennsylvania	2,508	304
Arizona	2,576	231
Florida	15,593	2,108
California	25,159	1,226

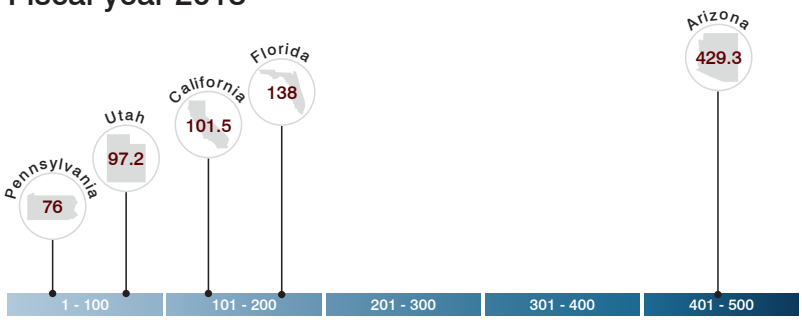
[1] Fraud investigations were not always completed in the same fiscal year that the fraud referral was received because these referrals can be received at any point during the fiscal year and fraud investigations take time to complete

Source: Auditor General staff review of Department and other states' information for fraud referrals and investigations for fiscal year 2018.

Department began piloting fraud-referral prioritization process in August 2018

Despite not investigating the majority of the fraud referrals it received from fiscal years 2009 through 2019, as shown in Figure 2 (see page 8), the Department only recently began piloting a prioritization process in August 2018 to ensure it effectively uses its investigative resources on high-priority referrals. Department staff reported that prior to piloting its prioritization process, the former Insurance Fraud Division director would determine which fraud referrals warranted further investigation. However, there was no systematic process for making these determinations, and there was no documentation of the former division director's decision-making process. Absent a formalized fraud-referral prioritization process, the Department could not ensure it was using its investigative resources effectively.

Figure 4
Number of insurance fraud referrals received per investigator for Arizona and other states we contacted Fiscal year 2018



Source: Auditor General staff review of Department and other states' information for fraud referrals and investigations for fiscal year 2018.

To help focus its investigative resources, we observed in March 2019 that the Department applied 2 criteria to determine if a referral should be prioritized for investigation and trained 1 of its 6 fraud investigators to triage

[10] We judgmentally selected states based on factors such as comparable size to Arizona and demonstrated best practices.

and prioritize all fraud referrals. Specifically, the Department applied the following 2 prioritization criteria: (1) the extent to which the fraud allegation(s) impact the public based on the number of people potentially affected by the alleged fraud, and (2) if the estimated loss to the insurance company, the public, or policyholders was at least $10,000. For example, the Department's prioritization guidance as of March 2019 indicated that it may prioritize a referral for investigation if the referral alleged that an insurance producer was selling insurance policies and pocketing policyholders' premiums without providing insurance coverage and the loss was estimated to be at least $10,000. In August 2019, the Department revised its prioritization process guidance to establish the following 3 priority levels for referrals: (1) allegations involving a physical or financial threat to public safety, (2) allegations involving economic loss or if repeat offenders are involved, and (3) no economic loss and no threat to public safety.

Department's fraud-referral prioritization process lacks important components to help ensure its effectiveness

Because the Department does not investigate all the fraud referrals that it determines warrant further investigation, an effective prioritization process would help to ensure it effectively uses its investigative resources by focusing on high-priority referrals. The 4 states we contacted reported having prioritization processes in place to focus their investigative resources on high-priority referrals. As shown in Table 3, these other states reported adopting additional components to enhance their prioritization processes that the Department has not incorporated in its prioritization process. Specifically:

Table 3
Components of other states' fraud-referral prioritization processes

	Arizona	California	Florida	Pennsylvania	Utah
Required referral information					
There are specific standards for the information required in an insurance fraud referral.	✗	✓	✗	✓	✓
Identifying fraud trends					
The department uses information included in insurance fraud referrals to identify fraud trends.	✗	✓	✓	✓	✓
Public outreach					
The department holds regular anti-fraud training and informational seminars for insurers.	✗	✓	✓	✓	✓

Source: Auditor General staff review of other states' insurance fraud investigation statutes and administrative codes.

- **Other states require specific, standardized referral information—**In contrast to Arizona, California, Pennsylvania, and Utah require insurance companies' fraud referrals to include specific, standardized information, and Pennsylvania prescribes a standardized form for doing so. For example, California requires referrals to include the total potential loss amount and a synopsis of why insurance fraud is suspected. California and Pennsylvania have also developed instructions for insurance companies operating in their states to define the level of detail regarding the alleged fraud that the insurance company should include in its referral. These practices help to ensure that these states have complete and accurate information to inform their prioritization efforts and focus on high-priority referrals.

  A.R.S. §20-466(G) permits the Department to prescribe the information that insurance companies must submit in a fraud referral, including information that the Insurance Fraud Division may require to investigate the referral. However, the Department has not established reporting requirements or instructions for insurance companies that define the specific information or level of detail regarding the alleged fraud that needs to be

included in a fraud referral.[11] As a result, some referrals do not contain the information the Department needs to prioritize the referral for investigation, including the estimated number of people affected or the estimated loss amount of the alleged fraud. Specifically, we reviewed a random sample of 20 of the 2,178 insurance fraud referrals that the Department received between July 1, 2018 and March 31, 2019, and determined that 4 of the 20 referrals did not include the estimated number of people affected or the estimated loss amount. Although Department staff reported that the Department has a process to follow up with the insurance company to obtain missing or additional information after a referral is received, we did not find evidence that Department staff conducted any follow-up work in these cases. Instead, the Department closed these 4 referrals immediately.[12]

- **Other states use referral data to identify fraud trends and then use fraud trend information to prioritize new referrals for investigation—**According to the Coalition Against Insurance Fraud, identifying fraud trends allows investigators to determine the types of insurance that are at higher risk for insurance fraud. Investigators can use this information to prioritize fraud referrals for investigation. In contrast to Arizona, California, Florida, Pennsylvania, and Utah reported analyzing the information included in fraud referrals to identify fraud trends. For example, California reported that it categorizes the type of insurance fraud alleged and geographic information included in fraud referrals to identify rising fraud trends and areas in the state where fraud is more prevalent.

  Although the Department manually tracks some referral information, it does not use referral data to identify fraud trends or prioritize new referrals because it cannot meaningfully analyze the data in its referral case management database. Specifically, Department staff compile a monthly report containing the number of fraud referrals received and the number of cases referred for prosecution. However, this report does not summarize the types of alleged insurance fraud—such as fraudulent automobile or health insurance claims—reported that month or indicate whether there are any discernible fraud patterns. Department staff reported that its fraud referral case management database has limited functionality and the Department does not require its investigators to report referral status information in standardized language to help ensure consistency in the data. Consequently, Department staff manually (1) categorize the alleged fraud type(s) reported, (2) update referral investigation status notes, and (3) provide a description for why a referral was closed. As a result, Department staff are incompletely and inconsistently capturing this information, which prevents the Department from analyzing referral data to identify fraud trends. For example, we reviewed the Department's database and found blank reporting fields and a lack of standardized language or descriptions to indicate why a referral was closed or if any further action was taken and the results of this action.

- **Other states conduct outreach events to help identify fraud trends and enhance their prioritization process—**In contrast to Arizona, California, Florida, Pennsylvania, and Utah reported initiating and holding regular outreach events and trainings with insurance companies' Special Investigative Units (SIUs) to increase awareness of rising fraud trends and investigative strategies. For example, Pennsylvania hosts an annual 2-day anti-fraud conference for all SIUs operating in the state. The conference provides training on identifying insurance fraud and presentations on rising fraud trends in Pennsylvania and across the country. As mentioned previously, identifying fraud trends helps investigators prioritize fraud referrals for investigation. In addition, providing targeted trainings to SIUs can improve the effectiveness of these entities' fraud detection and reporting efforts, thereby strengthening the state's insurance fraud department's ability to receive and investigate high-priority fraud referrals.

  During the audit, Department staff reported that Insurance Fraud Division staff meet informally with insurance companies, insurance industry experts, and law enforcement entities to discuss national and Arizona-specific fraud trends and coordinate or leverage these entities' anti-fraud resources. For example, we attended a February 2019 meeting between the Department and the Coalition Against Insurance Fraud where fraud

[11] Although the Department's website has an online fraud referral form for the public's use, it does not have a standardized form for insurance companies to submit fraud referrals.

[12] For 3 of the 4 referrals, the Department took no further action. For the remaining referral, the Department provided notice to the insurance company indicating it did not have the necessary resources to conduct an investigation.

trends that may affect Arizona in the future were discussed. However, the Department does not have a process to incorporate the information obtained during these meetings into its fraud-referral prioritization process or assess whether these events help it to effectively prioritize its investigative efforts.

In addition to the other states' practices that the Department has not adopted, we identified some deficiencies in the Department's prioritization process. First, although the Department has piloted its fraud-referral prioritization process, it has yet to evaluate whether this new process effectively focuses the Department's investigative resources on high-priority fraud referrals. Additionally, it has not established a supervisory review process to help ensure that the sole fraud investigator responsible for prioritizing referrals does not incorrectly close referrals that meet the Department's prioritization criteria and should be investigated. As shown previously in Figure 3 (see page 8), of the 3,500 referrals that the Department took action on in fiscal year 2019, the Department determined that 1,771, or 51 percent, did not provide sufficient evidence to open an investigation and 1,316, or 38 percent, of referrals had merit but were a lower priority, resulting in a notice being sent to the insurance company. Without supervisory review for these determinations, the Department cannot ensure that staff make appropriate decisions about which referrals to prioritize for investigation. Finally, the Department has not developed policies and procedures to help ensure the consistent and appropriate execution of its prioritization process.

Recommendations:

The Department should:

1. Strengthen its fraud-referral prioritization process by:

   a. Developing and implementing a referral template, reporting requirements, and/or instructions that define the specific information and level of detail that insurance companies should provide when reporting suspected instances of insurance fraud.

   b. Developing and implementing a process to use available referral data to help identify fraud trends and prioritize fraud referrals.

   c. Developing and implementing instructions to guide investigators' efforts to input referral and investigation information into the database completely and consistently.

   d. Developing and implementing policies and procedures to incorporate the information discussed during the outreach events it conducts into its fraud-referral prioritization process and evaluating the effectiveness of these events.

   e. Developing and implementing a risk-based supervisory review process for referrals that are not investigated to help ensure that Department staff do not inappropriately close referrals that should be prioritized for investigation.

   f. Developing and implementing policies and procedures for its fraud-referral prioritization system and training additional staff on these policies and procedures.

2. Evaluate whether its prioritization process has facilitated the Department's ability to focus on high-priority referrals and determine and implement any changes needed to continue to improve the prioritization process.

3. Once the Department has taken steps to evaluate and strengthen its prioritization process, the Department should assess its fraud investigative staffing needs to help ensure it investigates all the high-priority fraud referrals it receives. This assessment should include a documented workload analysis that compares the Department's workload, including an estimate of future workload, with its staff resources and then identifies the level of resources needed based on workload and responsibilities. If the Department determines additional resources are needed, it should work with the Legislature to obtain these resources.

   Department response: As outlined in its **response**, the Department agrees with the finding and will implement the recommendations.

Department's practices for managing conflicts of interest increase risk of nondisclosure

Statute addresses conflicts of interest for public-agency employees and public officers

Arizona law requires public officers and employees to avoid conflicts of interest that might influence or affect their official conduct. To determine whether a conflict of interest exists, public officers/employees must first evaluate whether they or a relative has a "substantial interest" in (1) any contract, sale, purchase, or service to the public agency, or (2) any decision of the public agency.

If a public officer/employee or a relative has a substantial interest in either circumstance, the public officer/employee is required to fully disclose the interest and refrain from voting upon or otherwise participating in the matter in any way as a public officer/employee.[13] The interest must be fully disclosed in the public agency's official records, either through a signed document or in the agency's official minutes. In addition, A.R.S. §38-509 requires public agencies to maintain a special file of all documents necessary to memorialize all disclosures of substantial interest—including both signed disclosure statements and official minutes disclosing substantial interests—and to make this file available for public inspection.

Ensuring compliance with these statutes can help deter self-dealing by public officers/employees and promote transparency and public confidence in an agency's official conduct.

Key terms

- **Substantial interest—**Any direct or indirect monetary or ownership interest that is not hypothetical and is not defined in statute as a "remote interest."
- **Remote interest—**Any of several specific categories of interest defined in statute that are exempt from the conflict-of-interest requirements. For example, a public officer or employee may participate in a decision that indirectly affects a relative who is an employee or an officer of another public agency or political subdivision, as long as the decision does not confer a direct economic benefit or detriment to the relative (such as a decision that would affect the relative's employment).
- **Relative—**A public officer's/employee's spouse, child, grandchild, parent, grandparent, full or half siblings and their spouses, and the parent, brother, sister, or child of the employee's/public officer's spouse.

Source: Auditor General staff review of A.R.S. §38-502 and Arizona Office of the Attorney General. (2018). *Arizona agency handbook*. Phoenix, AZ. Retrieved 5/1/2019 from https://www.azag.gov/outreach/publications/agency-handbook.

Deficiencies in Department's process increase risk of nondisclosure

Although the Department has developed and implemented a conflict-of-interest disclosure form (form) and maintains a special disclosure file, we identified some deficiencies in its disclosure process and form that result in the Department's noncompliance with statute and increase the risk that Department employees and public officers may not appropriately disclose interests. Specifically, the Department:

[13] See A.R.S. §§38-502 and 38-503(A)(B).

- **Lacks a conflict-of-interest policy and did not require employees to disclose interests annually—** The Department lacks a formal conflict-of-interest policy. Instead, Department staff reported that in practice, it requires new employees to complete the form when hired but did not ensure existing employees completed the form annually. Although annual disclosures are not explicitly required by statute, doing so regularly reminds public officers and employees of the importance of complying with conflict-of-interest laws and helps to ensure that potential conflicts of interest are disclosed if a public officer's or employee's circumstances change. The Department reported that if an employee identifies and discloses a potential conflict, the Department's director, deputy director, or assistant director of Administrative Services is responsible for notifying the employee in writing to refrain from working on matters relating to the entity with which the employee has a potential conflict, unless the employee receives written permission to do so.

- **Does not require board members to disclose interests annually—**As described in the Introduction (see page 5), the Department supports 3 active boards—the Arizona Life and Disability Insurance Guaranty Fund Board, the Arizona Property and Casualty Insurance Guaranty Fund Board, and the Arizona Workers' Compensation Appeals Board. According to A.R.S. §38-501(A), the State's conflict-of-interest statutes apply to all public officers and employees of any of the State's departments, commissions, agencies, bodies, or boards, including board members.[14] However, we did not find evidence that the Department required nonemployees who are members of the Department-supported boards to complete the Department's form, and as of May 2019, none of the board members had completed a form to disclose relevant interests.

  Further, the 3 Department-supported boards have different disclosure standards. Specifically:

  - The Arizona Property and Casualty Insurance Guaranty Fund Board's policy is silent on conflict of interest, and therefore, board members may not be aware of the statutory requirement that they disclose and refrain from participating in any matter related to a conflict.

  - The Arizona Life and Disability Insurance Guaranty Fund Board's policy includes a disclosure form; however, this form is not as robust as the Department's form. For example, the board's form does not include a field for the employee to attest that she/he does not have any substantial interests, also known as an "affirmative no."

  - The Arizona Workers' Compensation Appeals Board's policy requires board members to refrain from participating in any manner, such as a discussion or decision-making action, if the member has a conflict of interest, and requires the interest to be memorialized in the board's official records. Department staff responsible for supporting this board reported 2 occurrences when board members disclosed potential conflicts of interest in 2015 and 2017. We determined that both disclosures were memorialized in the board's meeting minutes and hearing transcripts; however, the official minutes were not included in the Department's special disclosure file.

- **Uses a form that does not address decision-making—**According to A.R.S. §38-503, all employees and public officers must disclose their "substantial interest" in (1) any contract, sale, purchase, or service to the public agency, or (2) any decision of the public agency. The Department's form requires employees to disclose any substantial financial interest, outside/secondary employment, any insurance-related licensure, and any direct or indirect financial interest in any entity subject to the Department's regulation, including any relative that has a significant interest in a regulated entity. However, the Department's form does not require employees to disclose a substantial interest in any Department decisions.

[14] A.R.S. §38-502(8) defines "public officer" as all elected or appointed officers of a public agency established by charter, ordinance, resolution, State constitution, or statute. According to the *Arizona Agency Handbook*, public officers include directors of State agencies and members of State boards, commissions, committees—whether paid or unpaid.

During audit, Department directed staff but not board members to complete updated annual disclosures, and not all staff completed disclosures

In February 2019, during the audit, Department leadership directed all staff, but not board members, to submit updated annual conflict-of-interest forms by March 1, 2019. We reviewed the Department's special disclosure file on March 27, 2019, and found that the Department had collected 43 forms for its 72.5 filled FTE at that time. However, the special disclosure file did not include completed forms from any board members or records from board meetings demonstrating that an interest had been disclosed. Additionally, although Department staff stated on April 16, 2019, that all staff had completed the required form, we subsequently reviewed the disclosure file again on April 22, 2019, and the missing forms had still not been added. As a result, there is no assurance that all Department staff have completed the required form.

Recommendations:

The Department should:

4. Develop and implement a conflict-of-interest policy that (1) requires all employees to complete an annual disclosure form; (2) defines a process for managing any disclosed potential conflicts of interest to ensure the conflict will not interfere with the performance of the employee's duties; and (3) defines a process for ensuring that completed forms are maintained in the Department's separate special disclosure file for public inspection.

5. Update and implement the policies and procedures for the Arizona Life and Disability Insurance Guaranty Fund Board, the Arizona Property and Casualty Insurance Guaranty Fund Board, and the Arizona Workers' Compensation Appeals Board to (1) require board members to complete an annual disclosure form; (2) define a process to allow board members to fully disclose substantial interests during public meetings, document these disclosures in the board's meeting minutes—including the name of the person with an interest (i.e., board member or board member's relative), the interest's description, and the reason the board member is refraining from discussing or otherwise participating; and (3) define a process for ensuring that completed forms are maintained in the Department's separate special disclosure file for public inspection.

6. Update its disclosure form to require employees and public officers to comply with conflict-of-interest statutes by requiring the disclosure of both substantial financial and decision-making interests.

Department response: As outlined in its **response**, the Department agrees with the finding and will implement or implement in a different manner all of the recommendations.

In accordance with A.R.S. §41-2954, the Legislature should consider the following factors in determining whether to continue or terminate the Department. The analysis of the sunset factors also includes findings and recommendations not discussed earlier in the report.

Sunset factor 1: The objective and purpose in establishing the Department and the extent to which the objective and purpose are met by private enterprises in other states.

The Arizona Constitution established the regulation of insurance within the Arizona Corporation Commission in 1912, and the Department was established as a separate State agency by constitutional amendment in 1968. Its mission is to protect Arizona citizens and business by promoting a safe, strong, innovative, and competitive insurance marketplace. The Department's key functions include licensing qualified insurance professionals and companies, investigating consumer complaints and instances of fraud, monitoring and analyzing insurance companies' annual financial statements, examining insurance companies for solvency, and reviewing insurance policies, rates, and products to protect the public from excessive, inadequate, or unfairly discriminatory insurance rates and deceptive or misleading advertising. The Department is also responsible for answering consumer questions and for collecting millions of dollars in premium taxes, which are remitted to the State General Fund (see Table 2, page 6). Further, the Department administers the Arizona Life and Disability Insurance Guaranty Fund and the Arizona Property and Casualty Insurance Guaranty Fund, which pay policyholders' claims when their insurance company becomes insolvent and cannot pay claims.

We did not identify any states that met the Department's objective and purpose through private enterprises. As of April 2019, all 50 states, the District of Columbia, and Puerto Rico were accredited by the National Association of Insurance Commissioners (NAIC) and rely on one another's monitoring and licensure of insurance companies and insurance professionals operating in each state to support regulation of the insurance industry. As previously stated in the Introduction, the NAIC reaccredited the Department for 5 years in April 2019.

However, we determined that Arizona and Arkansas are the only states that have both guaranty funds under the management of a public agency. In contrast, the other 48 states and the District of Columbia have statutorily established nonprofit associations that manage their insurance guaranty funds.

Sunset factor 2: The extent to which the Department has met its statutory objective and purpose and the efficiency with which it has operated.

The Department has met its statutory objectives and purposes by issuing licenses to qualified individuals in a timely manner and monitoring insurance companies' financial solvency in line with NAIC requirements. Specifically:

- **Department issued licenses to qualified applicants for license applications we reviewed, and issued licenses to insurance professionals in a timely manner according to Department data—**As part of its regulatory responsibilities, the Department issues licenses to various qualified individuals, such as insurance producers and claims adjusters (see Introduction, page 1, for definitions of these terms). The Department and all other states rely on NAIC reciprocal licensing for individuals operating in multiple states. Applicants for licensure apply through the NIPR, which ensures that the individual has passed all required examinations for the license(s) for which they are applying before allowing them to submit an application. Individuals residing in other states must submit a completed application and licensing fee to operate in Arizona. Individuals residing in Arizona must submit proof of lawful presence in the United States and fingerprints for a criminal history background check in addition to a completed application and licensing fee.

In fiscal year 2018, the Department processed 69,359 new and renewal license applications received through the NIPR and paper applications. The Department is required by rule to process licensing applications within 180 days, and according to Department data, in September 2018, the Department processed applications in less than 2 days on average. We reviewed a random sample of 3 renewal license applications and 3 initial license applications from the 7,437 applications the Department processed in September 2018 and found that the Department issued licenses to qualified applicants in a timely manner—on average 2 days—for the applications we reviewed.

- **Department's financial monitoring and insurance company licensing functions reaccredited by the NAIC in 2019—**The Department, similar to all other NAIC-accredited states, oversees the financial transactions of multistate and single-state insurance companies domiciled in the State and monitors insurance companies for potential insolvency using NAIC guidelines. Some of the standards include requiring insurance companies to submit financial filings, such as an audited financial report, to the Department regularly. Additionally, the NAIC provides standards for how the Department should assess the financial condition of an insurance company and identify any potential future risks through its review of these financial filings. As previously stated in the Introduction, the Department was reaccredited by the NAIC for 5 years in April 2019.

However, we also identified areas where the Department should improve its efficiency and effectiveness. Specifically:

- **Department does not review long-term care insurance rates in a timely manner and lacks a formal process for notifying insurance companies when the review time frame is not met—**The Department is statutorily responsible for approving long-term care insurance rates before they go into effect. Insurance companies file proposed rate increases or policy changes with the Department for review, and statute permits the Department up to 45 days to review and approve or disapprove the proposed changes (see Introduction, page 2, for the definition of long-term care insurance).[15] A.R.S. §20-1691.08(A) states that long-term care rates or policies may not be issued in Arizona until the Department has approved the rate or policy. The review process, which includes an actuarial analysis, helps to ensure that long-term care insurance rates are not excessive, inadequate, or unfairly discriminatory, that the insurance company fully discloses the terms of the insurance policy to the consumer, and that the policy's language is comprehensible and fair. The Department contracts with an external actuary to analyze long-term care rate filings that impact more than 200 policyholders.[16] The Department's actuary then reviews the completed analysis from the contracted actuary before the Department director approves or disapproves the rate.

  However, the Department is not meeting the 45-day statutory review time frame for long-term care policies and rates. Specifically, according to Department data, it received 35 long-term care insurance rate filing increases for review in calendar year 2017 and took an average of 261 days to perform its review. In calendar year 2018, it received 41 rate filings and took an average of 250 days for the 12 rate filings that had been reviewed as of January 2019 (see Figure 5 on page 19 for the outcome of the Department's review). The calendar year 2018 rate filings proposed rate increases between 8 and 150 percent and affected more than 8,000 Arizona policyholders.

  In cases when the Department has not met the 45-day statutory review time frame, the Department sends a notice to the insurance company to request that it waive the time frame requirement. This practice extends the Department's review time frame indefinitely. Department staff reported that insurance companies typically elect to waive the time frame requirement because if Department staff cannot determine that the proposed rate or policy change is appropriate within 45 days, the Department will disapprove the rate because the rate has not yet reached a compliant state, and as a result, the insurance company must revise and refile the rate. However, the Department lacks a formal process for notifying the insurance companies to request

[15] Unless the director issues an order affirmatively approving or disapproving the form or rate within 30 days after filing, the form or rate is deemed approved. On written notice given to the insurer within the 30-day period, the director may extend the 30-day review period for up to 15 additional days.

[16] The Department's internal actuary reviews rate filings that do not meet these criteria.

Figure 5
Department's long-term care insurance rate review outcomes for rate filings received in calendar year 2018 and reviewed as of January 2019

[1] Based on actuarial analysis and standards, the Department determined that the proposed rate increases did not comply with statute and rule.

[2] The Department approved an average reduced rate of 33 percent.

Source: Auditor General staff review of Department information.

to waive the time frame requirement. As a result, the Department notifies insurance companies at different times during the review process about the opportunity to elect to waive the time frame requirement. Although notices for the 2 rate filings we reviewed were sent by the 45th day, absent a formal process, the Department is at risk for not sending the notice and, thereby, not extending its review time frame, which could result in rate filings being automatically deemed approved. For the rate filings we reviewed, it took the Department 148 and 181 days, respectively, to review these rates.

The Department reported that timely rate review for long-term care insurance is a nation-wide issue. We contacted 2 other states, Utah and California, both of which reported that between conducting the actuarial analysis of long-term care insurance rates and corresponding with insurance companies to obtain further information, the reviews can take up to 6 months to complete. The NAIC reported that it formed a task force in 2017 for long-term care insurance that plans to evaluate the sufficiency of actuarial standards when analyzing long-term care insurance rates and is considering potential state and federal solutions for stabilizing the long-term care insurance market in 2019, both of which could potentially reduce the amount of time state regulatory agencies take to review rates.

- **Department never formed required Insurance Consumer Advisory Board—**Laws 1987, Ch. 136, §3, established an Insurance Consumer Advisory Board under the Department. The board was intended to be composed of consumers and licensed insurance professionals to provide advice and counsel to the director on matters relating to certain types of insurance, such as commercial property and casualty insurance. The Department reported that it never established this board because when the statute was enacted, there was not enough public interest and the Department could not find enough members of the public to serve on the board. Although a Department task force recommended in 2002 that the board be repealed, the Department has not taken steps to propose repealing the Board. We determined that the NAIC and some other states, such as Oregon and Washington, have an advisory board or committee with consumer and other representatives that meet periodically to discuss key issues and provide information or advice to the state's insurance regulatory agency.

- **Department has not convened Continuing Education Review Committee since 2005—**In line with NAIC licensing standards, Arizona requires licensees to complete 48 hours of continuing education every 4 years. The NAIC does not set the standards for course curriculum, but A.R.S. §20-2905 requires the Department to administer a Continuing Education Review Committee that is responsible for establishing minimum standards for continuing education courses provided to licensees, approving continuing education providers, and establishing minimum performance standards for the administration of the continuing education program. Department staff reported that the Department determined that the committee has not needed to meet since 2005 because the NAIC's continuing education standards had not changed. However, Department staff also indicated that future NAIC changes to continuing education standards may necessitate the Department reestablishing this committee.

- **Department does not have comprehensive, up-to-date policies and procedures for its administration of the 2 insurance guaranty funds—**The Department has not updated its policies and procedures manual for the Arizona Property and Casualty Insurance Guaranty Fund and the Arizona Life and Disability Guaranty Fund since 1999. Specifically, the Department has not developed policies and procedures for its administration of the Workers' Compensation Insurance Account, which was transferred to the Department from the Industrial Commission of Arizona in 2015. The Workers' Compensation Insurance Account under the Arizona Property and Casualty Insurance Guaranty Fund provides workers' compensation benefits to claimants of insolvent insurance companies. The Department lacks policies and procedures for the activities involved in the administration of this account and fund, including the activities required to oversee the Fund's contracted claim adjusters. For example, the Department's claim manager conducts a review of all workers' compensation claims handled by the Department's third-party adjuster at the end of each month. However, this process is not documented in policies and procedures. Although we did not identify any issues with claims processing, the absence of updated policies and procedures puts the Department at risk for not consistently and appropriately processing claims.

- **Department has not implemented required monthly financial review—**The *State of Arizona Accounting Manual* (SAAM) requires State agencies to perform a monthly financial review. Specifically, an agency director or deputy director should review and verify the accuracy of the agency's overall financial position, including reviewing revenues and expenditures to identify and explain any unusual changes or trends. Monthly financial summaries should be reviewed and signed by the agency's director or deputy director. Such a review of revenues and expenditures by someone other than the preparer of the monthly financial summary is important to identify any unusual or unexpected spending and helps to ensure that the revenues received by the Department—including licensing fees and premium taxes—are appropriately reflected in the Department's records. Although the Department's accounting staff prepare and place a monthly financial summary in a shared drive for Department leadership to review, we did not see any evidence that these monthly summaries were reviewed and signed by the Department director or deputy director, as required by the SAAM. Additionally, the Department has not performed all required reconciliations.

- **Department has not implemented Arizona Strategic Enterprise Technology Office (ASET)-required information technology (IT) policies and procedures, has not conducted an IT risk assessment, and has not documented Department staff and ASET responsibilities for specific IT services and support—**Arizona State agencies are required to develop IT security-specific policies and procedures consistent with ASET's State-wide policies. ASET's policies are intended to help State agencies implement recommended IT security practices and to protect the State's IT infrastructure and the data contained therein. The Department has begun drafting policies for 9 ASET-required areas; however, it has not yet finalized these draft policies or developed detailed procedures to implement these policies. For example, the Department's draft security awareness training policy requires the Department to (1) develop a security awareness training program for all staff, (2) identify staff who have access to sensitive information and, therefore, require additional specialized training within 60 days of being granted access to the information, and (3) ensure that staff complete required training. However, the Department does not have a process to identify and ensure that staff with access to sensitive information complete role-based security training or monitor that all staff complete security awareness training. In addition, although the Department's draft policy requires all employees to understand and acknowledge the acceptable use requirements of the Department's IT systems, the Department does not have a process to track and monitor whether staff complete and sign an acceptable use agreement.

  Additionally, the Department has not conducted a formal IT risk assessment. A risk assessment is a structured process recommended by credible industry standards such as those developed by the National Institute of Standards and Technology (NIST) and required by ASET policy that identifies IT system risks within an organization—such as weak security practices, outdated systems, or the lack of a plan for restoring IT following a disaster—and determines the controls needed to lessen these risks.[17]

[17] National Institute of Standards and Technology (NIST). (2013). *NIST Special Publication 800-53, Revision 4: Security and privacy controls for federal systems and organizations*. Gaithersburg, MD.

Finally, although the Department has an interagency service agreement with ASET to obtain IT security services and support, the agreement states that the specific services ASET agrees to provide to the Department should be identified in a separate "Scope of Services."[18] Department staff reported that they have requested but not yet received separate services orders or a "Scope of Services" from ASET, and as a result, the Department does not have assurance that the services it expects to obtain from ASET are being provided. For example, ASET is responsible for providing continuous logging and monitoring services of the Department's IT systems. However, the Department has not communicated or documented the types of logging activities ASET should monitor and report or outlined time frames for doing so, and it has not established procedures that Department staff should follow when ASET reports unusual activity to the Department.

We also recommended that the Department:

- Take several steps to improve its fraud-referral prioritization process and evaluate the effectiveness of this process (see Finding 1, pages 7 through 12).
- Develop and implement conflict-of-interest policies for its employees and board members to help ensure that substantial financial and decision-making interests are appropriately disclosed and that the information is maintained in the Department's separate special disclosure file for public inspection, as required by statute (see Finding 2, pages 13 through 15).

Recommendations

7. To improve its administration of long-term care insurance rate reviews, the Department should:

    a. Research an appropriate time frame and then provide information to the Legislature regarding the need to revise the statutory time frame in order to allow more time to review long-term care insurance rates.

    b. Establish and implement a formal process for notifying insurance companies to waive the time frame requirement for long-term care insurance rates.

    c. Implement the NAIC long-term care insurance task force's recommendations for improving long-term care insurance rate review when available and if appropriate and helpful.

8. The Department should determine whether the Insurance Consumer Advisory Board is necessary and provides value to the Department and, based on its determination, take appropriate steps to either form this body to perform its statutory function or provide information to the Legislature regarding the need for a statutory change to sunset this body.

9. The Department should determine whether it is necessary to reconvene the Continuing Education Review Committee. If the Department determines it is not necessary to reconvene this body, it should provide information to the Legislature regarding the need for a statutory change to sunset this body.

10. The Department should update and finalize its policies and procedures manual for the Arizona Property and Casualty Insurance Guaranty Fund and the Arizona Life and Disability Insurance Guaranty Fund.

11. The Department should ensure that all required reconciliations are completed and that a monthly financial review is being performed and subsequently verified by Department leadership, consistent with SAAM requirements.

12. The Department should conduct a risk assessment to evaluate, document, and prioritize the areas in the Department's IT systems with the highest security risks, and use the results of its risk assessment to guide its efforts to develop and implement all required IT security program policies and procedures in line with ASET requirements and credible IT standards, focusing on high-risk areas first.

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[18] We have reported on ASET's lack of specific, formal agreements with State agencies seeking to obtain specific IT services in the State's single audit reports since fiscal year 2014 and in our August 2012 IT procedural review of the State Data Center.

13. Once it has developed and implemented all required IT policies and procedures, the Department should provide training to its employees on these policies and procedures.

14. The Department should work with ASET to define and document the scope of IT security services ASET provides to the Department and ensure that ASET provides these services.

    Department response: As outlined in its **response**, the Department agrees with the finding and will implement or implement in a different manner all of the recommendations.

Sunset factor 3: The extent to which the Department serves the entire State rather than specific interests.

The Department serves the entire State by licensing qualified insurance professionals and companies operating throughout the State, investigating consumer complaints and instances of fraud, answering consumer questions about insurance, and monitoring insurance rates and products to encourage safe competition within the State's insurance market. The Department also administers the Arizona Life and Disability Insurance Guaranty Fund and the Arizona Property and Casualty Insurance Guaranty Fund, which pay Arizona policyholders' claims when their insurance company becomes insolvent and cannot pay claims. In 2017, the 2 funds paid more than $17 million in claims, including claims resulting from 3 new insurance company insolvencies that affected consumers across the State. One of the 2017 insolvencies resulted in 4 new auto and liability claims and 39 new workers' compensation claims. In 2018, the 2 funds paid over $23 million in claims, including claims resulting from 1 new insolvency that resulted in 29 new auto claims.

However, we found that deficiencies in the Department's conflict-of-interest process increases the risk of nondisclosure and recommended that the Department improve its conflict-of-interest disclosure process, update its disclosure form, and require all employees and public officers to annually disclose potential conflicts of interest (see Finding 2, pages 13 through 15).

Sunset factor 4: The extent to which rules adopted by the Department are consistent with the legislative mandate.

The Department has adopted rules for its various areas of responsibility. A.R.S. §41-1056 requires each State agency to review all of its rules to determine whether the rule should be amended or repealed and report the results of this review and a proposed course of action to the Governor's Regulatory Review Council (GRRC) at least once every 5 years. To comply with this requirement, the Department reviews and submits 5-year rule review reports to GRRC for portions of its rules cyclically. In its 2016 and 2018 5-year rule review reports, the Department identified rules that needed to be updated for clarity or to reflect changes in NAIC standards. For example, the Department indicated that its rules do not reflect significant changes in health insurer advertising methods and venues resulting from the evolution of social media. The Department reported that it had not pursued some of these rule changes because of resource limitations, other rulemakings that the Department determined it needed to prioritize, and the Governor's continued moratorium on rulemaking.[19]

Recommendations

15. The Department should conduct rulemakings to adopt or revise rules it has identified that need to be established, amended, or repealed.

    Department response: As outlined in its **response**, the Department agrees with the finding and will implement the recommendation.

Sunset factor 5: The extent to which the Department has encouraged input from the public before adopting its rules and the extent to which it has informed the public as to its actions and their expected impact on the public.

We evaluated the extent to which the Department has encouraged input from the public and informed the public of its actions and their expected impact on the public and found the following:

[19] Executive Order 2019-01, "Moratorium on Rulemaking to Promote Job Creation and Customer-Service-Oriented Agencies; Protecting Consumers Against Fraudulent Activities," has continued restrictions on State agencies' rulemaking.

- **Department sought input from the public before adopting rules—**The Department has provided opportunities for public input as part of the rulemakings it undertook between January 2015 and January 2019. Specifically, the Department provided opportunities for public input by publishing notices of proposed rulemaking in the Arizona Administrative Register, listing the names of Department staff who could be contacted to provide input about the proposed rulemaking, allowing the public to submit written comments on proposed rule changes for at least 30 days after it published the notice, and in some cases, holding meetings where the public could provide input.

- **Department did not comply with some provisions of the State's open meeting law—**As reported on page 5 of the Introduction, statute establishes several boards and committees within the Department. We attended 3 public meetings between November 2018 and April 2019 for the 3 boards that are active and subject to open meeting law requirements.[20] We determined that 2 of the boards—the Arizona Life and Disability Insurance Guaranty Fund Board and the Arizona Workers' Compensation Appeals Board—met the open meeting law requirements we tested, including providing the meeting notice at least 24 hours in advance; providing the date, time, and location of the meeting; and providing accurate meeting minutes within 3 business days following the board meeting. However, the Arizona Property and Casualty Insurance Guaranty Fund Board provided its meeting minutes to us more than 3 weeks after the meeting occurred, not within 3 business days, as required by A.R.S. §38-431.01(D).

Recommendation

16. The Department should ensure that it makes board meeting minutes or a recording of board public meetings for the boards it supports available for public inspection 3 working days following a meeting as required by statute.

    Department response: As outlined in its **response**, the Department agrees with the finding and will implement the recommendation.

Sunset factor 6: The extent to which the Department has been able to investigate and resolve complaints that are within its jurisdiction.

The Department has statutory authority to investigate and resolve complaints made against insurance companies and insurance professionals within its jurisdiction and has various disciplinary actions available to address violations (see textbox). Department data indicates that it resolved 2,984 complaints in fiscal year 2018. Complaints are categorized as either a consumer or enforcement complaint based on the nature of the allegation. Specifically, consumer complaints focus on ensuring that consumers receive the rights and benefits to which they are entitled under their insurance policies and can include complaints about an unpaid claim payment. In contrast, enforcement complaints include allegations of violations of Arizona insurance laws, such as allegations of forgery.

Examples of disciplinary actions available to the Department:

- Revoke, suspend, or refuse to renew any license.
- Enforce a fine or civil penalty.
- Issue a cease and desist order.

Source: Auditor General staff review of A.R.S. §§20-220, 20-401.02, 20-456, and 20-295.

We reviewed a random sample of 10 consumer complaints and 5 enforcement complaints from the 2,984 complaints the Department resolved in fiscal year 2018 and found that generally, the Department reviewed and responded to these complaints in a timely manner and consistent with its complaint-handling process:

- **13 of 15 complaints we reviewed were resolved in a timely manner; Department kept remaining 2 complaints open awaiting additional information from complainants who never responded—** Although there is no statutory requirement to resolve complaints within a certain time frame, 13 of the 15 complaints we reviewed were closed between 0 days and 179 days. The 2 remaining complaints were open

[20] As reported in the Introduction (see page 5, including footnote 5) and Sunset Factor 2 (see pages 19 through 20), 3 of the Department's 6 boards and committees are not active. Therefore, we could not assess whether these boards complied with open meeting law requirements.

for 331 days and 421 days, respectively, because the Department was awaiting additional, needed information from the complainants. The Department administratively closed these 2 complaints when the complainants failed to provide the requested information.

- **14 of 15 complaints we reviewed were resolved in accordance with the Department's process; we could not determine if this was the case for the remaining 1 complaint—**For the consumer complaints we reviewed, the Department sent an initial response to the complainant acknowledging receipt of the complaint and indicating that the Department would contact the complainant if further information was needed. The Department then contacted the insurance company for claim information and to facilitate a resolution between the company and the complainant. After the insurance company had an opportunity to respond and potentially resolve the complaint, the Department either sent a closing letter to the complainant with the disposition of the complaint or ensured that the insurance company provided a response to the complainant.[21] For the 5 enforcement complaints we reviewed, the Department followed its process for investigating and resolving these complaints. The Department issued a civil penalty for 1 of these complaints and determined that the other 4 complaints did not warrant further action.

Sunset factor 7: The extent to which the Attorney General or any other applicable agency of state government has the authority to prosecute actions under the enabling legislation.

The Attorney General serves as the Department's legal advisor and provides legal services as the Department requires. Several other statutes give the Department authority to refer matters for prosecution, civil remedy, or for administrative action:

- A.R.S. §20-152 authorizes the Director of the Department of Insurance to involve the Attorney General in prosecution and defense matters, and A.R.S. §20-466(F) gives the director the authority to refer insurance fraud cases to a county attorney or the Attorney General for prosecution.
- A.R.S. §41-191.04 authorizes the Attorney General to provide to the Department the legal services necessary to collect outstanding civil penalties.
- A.R.S. §20-466.04 authorizes the director to refer the name of a person convicted of insurance fraud to the appropriate licensing agency for further administrative action.

Sunset factor 8: The extent to which the Department has addressed deficiencies in its enabling statutes that prevent it from fulfilling its statutory mandate.

The Department did not identify any deficiencies in its enabling statutes that prevent it from fulfilling its statutory mandate. However, as mentioned previously in the Introduction (see page 1), the Department's enabling statutes will change significantly when Laws 2019, Chapter 252, §1, becomes effective in July 2020 and consolidates the Arizona Department of Financial Institutions and the Automobile Theft Authority as divisions within the Department and renames the Department the Arizona Department of Insurance and Financial Institutions.

Sunset factor 9: The extent to which changes are necessary in the laws of the Department to adequately comply with the factors listed in this sunset law.

As described previously in Sunset Factor 2 (see page 19), the Department identified 2 statutorily required public bodies—the Insurance Consumer Advisory Board and the Continuing Education Review Committee—that are not fulfilling their statutory purpose.[22] The Department should determine the need for these bodies and, based on its determinations, convene the bodies and/or provide information to the Legislature regarding the need for a statutory change to eliminate these bodies.

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[21] We could not assess whether the Department followed its process for 1 consumer complaint because the file was corrupted in the Department's database. Additionally, the Department was unable to send correspondence to 1 complainant because the complainant did not provide contact information. However, we determined that the Department followed its process to resolve this anonymous complaint.

[22] As reported in footnote 5 on page 5, the Uniform Employee Health Status Questionnaire Committee completed its required questionnaire and the Department reported it has not needed to convene the Committee since that time.

Sunset factor 10: The extent to which the termination of the Department would significantly affect the public health, safety, or welfare.

Without transferring its responsibilities to another agency, terminating the Department could harm the public health, safety, and welfare. Regulating the insurance industry is necessary to protect the public in transactions that can significantly affect their financial welfare. Further, federal law requires states to regulate insurance, and the NAIC—in partnership with state insurance regulatory agencies—has established regulatory standards and model regulations. If the Department was terminated, its responsibilities to implement federal requirements that the insurance industry be regulated for consumer protection purposes would need to be transferred to another State entity.

Sunset factor 11: The extent to which the level of regulation exercised by the Department compares to other states and is appropriate and whether less or more stringent levels of regulation would be appropriate.

The level of regulation the Department exercises is generally similar to other states due to the guidance, model regulations, and requirements for state insurance regulatory agencies established by the NAIC (see the Introduction, pages 1 through 2, for more information). We judgmentally selected 4 states for review for comparative purposes—California, Florida, Pennsylvania, and Utah—based on factors such as comparable size to Arizona and demonstrated best practices. We identified the following similarities or differences in levels of regulation compared to these other states:

- **NAIC licensing standards for insurance companies and professionals—**Similar to Arizona, the 4 states we contacted follow NAIC licensing standards and guidelines for licensing insurance companies and insurance professionals operating within each respective state.

- **Regulatory organizational structure—**Utah is similar organizationally to Arizona in that it has a Department of Insurance that is the main regulatory agency for the insurance industry. However, some states have multiple agencies that share regulatory responsibility for the insurance industry. For example, the California Department of Insurance regulates most aspects of the insurance industry in California, with the exception of managed health-care plans, which are regulated by the California Department of Managed Health Care. Additionally, Florida's Office of Insurance Regulation is responsible for financial oversight of insurance companies and market regulation, and its Department of Financial Services is responsible for investigating insurance fraud. Further, Pennsylvania has an insurance department that is responsible for consumer affairs and administering receiverships, which are insolvent insurance companies that are generally ordered by state law to be managed by insurance regulators for conservation, rehabilitation, or liquidation administration. Further, the Pennsylvania Office of Attorney General has an insurance fraud section that is responsible for investigating insurance fraud.

- **Complaints—**Similar to Arizona, the 4 states we contacted receive and investigate complaints within their jurisdictions. Florida's Department of Financial Services receives and investigates insurance-related complaints, and the California, Pennsylvania, and Utah Departments of Insurance receive and investigate insurance-related complaints. Arizona, Florida, Pennsylvania, and Utah have the authority to impose fines when an investigation of a complaint finds that a person has violated insurance statute. California may specifically impose monetary penalties against a person who has been found to have operated without a license.

Sunset factor 12: The extent to which the Department has used private contractors in the performance of its duties as compared to other states and how more effective use of private contractors could be accomplished.

The Department reported it uses private contractors to perform various duties, including conducting actuarial analysis and consultation for reviewing long-term care insurance rates, administering receiverships, managing investments of and providing banking for Arizona's 2 insurance guaranty funds, administering licensing exams to insurance professionals, and reviewing and approving continuing education course providers. We compared the Department's use of contractors for these services to those used by 3 states: California, Florida, and Utah.

We found that the Department used contractors to a similar extent as the other states and did not identify any additional areas where the Department should consider using private contractors. Specifically:

- California reported that it uses contracted actuaries who have extensive previous experience with long-term care to review long-term care insurance rate increases.
- Florida reported that 2 different third-party adjusting firms process its workers' compensation claims for the Florida Workers' Compensation Insurance Guaranty Association.
- Utah reported that it contracts with third parties to conduct financial examinations of insurance companies as needed, based on its staff availability.

Auditor General makes 16 recommendations to the Department

The Department should:

1. Strengthen its fraud-referral prioritization process by:

    a. Developing and implementing a referral template, reporting requirements, and/or instructions that define the specific information and level of detail that insurance companies should provide when reporting suspected instances of insurance fraud.

    b. Developing and implementing a process to use available referral data to help identify fraud trends and prioritize fraud referrals.

    c. Developing and implementing instructions to guide investigators' efforts to input referral and investigation information into the database completely and consistently.

    d. Developing and implementing policies and procedures to incorporate the information discussed during the outreach events it conducts into its fraud-referral prioritization process and evaluating the effectiveness of these events.

    e. Developing and implementing a risk-based supervisory review process for referrals that are not investigated to help ensure that Department staff do not inappropriately close referrals that should be prioritized for investigation.

    f. Developing and implementing policies and procedures for its fraud-referral prioritization system and training additional staff on these policies and procedures (see Finding 1, pages 7 through 12, for more information).

2. Evaluate whether its prioritization process has facilitated the Department's ability to focus on high-priority referrals and determine and implement any changes needed to continue to improve the prioritization process (see Finding 1, pages 7 through 12, for more information).

3. Once the Department has taken steps to evaluate and strengthen its prioritization process, it should assess its fraud investigative staffing needs to help ensure it investigates all the high-priority fraud referrals it receives. This assessment should include a documented workload analysis that compares the Department's workload, including an estimate of future workload, with its staff resources and then identifies the level of resources needed based on workload and responsibilities. If the Department determines additional resources are needed, it should work with the Legislature to obtain these resources (see Finding 1, pages 7 through 12, for more information).

4. Develop and implement a conflict-of-interest policy that (1) requires all employees to complete an annual disclosure form; (2) defines a process for managing any disclosed potential conflicts of interest to ensure the conflict will not interfere with the performance of the employee's duties; and (3) defines a process for ensuring that completed forms are maintained in the Department's separate special disclosure file for public inspection (see Finding 2, pages 13 through 15, for more information).

5. Update and implement the policies and procedures for the Arizona Life and Disability Insurance Guaranty Fund Board, the Arizona Property and Casualty Insurance Guaranty Fund Board, and the Arizona Workers'

Compensation Appeals Board to (1) require board members to complete an annual disclosure form; (2) define a process to allow board members to fully disclose substantial interests during public meetings, document these disclosures in the board's meeting minutes—including the name of the person with an interest (i.e., board member or board member's relative), the interest's description, and the reason the board member is refraining from discussing or otherwise participating; and (3) define a process for ensuring that completed forms are maintained in the Department's separate special disclosure file for public inspection (see Finding 2, pages 13 through 15, for more information).

6. Update its disclosure form to require employees and public officers to comply with conflict-of-interest statutes by requiring the disclosure of both substantial financial and decision-making interests (see Finding 2, pages 13 through 15, for more information).

7. Improve its administration of long-term care insurance rate reviews by:

   a. Researching an appropriate time frame and then providing information to the Legislature regarding the need to revise the statutory time frame in order to allow more time to review long-term care insurance rates.

   b. Establishing and implementing a formal process for notifying insurance companies to waive the time frame requirement for long-term care insurance rates.

   c. Implementing the NAIC long-term care insurance task force's recommendations for improving long-term care insurance rate review when available and if appropriate and helpful (see Sunset Factor 2, pages 17 through 22, for more information).

8. Determine whether the Insurance Consumer Advisory Board is necessary and provides value to the Department and, based on its determination, take appropriate steps to either form this body to perform its statutory function or provide information to the Legislature regarding the need for a statutory change to sunset this body (see Sunset Factor 2, pages 17 through 22, for more information).

9. Determine whether it is necessary to reconvene the Continuing Education Review Committee. If the Department determines it is not necessary to reconvene this body, it should provide information to the Legislature regarding the need for a statutory change to sunset this body (see Sunset Factor 2, pages 17 through 22, for more information).

10. Update and finalize its policies and procedures manual for the Arizona Property and Casualty Insurance Guaranty Fund and the Arizona Life and Disability Insurance Guaranty Fund (see Sunset Factor 2, pages 17 through 22, for more information).

11. Ensure that all required reconciliations are completed and that a monthly financial review is being performed and subsequently verified by Department leadership, consistent with SAAM requirements (see Sunset Factor 2, pages 17 through 22, for more information).

12. Conduct a risk assessment to evaluate, document, and prioritize the areas in the Department's IT systems with the highest security risks, and use the results of its risk assessment to guide its efforts to develop and implement all required IT security program policies and procedures in line with ASET requirements and credible IT standards, focusing on high-risk areas first (see Sunset Factor 2, pages 17 through 22, for more information).

13. Once it has developed and implemented all required IT policies and procedures, provide training to its employees on these policies and procedures (see Sunset Factor 2, pages 17 through 22, for more information).

14. Work with ASET to define and document the scope of IT security services ASET provides to the Department and ensure that ASET provides these services (see Sunset Factor 2, pages 17 through 22, for more information).

15. Conduct rulemakings to adopt or revise rules it has identified that need to be established, amended, or repealed (see Sunset Factor 4, page 22, for more information).

16. Ensure that it makes board meeting minutes or a recording of board public meetings for the boards it supports available for public inspection 3 working days following a meeting as required by statute (see Sunset Factor 5, page 23, for more information).

Objectives, scope, and methodology

The Office of the Auditor General has conducted a performance audit and sunset review of the Department pursuant to a September 14, 2016, resolution of the Joint Legislative Audit Committee. The audit was conducted as part of the sunset review process prescribed in A.R.S. §41-2951 et seq. This audit addresses the Department's process for prioritizing insurance fraud referrals it receives for further investigation and its process for managing potential conflicts of interest. It also includes responses to the statutory sunset factors.

We used various methods to study the issues in this performance audit and sunset review of the Department. These methods included reviewing the Department's statutes, rules, annual reports, and policies and procedures; interviewing Department staff; and reviewing information on the Department's website.

In addition, we used the following specific methods to meet the audit objectives:

- To assess the Department's fraud-referral prioritization process, we conducted observations and interviews with Department staff and reviewed Department information about referrals for fiscal years 2009 through 2019, including information from the Department's referral case management system. To determine the level of information included in insurance fraud referrals, we reviewed a random sample of 20 of the 2,178 fraud referrals received by the Department between July 1, 2018 and March 31, 2019. We also contacted 4 other states—California, Florida, Pennsylvania, and Utah—to gather information on their insurance fraud prioritization processes.[23] Additionally, we reviewed statistics and other information about insurance fraud from the Coalition Against Insurance Fraud, the Federal Bureau of Investigation, and the National Association of Insurance Commissioners (NAIC), and interviewed a representative from the Coalition Against Insurance Fraud.

- To assess the Department's compliance with the State's conflict-of-interest laws, we reviewed statutes, the *Arizona Agency Handbook*, and the conflict-of-interest policies and procedures for the Department's 3 active boards. We also reviewed the Department's conflict-of-interest special disclosure file and completed staff disclosure forms on March 27, 2019 and April 22, 2019.

- To obtain information for the Introduction, we reviewed statutes, the Department's website, the Department's fiscal year 2017 and 2018 annual reports, and other Department-prepared documents relating to its responsibilities, functions, boards and committees, and staffing. Additionally, to determine the national regulatory standards for insurance regulatory agencies, we reviewed accreditation reports, and policy and procedure handbooks and guidelines from the NAIC. To obtain information about the National Insurance Producer Registry (NIPR), we conducted interviews with Department staff and reviewed information on the NIPR and NAIC websites. We also conducted observations and interviews with Department staff about its fraud-referral prioritization process. Finally, we compiled and analyzed unaudited information from the Arizona Financial Information System *Accounting Event Transaction File* for fiscal years 2017 through 2019 and the State of Arizona *Annual Financial Report* for fiscal years 2017 through 2018.

- To assess the Department's compliance with the State's open meeting law requirements, we reviewed the notice, agenda, and meeting minutes or audio recordings from 3 public meetings that we attended: the November 2018 Arizona Life and Disability Insurance Guaranty Fund Board meeting, the March 2019

[23] We judgmentally selected states based on factors such as comparable size to Arizona and demonstrated best practices.

Arizona Property and Casualty Insurance Guaranty Fund Board meeting, and the April 2019 Arizona Workers' Compensation Appeals Board meeting.

- To obtain information for the Sunset Factors, we contacted and reviewed the statutes and/or rules for insurance in 4 other states—California, Florida, Pennsylvania, and Utah. We also contacted these states to obtain information about their use of private contractors. To determine the Department's compliance with federal regulatory standards, we reviewed the 2019 NAIC Financial Regulation Standards Accreditation Report and the 2018 NAIC Interim Financial Regulation Standards Accreditation Report. To determine the number of new insolvencies administered and the number of claims paid by the 2 guaranty funds, we reviewed the calendar year 2017 and 2018 annual reports for the Arizona Property and Casualty Insurance Guaranty Fund and the Arizona Life and Disability Insurance Guaranty Fund. We also reviewed the Arizona Administrative Register and the Department's rulemakings from January 2015 through January 2019 to determine if the Department provided opportunities for public input during the rulemaking process. To assess the effectiveness of the Department's licensing process, we reviewed a random sample of 3 initial licensing applications and 3 licensing renewal applications from the 7,437 licenses the Department approved in September 2018. To assess the Department's effectiveness in resolving complaints, we reviewed a random sample of 10 consumer complaints and 5 enforcement complaints from the 2,984 complaints the Department resolved in fiscal year 2018.

- To assess the Department's efforts to implement an IT security program and related policies and procedures, we interviewed Department staff and analyzed the Department's IT security-related policies and other documents and compared them to the Arizona Department of Administration, Arizona Strategic Enterprise Technology Office's requirements and credible industry standards.[24]

- Our work on internal controls, including information system controls, focused on reviewing the Department's policies, procedures, and/or processes for prioritizing referrals of suspected insurance fraud against insurance companies for further investigation; disclosing conflicts of interest; reviewing long-term care insurance rates; administering the 2 state insurance guaranty funds; complying with State and credible industry standards' IT requirements; complying with open meeting law requirements; and handling complaints. Through this work, we determined that the Department's data was sufficiently reliable for audit purposes. We also reviewed the Arizona Department of Administration, General Accounting Office's August 2017 audit of the Department's internal controls and accounting procedures and assessed the Department's efforts to address the audit findings. In addition, we assessed the Department's internal controls related to cash receipts, cash disbursements—specifically over purchasing card purchases, travel card purchases, and travel reimbursements—and payroll for the period of July 1, 2017 through December 31, 2018, and compared these controls to the policies and procedures required by the *State of Arizona Accounting Manual*, as appropriate. We reported our conclusions on these internal and information system controls and the Department's needed efforts to improve them in Findings 1 and 2 (see pages 7 through 15), and in our responses to Sunset Factors 2 and 5 (see pages 18 through 22 and 22 through 23).

We conducted this performance audit and sunset review of the Department in accordance with generally accepted government auditing standards. The standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We express our appreciation to the Department and its Director and staff for their cooperation and assistance throughout the audit.

[24] National Institute of Standards and Technology (NIST). (2013). *NIST Special Publication 800-53, Revision 4: Security and privacy controls for federal systems and organizations*. Gaithersburg, MD.

AGENCY RESPONSE

Office of the Director
Arizona Department of Insurance
100 North 15th Avenue, Suite 102, Phoenix, AZ 85007-2624
Phone: (602) 364-3100 | Web: https://insurance.az.gov

Douglas A. Ducey, Governor
Keith A. Schraad, Director

September 16, 2019

Ms. Lindsey Perry, Auditor General
Arizona Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

Re: Department of Insurance - Performance Audit and Sunset Review

Dear Ms. Perry:

The Arizona Department of Insurance would like to thank you for the work you performed to evaluate how well the Department is fulfilling its mission, and for providing us the opportunity to respond to the recommendations and findings in your preliminary report draft of the performance audit and sunset review dated September 10, 2019.

Highlighting a few key successes for the Department:

- ADOI is very proud to be the most efficiently run department of insurance in the US based on data from the National Association of Insurance Commissioners (NAIC).
- ADOI has been fully committed to the Arizona Management System's initiative to bring never-ending improvements to the Department and has implemented numerous programs that have resulted in maximizing taxpayer dollars while better serving Arizona citizens.
- The Department brings in over $500 million a year in premium tax payments, the third largest source of Arizona General Fund revenue.

We carefully reviewed the observations, feedback, research and recommendations you provided, and we are committed to using the report to improve our department.

Sincerely,

Keith Schraad
Director

Finding 1: Department's new fraud referral prioritization process lacks components to ensure it investigates high-priority referrals

Recommendation 1: The Department should strengthen its fraud-referral prioritization process by:

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department proposes to implement recommendations as detailed in 1a through 1f, as follows.

Recommendation 1a: Developing and implementing a referral template, reporting requirements, and/or instructions that define the specific information and level of detail that insurance companies should provide when reporting suspected instances of insurance fraud.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department is activity participating on the NAIC's Anti-fraud Task Force and the Anti-fraud Information Systems Working Group to develop a uniform standard and process by which insurance companies can report the sum and substance of information that states need to receive in order to prioritize, investigate and prosecute insurance fraud referrals. Although A.R.S. § 20-466(G) provides the director authority to prescribe a form that insurance companies must use in Arizona to report suspected insurance fraud, the director is sensitive to the fact that insurance companies must fulfill fraud reporting requirements imposed in other states and territories throughout the U.S., and believes that working with other jurisdictions to create a uniform nationwide standard and system will facilitate fraud reporting and could help streamline processes for taking in, prioritizing and assigning cases. In the meantime, the Department will evaluate the fraud reporting standards and forms that other states employ to identify best practices that the Department can incorporate into its operations and can advocate in a multi-state uniform standard.

Recommendation 1b: Developing and implementing a process to use available referral data to help identify fraud trends and prioritize fraud referrals.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department will work to identify how best to perform this activity given the resources it has at its disposal.

Recommendation 1c: Developing and implementing instructions to guide investigators' efforts to input referral and investigation information into the database completely and consistently.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: We have already begun implementing this recommendation in two ways. First, as previously described, the Department is participating in NAIC initiatives to unify insurance fraud reporting and processing, which will improve the quality and consistency of information that is automatically loaded into the Department's fraud referral records. Second (in the meantime), our special agent supervisor and a newly hired special agent are writing a training manual that, in part, addresses how case information needs to be entered into the database.

Recommendation 1d: Developing and implementing policies and procedures to incorporate the information discussed during the outreach events it conducts into its fraud-referral prioritization process and evaluating the effectiveness of these events.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department will continue to receive information from, and will participate in education events and conferences hosted by, the National Association of Insurance Commissioners, the International Association of Financial Crimes Investigators, the Arizona Association of Chiefs of Police, the Arizona Association of Special Investigation Units, the National insurance Crime Bureau and the Coalition Against Insurance Fraud, to remain abreast of trends in insurance fraud, both nationally and locally. The Department will formalize its current outreach efforts by establishing routinely scheduled meetings with insurance industry stakeholders and other insurance fraud opponents (National Insurance Crime Bureau, Coalition Against Insurance Fraud) to learn about trends they see developing, and their ideas for areas where we should focus our investigation resources. The insurance industry has expressed intense interest in the Department having sufficient resources to combat insurance fraud, and the Department is committed to utilizing the resources it is provided to yield the most effective results.

Recommendation 1e: Developing and implementing a risk-based supervisory review process for referrals that are not investigated to help ensure that Department staff do not inappropriately close referrals that should be prioritized for investigation.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department will continue its practice of encouraging its special agents to ask questions as needed to determine whether referrals warrant investigation, and will develop and implement a process for reviewing a sample of referrals closed without investigation to verify the appropriateness of the decisions made by the special agents, and to provide further instructions to special agents if needed.

Recommendation 1f: Developing and implementing policies and procedures for its fraud-referral prioritization system and training additional staff on these policies and procedures.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: Our special agent supervisor and a newly hired special agent are writing a training manual that, in part, addresses how to prioritize referrals for investigation.

Recommendation 2: The Department should evaluate whether its prioritization process has facilitated the Department's ability to focus on high priority referrals and determine what changes, if any, are needed to continue to improve the prioritization process.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department shall develop as part of its policy and procedures a method to periodically review the priority levels assigned to a sampling of open referrals.

Recommendation 3: Once the Department has taken steps to evaluate and strengthen its prioritization process, the Department should assess its fraud investigative staffing needs to help ensure it investigates all the high priority fraud referrals it receives. This assessment should include a documented workload analysis that compares the Department's workload, including an estimate of future workload, with its staff resources and then identifies the level of resources needed based on workload and responsibilities. If the Department determines additional resources are needed, it should work with the Legislature to obtain these resources.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department shall apply its fraud-referral evaluation process to identify the number of fraud referrals that warrant investigation, to identify high-priority cases from among all cases warranting investigation, to develop an approach or calculation to estimate the investigation hours that would be required to investigate all the referrals, and to extrapolate the resources it would need to investigate all the high-priority fraud cases awaiting investigation and those it expects to receive annually.

Finding 2: Department's practices for managing conflicts-of-interest increase risk of nondisclosure

Recommendation 4: The Department should develop and implement a conflict-of-interest policy that (1) requires all employees to complete an annual disclosure form; (2) defines a process for managing any disclosed potential conflicts of interest to ensure the conflict will not interfere with the performance of the employee's duties; and (3) defines a process for ensuring that completed forms are maintained in the Department's separate special disclosure file for public inspection.

Department Response: The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

Response explanation: In addition to the conflict of interest statutes provided in Title 38, Chapter 3, Article 8, A.R.S. § 20-149 also prohibits direct and indirect financial interests by the director, or any deputy, examiner, assistant or employee (collectively "Department employee") in any insurer, agency or other entity regulated under A.R.S. Title 20 except as a policyholder or claimant under a policy, and requires a conflict of interest disclosure from any Department employee who has a relative with certain forms of beneficial interests in entities regulated under A.R.S. Title 20. However, as the report notes, Arizona law does not require employees to complete a form on an annual basis. Instead, they require disclosure

when a public employee, or the public employee's relative, has "a substantial interest in any decision of the public agency." A.R.S. § 38-503(B). The Department of Insurance will be consolidating with the Department of Financial Institutions and the Arizona Automobile Theft Authority effective July 1, 2020. The Department shall determine the conflict of interest provisions contained in the laws applicable to the employees and contractors of the consolidating agencies, including the general provisions in Title 38. The Department shall develop a comprehensive conflict of interest policy and form that (1) is made readily and continuously accessible to Department employees, (2) requires disclosure when required, including but not limited to when an employee has, or may be perceived as having, an substantial interest in a party involved in a matter being considered by the Department, (3) defines the process for managing disclosed potential conflicts of interest to ensure conflicts will not interfere with the performance of the employee's duties or with the perception of outcomes, (4) requires each employee to complete a form, attesting to their understanding of the policy and disclosing any known conflicts of interest, (5) describes the process of maintaining and making available for public inspection the repository of completed forms, open to public inspection, (6) requires new employees to review the policy and to attest to the review, (7) requires a designated employee to periodically review the repository to ensure that it has a form from each Department employee, and (8) requires that employees are reminded at least annually about the Department's conflict of interest policy and the need to disclose conflicts of interest.

Recommendation 5: The Department should update and implement the policies and procedures for the Arizona Life and Disability Insurance Guaranty Fund Board, the Arizona Property and Casualty Insurance Guaranty Fund Board, and the Arizona Workers' Compensation Appeals Board to (1) require board members to complete an annual disclosure form; (2) define a process to allow board members to fully disclose substantial interests during public meetings, document these disclosures in the board's meeting minutes—including the name of the person with an interest (i.e., board member or board member's relative), the interest's description, and the reason the board member is refraining from discussing or otherwise participating; and (3) define a process for ensuring that completed forms are maintained in the Department's separate special disclosure file for public inspection.

Department Response: The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

Response explanation: The Department shall develop a model policy and procedure that it will recommend be adopted by each of the boards into their plans of operation to be consistently administered by the board to inform each board member of the conflict of interest policy and disclosure requirements. The policy shall include the process, content, disposition and retention for a disclosure. The policy may include a provision that each meeting notice and agenda remind members of the conflict of interest policy and disclosure requirements.

Recommendation 6: The Department should update its disclosure form to require employees and public officers to comply with conflict-of-interest statutes by requiring the disclosure of both substantial financial and decision-making interests.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The policy that the Department develops will incorporate disclosure of both substantial financial and decision-making interests.

Sunset Factor 2: The extent to which the Department has met its statutory objective and purpose and the efficiency with which it has operated

Recommendation 7: The Department should improve its administration of long-term care insurance rate reviews by:

Department Response: The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

Response explanation: The Department proposes to implement recommendations as detailed in 7a through 7c, as follows.

Recommendation 7a: Researching an appropriate time frame and then provide information to the Legislature regarding the need to revise the statutory time frame in order to allow more time to review long-term care insurance rates.

Department Response: The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

Response explanation: The Department will work with the NAIC to research the long-term care review time frames established in other states' laws, and will work to collect data about the time it actually takes states to review long-term care rates. We believe this information would be useful if policymakers consider revising the statutory time frame to allow more time to review long-term care insurance rates. The Department will make itself available to respond to questions and to offer insights as to the resources and conditions needed for the Department to meet proposed time frames.

Recommendation 7b: Establishing and implementing a formal process for notifying insurance companies to waive the time frame requirement for long-term care insurance rates.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department will establish and implement a uniform communication process to notify an insurance company of the opportunity to waive the long-term care insurance rate review time frame within a specified amount of time after the Department has determined a long-term care rate filing contains all required elements.

Recommendation 7c: Implementing the NAIC long-term care insurance task force's recommendations for improving long-term care insurance rate review when available and if appropriate and helpful.

Department Response: The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

Response explanation: The Department will evaluate the recommendations from both NAIC Long Term Care Task Forces, will implement appropriate recommendations to the

extent they fall within the Department's administrative authority, and will make itself available to provide information and input to policymakers as appropriate.

Recommendation 8: The Department should determine whether the Insurance Consumer Advisory Board is necessary and provides value to the Department and, based on its determination, take appropriate steps to either form this body to perform its statutory function or provide information to the Legislature regarding the need for a statutory change to sunset this body.

Department Response: The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

Response explanation: The purpose of the Insurance Consumer Advisory Board ("Board") as specified in A.R.S. 20-400.08(D) is to "…advise and counsel with the director on matters relating to the condition of the insurance marketplace in terms of competition and compliance with [Article 4.2, Chapter 2, Title 20]." Article 4.2 applies to commercial property and casualty insurance. It does not apply to personal lines automobile, dwelling and homeowner insurance policies, mortgage guaranty insurance, title insurance, disability or life insurance, hospital service or medical service corporations, investment companies, mutual benefit associations or fraternal beneficiary associations. A.R.S. § 20-400. We believe this specification is important because without reading A.R.S. § 20-400.08(D), one may infer from its name that the Board would have similar functions as the type of consumer advisory boards or committees that other states may have to provide advice to the state's insurance regulatory agency. The Department actively participates as a member of the NAIC, which facilitates discussions, analysis and consideration of key issues involving insurance consumers, industry members , prospective vendors to the industry or regulators, and regulators. We agree that the usefulness of this board is questionable, given that the director already has broad discretion to establish task forces, committee, and advisory groups. The Department established a Commercial Lines Markets Task Force in 2002, which recommended that the Legislature consider repealing this board. The Department will make itself available to respond to questions and to offer insights if policymakers consider pursuing a statutory change to sunset the Board.

Recommendation 9: The Department should determine whether it is necessary to reconvene the Continuing Education Review Committee. If the Department determines it is not necessary to reconvene this body, it should provide information to the Legislature regarding the need for a statutory change to sunset this body.

Department Response: The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

Response explanation: We agree that the usefulness of this committee is questionable, given that the director already has broad discretion to establish task forces, committees, and advisory groups. The Department will make itself available to respond to questions and to offer insights if policymakers consider pursuing a statutory change to sunset the Committee and to provide the director the authority to create and update standards that apply to continuing education courses and course providers that Arizona insurance producers may use to satisfy their continuing education requirements.

Recommendation 10: The Department should update and finalize its policies and procedures manual for the Arizona Property and Casualty Insurance Guaranty Fund and the Arizona Life and Disability Insurance Guaranty Fund.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department shall review and update its policies and procedures manual for the guaranty funds, and shall present the draft policies and procedures to each guaranty fund board for comment and approval.

Recommendation 11: The Department should ensure that all required reconciliations are completed and that a monthly financial review is being performed and subsequently verified by Department leadership, consistent with SAAM requirements.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: An appropriate member of the Department's accounting team shall prepare reconciliations, and shall present them to the administration division manager, deputy director or director for review. The division manager, deputy director or director shall ask questions about any information that is unclear or appears incorrect, and shall signify approval of clear and correct reconciliations.

Recommendation 12: The Department should conduct a risk assessment to evaluate, document, and prioritize the areas in the Department's IT systems with the highest security risks, and use the results of its risk assessment to guide its efforts to develop and implement all required IT security program policies and procedures in line with ASET requirements and credible IT standards, focusing on high-risk areas first.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department will work with ASET to conduct a risk assessment to evaluate, document and prioritize the areas in the Department's IT systems that have the highest security risks, and shall use the results to develop and help implement IT security program policies and procedures for the Department.

Recommendation 13: Once it has developed and implemented all required IT policies and procedures, the Department should provide training to its employees on these policies and procedures.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department shall provide training to its employees pursuant to ASET policies and recommendations.

Recommendation 14: The Department should work with ASET to define and document the scope of IT security services provided by ASET to the Department and ensure that ASET provides these services.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department will continue to ask ASET to define and document the scope of IT security services it provides, and will work with ASET to devise a method by which the Department can verify that ASET is providing those services

Sunset Factor 4: The extent to which rules adopted by the Department are consistent with the legislative mandate

Recommendation 15: The Department should conduct rulemakings to adopt or revise rules it has identified that need to be established, amended, or repealed.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The report recognizes that the Department must determine how best to apply its limited resources to promulgate rules that Arizona law requires the director to adopt, to promulgate rules that will help ensure the Department maintains NAIC accreditation, and to eliminate rules that are antiquated, redundant or otherwise no longer necessary for the operation of state government. The Department will continue to publish its regulatory agenda as a means for keeping the public informed as to the Department's rulemaking priorities, and will continue to apply resources toward improving or eliminating outmoded rules.

Sunset Factor 5: The extent to which the Department has encouraged input from the public before adopting its rules and the extent to which it has informed the public as to its actions and their expected impact on the public

Recommendation 16: The Department should ensure that it makes board meeting minutes or a recording of board public meetings for the boards it supports available for public inspection 3 working days following a meeting as required by statute.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department shall post minutes to its Internet website or make a recording of each meeting available for public inspection within 3 working days following each board meeting.


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