State of Arizona
Office
of the
Auditor General

PERFORMANCE AUDIT

ARIZONA DEPARTMENT OF INSURANCE

Report to the Arizona Legislature
By Douglas R. Norton
Auditor General

November 1998
Report Number 98-21

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OFFICE OF THE
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November 20, 1998

Members of the Arizona Legislature

The Honorable Jane Dee Hull, Governor

Mr. Charles Cohen, Director
Arizona Department of Insurance

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Arizona Department of Insurance. This report is in response to a May 27, 1997, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the Sunset review set forth in A.R.S. §41-2951 through 41-2959.

We found the Department generally functions effectively. However, the Department can improve the manner in which it reviews insurance rates and investigates insurance fraud. Arizona adopted an open competition approach to regulating most property and casualty rates in 1980. Nevertheless, the Department continues to review all rate filings for adequacy. Since market forces serve as the primary regulator of rates in an open competition environment, such detailed and comprehensive reviews are generally unnecessary. Instead, the Department should target its rate reviews to those companies which may be at the greatest risk from charging inadequate rates, or companies which may be engaging in predatory pricing. Further, the Department should expand its market monitoring activities to ensure that all insurance markets remain competitive.

We also found that the Department's Fraud Unit has recently demonstrated a stronger impact in the fight against insurance fraud. For example, between fiscal years 1995 and 1997, the rate of indictments and convictions increased from 48 percent to 73 percent. Despite this improvement, the Unit's overall impact may still be limited because it does not adequately track whether insurance companies comply with fraud reporting requirements.

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As outlined in its response, the Department of Insurance agrees with the findings and recommendations, although it does not agree with all of the report's underlying analysis regarding rate review. Because the Department's disagreement with the analysis is largely philosophical, we have enclosed an Auditor's Note immediately following the response summarizing our position on the issues raised by the Department.

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

This report will be released to the public on November 23, 1998.

Sincerely,

Douglas R. Norton
Auditor General

Enclosure

SUMMARY

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Insurance (Department), pursuant to a May 27, 1997, resolution of the Joint Legislative Audit Committee. This audit was conducted as part of the Sunset review set forth in Arizona Revised Statutes (A.R.S.) §§41-2951 through 41-2957.

The Department was established in 1913 to regulate the insurance industry in Arizona. As provided in the Arizona State Constitution, all companies selling insurance within the State shall be subject to licensing, control, and supervision by a department of insurance. Further, Title 20 authorizes the Arizona Department of Insurance to license insurance companies and agents, provide consumer assistance, investigate complaints from the public, review insurance forms and rate filings, monitor the financial status of insurers, oversee guaranty funds, and collect premium taxes and other fees.

Rates and Regulations Division Uses Ineffective Rate Review Process

(See pages 9 through 16)

Although Arizona adopted an open competition approach to regulating rates in 1980, the Rates and Regulations Division (the Division) within the Department uses an ineffective rate review process. State law requires that insurance rates not be excessive, inadequate, or unfairly discriminatory. Typically, state insurance departments regulate rates for these standards using two primary approaches:

- **Prior Approval**—which requires that no insurer use an insurance rate without first filing and receiving the state insurance department's approval; or
- **Open Competition**—which relies on competition as the primary regulator of rates. However, insurance departments may still review rates to ensure they are not inadequate or unfairly discriminatory.

While prior approval and open competition are equally effective in ensuring fair insurance prices, there is typically less cost associated with an open competition approach. Although insurance companies no longer need approval before using open competition rates in Arizona, the Division continues to subject the approximately 3,000 rate filings it receives each

year to the same scrutiny as those under a prior approval approach. Consequently, the Division has not taken advantage of the potential cost savings associated with an open competition environment.

While the Division continues to review all rate filings, these reviews offer minimal consumer protection. First, the Division cannot disapprove a rate filing even if it appears excessive because, under the State's open competition rating law, rates are presumed not to be excessive if a reasonable degree of competition exists. Second, the Division's current process for reviewing rates for adequacy is not sufficient to identify insurers at risk of future insolvency. By focusing on only one rate of many that a company may have in effect, the Division cannot determine possible future solvency problems. Further, the Division does not disapprove rates when they appear to be inadequate, and has a 15-month backlog of rates to be reviewed. Therefore, the Division can more effectively use its resources by targeting its rate reviews to those companies most in danger of future insolvency should they charge inadequate rates.

In addition to targeting its rate review activities, the Division should also expand its monitoring of the State's insurance markets to ensure a competitive environment. This expanded market monitoring should consider at least the following four statutorily required "tests of competition" for all markets, where feasible:

1) The number of insurers actively engaged in the business;

2) The market share and changes in market share of insurers;

3) The existence of price differentials; and

4) The ease with which new insurers can enter the market.

Fraud Unit Can Further Enhance Its Performance (See pages 17 through 22)

While the Department's Fraud Unit has improved since its inception in fiscal year 1995, it can take additional steps to further enhance its effectiveness. Although the Fraud Unit produced a minimal number of cases for prosecution in its first 2 to 3 years, it has recently demonstrated a stronger impact in the fight against insurance fraud. For example, between fiscal years 1995 and 1998, the number of insurance company fraud referrals increased from 620 to 1,355, while the number of fraud referrals submitted for prosecution increased from 23 to

147. Additionally, between fiscal years 1995 and 1997 the rate of indictments and convictions obtained from those cases submitted for prosecution increased from 48 percent to 73 percent.[1]

Despite this improvement, the Unit's inadequate tracking and analysis of fraud referrals may ultimately limit its impact. Although statute requires insurance companies to report suspected fraud cases to the Department, some insurers may not report suspected fraud. However, due to limitations in its fraud referral database, the Department cannot determine which insurance companies have reported suspected fraud and which have not. The Fraud Unit should revise its referral form to capture an insurance company's unique identifier and enter this number in the fraud referral database. This will allow the Unit to identify those companies that have not reported suspected fraud. In addition, the Fraud Unit should enact procedures to inform and educate insurance companies regarding case referrals.

Other Pertinent Information (See pages 23 through 26)

During the audit, other pertinent information was collected regarding the Department's regulatory oversight of public risk pools. A public risk pool is a cooperative group of government entities that join together to finance self-insurance expenses and share losses. Three public risk pools have become insolvent in recent years, leaving some public entities liable for their own claims. Because these pools are considered a form of self-insurance, they are regulated at a much lower level than traditional insurers. For example, public risk pools do not have to meet as strict financial requirements as do traditional insurers and the Department has no authority to intervene in the operations of public risk pools to avoid insolvencies. Instead, the Department's role is primarily limited to providing recommendations to abate an insolvency should one occur.

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[1] Indictment and conviction rate is based upon fiscal year 1995 through 1997 data because a large number of referrals are pending review by prosecutors in fiscal year 1998. The number of indictments and convictions reported for fiscal year 1998 may change significantly due to the high number of pending referrals.

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INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Insurance (Department), pursuant to a May 27, 1997, resolution of the Joint Legislative Audit Committee. This audit was conducted as part of the Sunset review set forth in Arizona Revised Statutes (A.R.S.) §§41-2951 through 41-2957.

The Department of Insurance was created and placed under the direction of the Arizona Corporation Commission in 1913. In 1968, Arizona voters approved a constitutional amendment creating an independent Department of Insurance. The amendment established that all insurers operating within the State shall be subject to the licensing, control, and supervision of a department of insurance. As such, the Department's mission is to:

> *"… promote a favorable insurance marketplace for the benefit of Arizona residents and to foster a financially and legally sound insurance environment that enhances Arizona's economic development and protects insurance consumers."*

In fulfilling its mission, the Department licenses or otherwise approves the transaction of insurance business by companies, agencies, brokers, and other insurance-related entities; monitors the financial health of insurers; protects insurance consumers against illegal business practices; and collects more than $144 million in insurance premium taxes and other revenue for the State.

Organization and Staffing

As of July 1, 1998, the Department is authorized 138 full-time equivalent employees (FTE) to fulfill its various responsibilities. Aside from the 7 executive staff within the Director's Office, the Department's remaining personnel are divided among 10 divisions:

- **Consumer Services and Investigations (27 FTEs)**—This Division provides a variety of consumer services, including responding to inquiries; distributing information; investigating complaints; and monitoring the activities of insurers, agents, brokers, adjusters, and bail bondsmen. The Division also assists consumers having difficulty in obtaining insurance coverage.

- **Corporate and Financial Affairs (24 FTEs)**—This Division monitors solvency of the more than 2,000 active insurance companies conducting business in Arizona through examination and analysis of insurers' financial information. In addition to staff, the Division also has 54 private contractors available to conduct financial examinations.[1]

- **Administrative Services (20 FTEs)**—This Division handles the Department's business and licensing functions, including accounting, budgeting, revenue forecasting, and payroll; and licensing agents, brokers, adjusters, and others who qualify for licensure under Arizona insurance law.

- **Fraud (16 FTEs)**—This Unit investigates complaints involving fraud committed against insurers.

- **Life and Health (15 FTEs)**—This Division reviews life and health insurance forms, rates, and advertising material for compliance with Arizona insurance laws.

- **Rates and Regulations (11 FTEs)**—This Division's primary responsibilities include reviewing property and casualty rates and forms for compliance with Arizona insurance laws; and licensing and registering various insurance-related entities, such as life and health insurance administrators.

- **Market Conduct Examination (7 FTEs)**—This Division monitors insurers to ensure they do not engage in any unfair trade or claims settlement practices. In addition to staff, the Division has between 25 to 30 private contractors in the field at any given time examining insurers' marketing, rating, underwriting, and claims practices.

- **Guaranty Funds (5 FTEs)**—This entity administers Arizona's two guaranty funds, which were established to pay claimants when insurers become insolvent and are unable to meet their obligations.

- **Receivership (3 FTEs)**—This division supervises and coordinates all domestic insurance companies (those incorporated in Arizona) that become insolvent.

- **Information Services (3 FTEs)**—This Division manages the Department's computer resources and maintains the Department's Internet Website.

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[1] Contract examiners' costs are covered by those insurers examined, as required by A.R.S. §20-156.

Table 1

Department of Insurance
Statement of Revenues, Expenditures, and Other Changes in Fund Balance[1]
Years Ended June 30, 1996, 1997, and 1998
(Unaudited)

	1996	1997	1998	
Revenues:				
State General Fund appropriations	$ 4,640,200	$ 4,388,500	$ 4,780,500	
Insurance premium taxes	114,146,310	120,515,441	124,636,458	
Licenses and fees[2]	11,992,819	12,027,697	13,569,099	
Sales and charges for services	126,022	109,443	117,562	
Fines and forfeits	1,029,373	1,527,470	810,287	
Interest on investments	17,812	16,058	15,307	
Other	48,445	111,811	801,468	6
Total revenues	132,000,981	138,696,420	144,730,681	
Expenditures:				
Personal services[3]	2,719,330	3,025,798	3,616,194	
Employee related	653,228	676,798	765,892	
Professional and outside services[4]	7,332,214	7,313,488	7,801,199	
Travel, in-state	22,387	25,191	28,617	
Travel, out-of-state	17,338	18,573	21,940	
Other operating	1,307,758	1,026,158	1,153,358	
Capital outlay	222,861	7,161	82,668	
Total expenditures	12,275,116	12,093,167	13,469,868	
Excess of revenues over expenditures	119,725,865	126,603,253	131,260,813	
Other financing uses:				
Remittances to the State General Fund[5]	119,853,354	126,693,733	130,575,128	
Reversions to the State General Fund	81,722	110,549	135,428	
Total other financing uses	119,935,076	126,804,282	130,710,556	
Excess of revenues under expenditures and other financing uses	(209,211)	(201,029)	550,257	
Fund balance, beginning of year	852,102	642,891	441,862	
Fund balance, end of year	$ 642,891	$ 441,862	$ 992,119	

1 The table excludes financial activity of the Arizona Property and Casualty Guaranty Fund and the Arizona Life and Disability Insurance Guaranty Fund since assets for these funds are held by the State on behalf of others. As of the end of fiscal year 1998, these funds had unaudited ending fund balances of $328,926 and $11,981,344, respectively.

2 Primarily includes fees charged to insurers for examinations performed in accordance with A.R.S. §20-156. The Department examines the affairs, transactions, accounts, records, and assets of insurers who have the authority to do business in the State.

3 From fiscal year 1996 through fiscal year 1998, the Department converted independent contractor positions to full-time equivalent positions within the Department. Thus, the Department's FTE count grew from 121 FTE in fiscal year 1996 to 134 in fiscal year 1998. Associated personal services and employee-related expenditures also increased.

4 Primarily includes compensation to independent contractors and reimbursement for expenditures related to examination services performed in accordance with A.R.S. §20-156.

5 Excludes amounts received from the Arizona Life and Disability Insurance Guaranty Fund, which are liquidated assets of insolvent insurers and are ultimately deposited in the State General Fund.

6 Primarily includes reimbursements for the administrative costs of operating the Guaranty Funds and Receivership Division. The Guaranty Funds were previously administered externally; therefore, there were no reimbursements for the Guaranty Funds in prior years. Additionally, reimbursements for administrative costs of the Receivership Division vary significantly depending on receivership collections.

Source: The Arizona Financial Information System (AFIS) *Accounting Event Extract File* for years ended June 30, 1996 and 1997, and the AFIS *Revenue and Expenditure by Fund Program, Organization, and Object* report, the AFIS *Trial Balance by Fund* report, AFIS *Status of Appropriations and Expenditures* report, and the *State of Arizona Appropriations* Report for the years ended June 30, 1996, 1997, and 1998.

Budget

The Department's operations are funded through a General Fund appropriation and fees that are assessed to insurers. The majority of revenue the Department collects is remitted to the State General Fund. As illustrated in Table 1 (see page 3), fiscal year 1998 premium tax revenues totaled $124.6 million, while licenses, fees, and other revenues amounted to $15.3 million. For its operations, the Department spent $13.4 million during fiscal year 1998. Table 1 also summarizes the Department's revenues, expenditures, and other changes in fund balance for fiscal years 1996 through 1998.

Follow-up on Prior Audits

As part of the current audit, concerns identified in the Auditor General's 1995 special investigation of the Insurance Examiners' Revolving Fund and the performance audit of the Department (Auditor General Report No. 89-8) were reviewed. The primary recommendations presented in the 1995 report and subsequent actions taken are described below:

- **Independent contractors still receive significant employee benefits**—While the Department has taken some action to reduce the benefits provided to independent contractors, they still receive significant employee benefits. The 1995 special investigation found that the "independent contractors" hired by the Department to perform financial and market conduct examinations and analysis may meet the common law definition of "employee" and therefore, the Department may be liable for applicable employment-related taxes and withholdings. As such, the report recommended that the Department exercise considerably less control over its independent contractors by maintaining a true independent, arm's-length relationship with them.

  Although the Department discontinued the policy of paying its contractors holiday pay, the Department continues to provide some of its contractors with office space, clerical assistance, computer equipment, office supplies, and reimbursement for travel expenses. Therefore, the Department should take additional steps to ensure it maintains an appropriate relationship with its independent contractors.

- **Oversight of contractor billings has improved**—The 1995 report also found that the Department did not adequately monitor the billings of contractors; however, the Department has since improved its oversight in this area. Specifically, the 1995 special investigation report recommended that the Department monitor and verify contractor billings, ensure that contract examiners do not process their employer's billings, and ensure that reimbursements are not made for unallowed expenses. This would help ensure that contract examiners are compensated for only those services actually provided and reimbursed only for allowable expenditures actually incurred. To improve contract en-

forcement and oversight, Department employees now review contractor billings and contractors must submit receipts for all expenses incurred (except meals).

Recommendations presented in the 1989 performance audit report and subsequent actions taken are described below:

- **Other reforms considered to control increasing automobile insurance rates**—The 1989 audit found that although statutes use rate regulation to control affordability of insurance, rates are not significantly affected by the type of rate regulation system. Therefore, the 1989 report recommended that the Legislature consider other types of reforms to reduce automobile rates including no-fault insurance, limitations on noneconomic damage awards, joint and several liability, and automobile theft and fraud initiatives.

  In the early 1990's, reforms were implemented to control increasing automobile insurance rates. Specifically, the Legislature established the Automobile Theft Authority in 1992 to assist law enforcement with funding and programs for reducing the State's auto theft rate. Legislation was also approved in 1994 to annually assess insurers a fixed amount to fund a fraud unit within the Department of Insurance. Finally, two referendums were initiated to pass no-fault insurance laws in 1990; however, Arizona citizens rejected them.

- **Delays in processing complaint cases referred to the Attorney General's Office have increased**—Although the Department has attempted to address lags in the processing of complaints referred to the Attorney General's Office, delays have not only continued, but have increased. According to the 1989 audit, it took an average of 72 days from referral of the complaint to issuance of a hearing notice or consent order. The Department now reports averages of 140 and 169 days for 1996 and 1997, respectively. The Department is attempting to address some of the continuing delay by reassigning a Department staff member to draft hearing notices and consent orders to submit to the Attorney General's Office with the complaint case files, thus relieving Attorney General staff from having to perform this activity.

- **Department's timeliness in resolving routine complaints continues to exceed desired time frame**—The 1989 audit found that the Department failed to resolve nearly half of all consumer complaints within its established standard of 30 working days, due primarily to a manual system of tracking complaints and inadequate staffing.

  The Department has attempted to address the issue of untimely complaint resolution by implementing an automated complaint tracking database, increasing its investigative staff by 50 percent, and upgrading the position classification for investigators. In addition, the Department has also revised its internal goal from 30 working to 60 calendar

days to more realistically reflect the time needed to resolve complaints. The Department now reports that in fiscal year 1997, it took an average of 71 calendar days to resolve a complaint. Department personnel point out that although 71 days exceeds the Department's goal, it compares favorably to the number of days required by other state regulatory agencies to resolve complaints, especially given the Department's complaint-to-staff ratio.

Notable Accomplishments

Similar to the 1989 audit, work performed for this audit indicates that the Department functions effectively in several areas. For example, the Department expedited its licensing process through implementation of the "On-the-Spot" licensing program, whereby an individual can bring in a completed license application and have it reviewed by a licensing specialist. If the application is in order, a license will be issued on-the-spot (i.e., within an average of 20 minutes).

In addition, in 1993 and 1998 the Department received accreditation from the National Association of Insurance Commissioners (NAIC) Financial Regulation Standards and Accreditation Committee.[1] In order to receive such accreditation, the Department must have the laws, resources, and operating procedures necessary to meet NAIC standards. Such standards ensure state insurance departments analyze the financial condition of their domestic insurers in a consistent and thorough manner. Consequently, accredited states may rely on the financial analyses of other accredited states so that multi-state insurers do not have to submit to costly and duplicative examinations in each state in which they transact business.

In conjunction with accreditation, the Department has enhanced its financial surveillance program, increasing its staff from 4 analysts in fiscal year 1992 to 11 analysts in fiscal year 1997. Additionally, the analysts now perform most of their analyses on computerized financial data, making their reviews more timely.

Audit Scope and Methodology

The audit focused on the Department's ability to efficiently and effectively fulfill its role to regulate the conduct of insurance business in this State. Specifically, audit work as-

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[1] The NAIC is an organization of insurance regulators from the 50 states, the District of Columbia, and the 4 U.S. territories. It was created in 1871 to provide a forum for the development of uniform policy when uniformity among states is appropriate.

sessed the impact of performing detailed reviews of property and casualty rates regulated under open competition law and the effectiveness of the Department's Fraud Unit.

To assess the value of the Department's current property and casualty rate review process, a review was conducted of state legislation pertaining to rate regulation, interviews were conducted with the Department's rate analysts, and analyst productivity statistics were examined. Additionally, articles and studies on the benefits and costs of rate regulation were reviewed. Various organizations and individuals were also contacted, including Property and Casualty Rate and Regulation Divisions in 13 other states with open competition rating laws, industry trade organizations, insurance research organizations, and a rate service organization.[1] Written communications from the Department's rate regulatory division to its financial regulatory division pertaining to potentially troubled insurers identified during rate reviews were also reviewed. Finally, documentation pertaining to prior reviews of Arizona's regulation of property and casualty rates was obtained and reviewed.

To evaluate the effectiveness of the Department's Fraud Unit, interviews were conducted with fraud investigation personnel from eight other states, industry fraud investigators, and state and county prosecutors responsible for prosecuting fraud cases.[2] Additionally, reviews and analyses were conducted of the Fraud Unit's database, investigation files, and performance data. Documentation from the National Insurance Crime Bureau and the Coalition Against Insurance Fraud was also obtained and reviewed. Further, two meetings of the Arizona International Association of Special Investigation Units were also attended. Finally, an auditor accompanied Fraud Unit investigators on an actual investigation.

This report presents findings and recommendations in two areas:

- The Department's Rates and Regulations Division needs to target its rate review activities and expand its current monitoring of insurance markets.

- The Department's Fraud Unit needs to improve its case referral tracking and formalize procedures for corresponding with and educating insurers about fraud referrals and investigations.

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[1] Organizations contacted included the National Association of Insurance Commissioners, American Insurance Association, Alliance of American Insurers, Insurance Information Institute, Center for Risk Management and Insurance Research, Insurance Institute of America, American Academy of Actuaries, and Insurance Services Office, Inc. States contacted included Colorado, Florida, Idaho, Illinois, Iowa, Kansas, Kentucky, Missouri, Tennessee, Utah, Vermont, Wisconsin, and Wyoming.

[2] States contacted were those with established insurance fraud units, the majority of which are located on the East Coast, and included California, Connecticut, Florida, Maryland, Massachusetts, New Jersey, North Carolina, and Pennsylvania.

In addition, the report contains an Other Pertinent Information section on the Department's current regulatory responsibility over public risk pools.

The audit was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the Director and staff of the Arizona Department of Insurance for their cooperation and assistance during the course of the audit.

FINDING I

RATES AND REGULATIONS DIVISION USES INEFFECTIVE RATE REVIEW PROCESS

Although Arizona adopted an open competition approach to regulating most property and casualty rates in 1980, the Rates and Regulations Division uses an ineffective process to review these rates. Further, the Division's current labor-intensive, time-consuming rate review process has a limited impact on consumer welfare. Therefore, the Division should revise its approach to regulating rates in an open competition environment by adopting a targeted approach to reviewing rates for inadequacy and expanding its market monitoring program.

Background

State law requires that insurance rates not be excessive, inadequate, or unfairly discriminatory. As such, Arizona, like most other states, has established a process to review insurance rates to ensure compliance with these three standards, thereby protecting consumers' interests. Typically, insurance departments regulate rates using two primary approaches:

- **Prior approval**—which requires that no insurer use an insurance rate without first filing and receiving approval by the state insurance department; or
- **Open competition**—which relies on competition as the primary regulator of rates.

However, even under the open competition approach, insurance departments may still review rates to ensure they are not inadequate or unfairly discriminatory. According to the NAIC, as of July 1998, about 80 percent of the states regulate some of their property and casualty lines of insurance through some variation of open competition.

Arizona Does Not Take Full Advantage of Open Competition Environment

Although an open competition approach to regulating rates is equally effective and less costly than a prior approval method, the Division has not realized the potential benefits available under open competition. In 1980, Arizona moved from a prior approval rating law to an open competition regulatory approach.[1] Evidence suggests it is equally effective at protecting consumers but less costly to administer. However, the Division has not taken advantage of these cost savings because it continues to subject all rate filings to a detailed review.

Open competition equally effective and less costly—Most of the empirical work on various regulatory approaches indicates prior approval and open competition are equally effective in ensuring fair insurance prices, but there is typically less cost associated with an open competition approach.[2] First, regulators incur fewer administrative costs because they do not have to subject each filing to a detailed review in order to determine if it meets statutory standards, since market forces serve as the primary regulator of rates. Second, insurers incur less cost because they can quickly adjust their rates in response to changing costs or competitive pressures without the delays associated with obtaining approval. Finally, consumers incur fewer costs because insurers can introduce new products in response to consumer needs without passing on the costs associated with prior approval regulation.

Division does not take advantage of cost savings—The Division has not taken advantage of these cost savings because although insurance companies no longer need prior approval to use open competition rates, the Division continues to subject all rate filings to the same scrutiny as it would under a prior approval approach. Specifically, the Division continues to review in detail each of the approximately 3,000 rate filings it receives each year, taking an average of two hours to complete each filing. Under a prior approval approach, analysts must review each rate filing, including examining supporting documentation, actuarial methodology, and rate calculations, to determine if a rate is excessive, inadequate, or unfairly discriminatory. However, under open competition, market forces are the primary regulator of rates. Consequently, the Division should not have to review or analyze every open competition rate filing to the same degree as a prior approval filing.

While Division officials contend that reviewing every rate filing in detail provides maximum consumer protection, studies suggest that applying a prior approval approach in

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[1] In Arizona, only workers' compensation and title insurance are still subject to prior approval regulation in the property and casualty market.

[2] Ettlinger, Hamilton & Krohm. "*State Insurance Regulation,*" 1995, pgs. 72-76.

an open competition environment is not only unnecessary but costly to taxpayers. Specifically, one study states, *"…certainly regulatory agencies in prior approval environments may appear to be more accountable to the consumers (voters); nevertheless, after the smoke clears…the taxpayers have expended a lot of money while receiving very little, if any, measurable benefit."*[1] Furthermore, as a study by the National Association of Insurance Commissioners (NAIC) points out, *"…if an insurance department attempts to evaluate each and every price of an individual insurer, little benefit would be obtained from the enactment of an open competition rating law."*[2]

In addition, other states that have enacted open competition laws do not review every rate filing in detail. Auditors contacted 13 states that have an open competition law and found that, in practice, 10 limit their detailed reviews to those rates that are of unique concern to that particular state.

Inefficient Rate Review Process Provides Minimal Consumer Protection

Even though the Division continues to review all rates, these reviews offer minimal consumer protection. Specifically, the Division's rate reviews are unnecessary to protect consumers against excessive rates. Additionally, the Division currently employs an ineffective process to ensure the adequacy of rates submitted by insurers.

Reviews unnecessary to protect against excessive rates—While the Division continues to review all filings for the purpose of protecting the consumer, reviewing filings for excessive rates is unnecessary. Under the State's open competition rating law, rates are presumed not to be excessive if a reasonable degree of competition exists. In fact, the Director cannot declare a rate excessive unless he has determined that a market is uncompetitive, a situation that has never occurred in the 18 years the open competition law has been in existence. Consequently, the Division does not need to review individual filings for excessive rates because the Director does not have the authority to disapprove a rate filing even if it appears to be excessive. Instead, the Division should monitor markets for excessive rates as discussed on page 14.

Reviews ineffective in ensuring adequacy of rates—The Division's current rate review process also does not effectively protect consumers against the effects of inadequate rates. One reason often given for reviewing filings for inadequate rates is to identify companies

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[1] Morrow, J. Glenn. "Regulatory Environments: Do They Matter?" *Journal of Insurance Regulation*, Fall 1992, p. 52.

[2] Hanson, Dineen & Johnson. "*Monitoring Competition: A Means of Regulating the Property and Liability Insurance Business*," 1974, p. 640.

that may be at risk for future insolvency. Theoretically, if insurance companies charge rates that generate insufficient revenue (premiums) to cover operating costs, insolvency can result and leave an insurer unable to pay the claims of policyholders. While statute prohibits insurers from charging inadequate rates to consumers, statute does not specify the process the Department should use to protect consumers from inadequate rates. Currently, the Division enforces this provision through individual rate reviews. However, individual rate reviews, as currently conducted, cannot necessarily determine whether a company may be at risk for future insolvency. Specifically, the Division would have difficulty in identifying and correcting future insolvency problems for the following reasons:

- **Scope of review limited**—The Division needs more information than just one rate filing to determine the potential for future insolvency. Currently, insurers are only required to submit new rates and rate changes and as such, the Division typically reviews only a segment of a company's possible rates at any one time. However, identifying one inadequate rate filing does not necessarily indicate solvency problems because an insurance company could have several other insurance products, which may be more profitable. Unless the Division reviews all of an insurer's rates at the same time, it cannot determine the company's overall profitability.

- **Division does not disapprove rates for inadequacy**—Although the Division has the authority to disapprove rates for inadequacy through an order issued by the Department's Director, it does not use this authority. Under the State's open competition rating law, insurers consider many factors besides losses and expenses when establishing their rates. Such factors include the company's overall profit, the types of investments, dividends, and savings; and "judgment factors," such as potential changes in the economy and demographic changes, when determining how much they need to charge for a particular insurance product. Knowing this, even when a rate request appears insufficient to cover a company's losses and expenses, the Division does not disapprove it. In fact, the Division has never formally disapproved a rate for inadequacy since the inception of the open competition law. Instead, the Division relies on insurers to provide additional support, withdraw or amend an inappropriate rate filing when questioned by Division analysts. However, because the Division does not track withdrawal information, it was not possible to determine the effectiveness of this approach.

- **Backlog impedes timeliness**—The Division currently has not reviewed approximately 2,000 rate filings, representing a 15-month backlog. Therefore, even if the reviews were effective in identifying potential insolvencies, they are not timely enough to impact the effects of inadequate rates.

Division Could Better Use Resources by Targeting Reviews and Monitoring Markets

Given the limited benefit offered by the current rate review process, the Division could better use its resources by targeting its rate reviews and increasing market monitoring efforts. Since inadequate rates do not always indicate future insolvency, the Division should target its rate reviews to identify those companies most in danger of future insolvency should they charge inadequate rates. In addition, because open competition depends on competitive markets, the Division should expand its market monitoring efforts to ensure that all markets remain competitive.

Future solvency better monitored through targeted reviews—Rather than review every rate filing, the Division should target its rate reviews to those companies most in danger of future insolvency should they charge inadequate rates. The Division can accomplish this, in part, by obtaining information from the financial surveillance program within the Corporate and Financial Affairs Division. This program monitors insurers' current financial condition using sources such as the NAIC's Insurance Regulatory Information System (IRIS) and annual financial statements. Through an automated analysis of such factors as profitability, quality of assets, liquidity, and risk exposure, staff can promptly detect companies that are undergoing significant financial changes. By targeting those companies already in a precarious financial condition, the Division can review those rates more likely to result in future insolvency.

In addition to obtaining financial information from the financial surveillance program, the Division could use additional methods to target filings at risk for inadequate rates. Some possible methods described in industry literature and/or discussed with Division staff include:

- **Targeting filings of companies showing significant increases in market share**—If a company has secured significantly more business in a relatively short time period, it might be an indication that it is charging inadequate rates in order to lure customers away from competitors. As such, identifying those companies with significant increases in market share can serve as a red flag that a company's rates might be inadequate.

- **Targeting filings of certain lines of insurance**—Some insurance products are more closely associated with greater financial risk than others. For example, non-standard auto insurance serves higher risk consumers not eligible for standard auto insurance, and therefore, may involve more frequent losses. In addition, many insurers that offer this product do not offer other types of insurance to help compensate for these losses. As such, the Division may want to target those lines associated with greater financial risks.

- **Targeting small and/or new companies**—According to Division staff, newer and smaller insurers may charge lower rates as a way of luring customers away from the larger, more established insurers. These lower rates may be inadequate. As such, the rates submitted by small or new companies might warrant review.

To successfully implement a targeted approach to review rates for inadequacy, the Department will require additional resources. According to Division staff, the Department will have the computer resources necessary to implement targeted rate reviews by February 1999. However, the Division will need additional time to make the required programming changes and to train staff on the new targeted rate review approach.

Monitoring markets critical to open competition approach—In addition to targeting rate reviews, monitoring markets can also ensure a successful open competition environment. According to an NAIC study, "*monitoring competition involves a continuing study of market (aggregate industry) performance as distinguished from a study of an individual company's performance."*[1] Under an open competition environment, market monitoring offers the only mechanism to protect consumers from excessive rates. As indicated earlier, no rate can be deemed excessive unless it is determined that a market is uncompetitive. Under Arizona law, the Department's Director has the authority to make such a determination after considering at least the following four specific "tests of competition": 1) the number of insurers actively engaged in the business, 2) the market share and changes in market share of insurers, 3) the existence of price differentials, and 4) the ease with which new insurers can enter the market. If, through monitoring, the Director determines that a market has failed to remain competitive, statutes authorize the Director to re-impose prior approval regulation until the market failure has been addressed.

Tests of competition, such as those listed above, can determine certain anti-competitive practices, including whether an insurer has sufficient market power to influence prices. Specifically, if the market has many insurers and each insurer has a relatively small market share, it is assumed that insurers are unable to control the price of the product that they sell. According to an NAIC report, when the combined market share of a national industry's four largest companies reaches 75 percent or greater, the market is considered highly concentrated (i.e. potentially uncompetitive).[2] As such, it may be possible for the leading compa-

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[1] Hanson, Dineen & Johnson, "*Monitoring Competition: A Means of Regulating the Property and Liability Insurance Business,*" 1974, p. 693.

[2] NAIC Insurance Availability and Affordability Task Force, "*Improving Urban Insurance Markets: A Handbook of Available Options,*" (draft, June 4, 1996), pgs. 28-29.

nies to control prices.[1] Such behavior is particularly important for state insurance departments to monitor since the insurance industry is exempt from most federal anti-trust laws that would otherwise address such practices.

Tests of competition can also be used to identify the effects of inadequate rates. For example, some insurers charge destructively low prices in order to gain a larger market share. In extreme cases, such practices can drive insurers out of the marketplace, resulting in little or no choice for consumers seeking those insurance products. Monitoring for large changes in market share could help identify destructively low prices and alert the Division to potential availability problems.

Division does some monitoring but should expand its program—Because of the importance of market monitoring under a competitive environment, the Division should take steps to expand its current efforts in this area. Currently, the Division collects information on all of the statutorily required tests of competition for the personal automobile market except for information on the ease of market entry. In addition, it collects price differential information for personal homeowners and mobile home insurance markets. While valuable, these efforts do not adequately identify anti-competitive behavior in the homeowner's insurance and mobile home markets. Furthermore, the Division currently does not collect any information on commercial markets. While some commercial markets do not lend themselves to monitoring because they are highly customized, others, such as commercial auto, and general and professional liability, are conducive to such monitoring. Therefore, the Division should expand its monitoring efforts to compile information on all four statutorily required tests of competition for all personal and some commercial markets, where feasible.

Once compiled, the Division should analyze this information over time to track patterns specific to Arizona insurance markets. In fact, the Department already maintains most of the information needed to monitor markets. Specifically, it maintains the number and size of insurers, changes in market share, and information on those firms that have entered or exited the market. However, the Division does not compile or sort this data in a manner that enables it to identify emerging market problems. As such, the Division will need to develop a database to store the data in a manner that is conducive to tracking market behavior.

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[1] Although precise standards for evaluating market concentration do not exist, economic and anti-trust literature provides various criteria for use in making preliminary judgments.

Recommendations

1. The Division should obtain information from its Corporate and Financial Affairs Division to assist it in targeting those companies that are at the greatest risk for insolvency should they charge inadequate rates. In addition to using this information, the Division should identify and use other factors to target filings for inadequate rate review, such as:

   - Targeting filings of companies showing significant increases in market share;
   - Targeting filings of certain lines of insurance; and
   - Targeting filings submitted by new and / or small companies.

2. The Division should expand its current market monitoring program by:

   a. Compiling and analyzing, at a minimum, data on the four economic indicators listed in statutes for all personal lines of insurance. The Division should also compile and analyze data for those commercial lines of insurance that are conducive to market monitoring such as commercial auto and general and professional liability; and

   b. Developing a database on which it can maintain the economic indicator data and track trends for determining shifts in market behavior.

FINDING II

FRAUD UNIT CAN FURTHER ENHANCE ITS PERFORMANCE

While the Department's Fraud Unit has shown some improvement from its early years, it can take steps to further enhance its effectiveness. Although in its first two to three years, the Fraud Unit produced a minimal number of cases for prosecution, it has more recently begun to demonstrate a stronger impact in the fight against insurance fraud. However, the Unit's inadequate tracking and analysis of referrals may ultimately limit its impact.

Insurance Fraud a Costly Crime

Insurance fraud is defined as untrue statements of material fact or the failure to state material facts to an insurance company or agent with respect to an insurance policy or claim. It occurs during the process of buying, using, selling, and underwriting insurance. Although the extent of insurance fraud is difficult to quantify, experts within the industry and among agencies that regulate insurance estimate that, nationally, fraud occurs in 16 percent of all personal auto insurance claims and in 10 percent of all homeowners', business, commercial, and health insurance claims. In June 1997, the Coalition Against Insurance Fraud estimated that the annual cost of insurance fraud to Arizona consumers in 1995 was $2.2 billion, or $1,616 per family. This cost to Arizona families is estimated to be 57 percent higher than the national average.

Once approved by the Legislature, the Department established the Fraud Unit in 1994 to combat fraud specifically committed against insurance companies.[1] The Unit receives referrals from insurance companies and determines which cases are potentially fraudulent and which can be criminally prosecuted. Using documentation provided by the referring insurance company, the Fraud Unit will investigate the case and, if investigators believe the case can be successfully prosecuted, submit it to the Attorney Gen-

[1] The Department also investigates complaints filed against insurance companies and agents through its Consumer Services and Investigations Division.

eral's Office or the Maricopa County Attorney's Office for criminal prosecution.[1] Successfully investigated and prosecuted insurance fraud cases may result in a felony conviction and an order to pay a fine and/or restitution to the insurance company for the loss incurred.

Fraud Unit Performance Steadily Improving

In its first four years, the Fraud Unit has improved its efforts and ability to successfully pursue insurance fraud. Despite a slow start, the Fraud Unit has increased the total number of referrals received and its rate of indictments and convictions. While several factors contributed to a slow start, the Unit has made significant strides in an effort to enhance its ability to investigate and ultimately prosecute insurance fraud cases.

Fraud Unit's impact increasing—Although the Fraud Unit's impact was initially limited, it has steadily increased in recent years. Table 2 (see page 19), illustrates various output statistics indicating the Unit's increasing impact. For example, between fiscal years 1995 and 1998, the number of referrals from insurance companies increased from 620 to 1,355, while the number of referrals submitted for prosecution increased from 23 to 147. Additionally, between fiscal years 1995 and 1997, the rate of indictments and convictions obtained from those referrals submitted for prosecution increased from 48 percent to 73 percent.[2]

Also, in comparison to other states, Arizona's Fraud Unit appears to be progressing at a normal rate given the Unit's relative newness. According to the Coalition Against Insurance Fraud, based on a review of fraud units across the country, there appears to be a direct correlation between the number of years a fraud unit has been in existence and its caseload and conviction rate. This suggests that fraud bureaus need a few years of experience to reach optimum effectiveness.

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[1] While the Maricopa County Attorney's Office handles only cases in Maricopa County, the Attorney General's Office handles referrals from all counties.

[2] Indictment and conviction rate is based upon fiscal year 1995 through 1997 data because of the large number of referrals pending review by prosecutors in fiscal year 1998. The number of indictments and convictions reported for fiscal year 1998 may change significantly due to the high number of pending referrals.

Table 2

Department of Insurance
Fraud Unit Annual Output Statistics
Years Ended June 30, 1995 through 1998
(Unaudited)

	1995	1996	1997	1998
Referrals	620	595	827	1,355
Referrals submitted for prosecution	23	44	70	147
Outcome of referrals submitted for prosecution[1]:				
Pending review by prosecutors	0	3	5	89
Closed as unprosecutable	12	12	14	14
Pending prosecution (indictments)	1	13	20	30
Convictions	10	16	31	14
Rate of indictments and convictions	48%	66%	73%	-

[1] Outcome of referrals submitted for prosecution will change over time as pending referrals are resolved.

Source: Auditor General staff analysis of Fraud Unit output statistics for years ended June 30, 1995 through 1998.

Several efforts made to improve performance—The Fraud Unit's enhanced performance has resulted from efforts in several areas:

- **Criminal Justice Focus**—In its first two years, the Unit lacked its current criminal justice focus. Specifically, disagreement among previous Fraud Unit administration and staff over whether the Unit would pursue criminal or civil prosecution in insurance fraud cases contributed to this lack of focus.

  In 1996, the Fraud Unit initiated several policies that emphasized the Unit's criminal justice nature. Specifically, the Unit began to primarily investigate and prosecute insurance fraud cases under the criminal legal code, aiming for the indictment and conviction of offenders. To complement this focus, the Fraud Unit hired investigators with appropriate criminal justice experience. Currently, most of the Unit's investigators each have 20 or more years of prior experience in law enforcement.

- **Dedicated Prosecuting Positions**—When initially established, the Fraud Unit referred insurance fraud cases to the Attorney General's Office, where they were assigned to at-

torneys who also worked on a wide variety of criminal cases in addition to insurance fraud. When compared to prosecuting violent crimes and drug cases, insurance fraud cases often merited a lower priority. In mid-1997, the Department entered into an intergovernmental agreement with both the Attorney General and Maricopa County Attorney to provide funding for prosecutor positions, thus ensuring the availability of resources to prosecute insurance fraud cases. This arrangement has contributed to a recent increase in prosecutable cases pursued by these justice agencies.

- **Management Stability**—Initially, the Fraud Unit experienced a high level of turnover among its management and investigative staff. Specifically, three different fraud bureau chiefs led the Unit in its first two fiscal years. However, leadership of the Unit appears to be much more stable, as the current bureau chief has been overseeing the Unit since September 1996. Additionally, even though only one of the ten original investigators remains with the Unit, only two investigators have left the Unit since July of 1996.

Inadequate Tracking and Analysis of Referrals May Limit Fraud Unit's Impact

While the Fraud Unit has improved its operational effectiveness, its overall impact may still be limited because the Unit does not adequately track and analyze fraud referrals. Specifically, the Unit cannot determine the extent to which insurance companies comply with fraud reporting requirements. In addition, the Fraud Unit lacks formal procedures to communicate its case investigation efforts and ensure these companies appropriately refer fraud cases.

Some insurers may not be reporting suspected fraud—Although statute requires insurance companies to report suspected fraud cases to the Department, some insurers may not be reporting suspected fraud. Specifically, A.R.S. §20-466(F) requires that:

> *"An insurer that believes a fraudulent claim has been or is being made shall send to the director . . . information relative to the claim . . ."*

Referrals are critical to the overall process, since the Fraud Unit cannot pursue potential fraud cases without a referral. However, a comparison between the number of referrals submitted to the Fraud Unit and the total number of insurers operating within the State suggests numerous insurers do not submit referrals to the Unit. Because companies may not make referrals for various reasons, such as they have no fraudulent claims or they are unaware of the statute that requires them to report suspected fraud, the Department should contact these companies to ensure that they are aware of the Unit's existence and the process

for making referrals. However, due to limitations in its fraud referral database, the Department cannot determine which insurance companies report suspected fraud to the Unit. This results primarily from the inconsistent data entry of insurance company names. Each time an insurance company submits a referral, Fraud Unit staff often enter the company name into the database differently. Given the large number of insurance companies and subsidiaries with similar names and abbreviations, it is difficult to identify which company actually made the referral. For example, a referral may come from State Farm Insurance Company, State Farm Fire and Casualty, or State Farm Mutual Automobile Insurance Company.

In order for the Fraud Unit to better determine which insurance companies are reporting fraud and which are not, it needs to track additional information on its database. Specifically, the Unit needs to revise its referral form to include a unique company identification code, known as the NAIC number, which should be entered in the fraud referral database. By capturing this information, the Unit can use the database to determine which companies are referring cases to the Unit. Moreover, the Unit can then identify companies that have not reported cases to determine if they need additional assistance in making referrals.

Fraud Unit lacks formal mechanism to correspond with and educate insurance companies— Even though the Fraud Unit's work depends on insurance company referrals, it has not established a formal mechanism to correspond with insurers regarding the status or adequacy of cases submitted. To a large extent, the Fraud Unit's success depends on the complete and thorough documentation collected by the insurance company making the referral. However, insurance company special investigation unit personnel interviewed by auditors indicated that the Fraud Unit did not consistently inform them of the status of their referrals. In addition, although the Unit closes many cases because it lacks the necessary information to prove fraud, the Unit has no formalized policy to educate insurers on what information is needed to successfully investigate and criminally prosecute insurance fraud.

Other states and the Department's own Consumer Services and Investigations Division have developed formal procedures for corresponding with insurance companies and complainants about referrals and also for educating them on information needed to successfully investigate and prosecute insurance fraud. For example, the Massachusetts Fraud Bureau reviews all referrals within 20 days of receipt and sends declination letters to companies whose cases are rejected. Additionally, the Bureau provides guidelines in conjunction with its training and education program that explain the types of evidence needed for each type of fraud to lead to a prosecutable case. For example, for a property loss referral, the guidelines indicate the Bureau needs such documents as police reports and proof-of-loss invoices submitted by the insured to effectively investigate the referral.

Similarly, the Department's own Consumer Services and Investigations Division, which investigates consumer complaints against insurance companies, sends form letters to complainants indicating whether it will investigate the complaint. If the Division does

not address the complaint, it explains the reason it was declined along with other options the complainant might pursue, such as civil court.

Recommendations

1. The Department should revise the Fraud Unit's referral form to capture an insurance company's unique identifier (i.e., NAIC number) and enter this number in the fraud referral database. This will allow the Unit to identify those companies that have not made reports of suspected fraud.

2. The Fraud Unit should enact formal procedures to inform and educate insurance companies regarding case referrals.

OTHER PERTINENT INFORMATION

During the audit, other pertinent information was collected regarding the Department's regulatory oversight over public entity risk pools.

Background

A public entity risk pool (public risk pool) is a cooperative group of government entities that join together to finance self-insurance expenses and share losses. Coverage provided by these pools includes property and liability, workers' compensation, and employee health care. Pooling resources to address insurance needs provides an attractive insurance alternative for some entities that are too small to legally or feasibly self-insure, but seek reduced costs and greater control over their loss exposure than traditional insurers can offer. Government entities involved in these pools range from cities, counties, and school districts to hospitals and libraries. Public risk pools can either transfer risk or retain it if they believe it is beneficial to keep the premiums rather than pay an outside party. Most public risk pools in Arizona do both, accepting some liability and transferring the remainder by purchasing a traditional insurance policy.

Regulatory Oversight Over Risk Pools Is Limited

Because public risk pools are not considered "insurers" but rather a form of self-insurance, they are regulated at a much lower level than traditional insurers. Specifically, public risk pools have minimum financial requirements and the Department's jurisdiction over these entities is limited.

Pools have minimum financial requirements—As compared to traditional insurers, public risks pools have minimal financial requirements. For example, traditional insurers must maintain minimum levels of capital and surplus at all times. That is, they must have adequate capital to pay "expected losses" as calculated by an actuary, as well as an additional "surplus" to cover unexpected losses.[1] While strong capitalization is important to the financial strength of any business, it is particularly important in insurance as it provides a finan-

[1] Expected losses are calculated based on a company's historical net reported incurred losses. For new companies that do not have a history of losses, expected losses are based on industry statistics.

cial buffer against losses that are not anticipated by the actuary. However, public risk pools are not required to maintain a surplus; only reserves equal to expected losses as calculated by an actuary.

According to some pool representatives, if minimum financial requirements similar to those imposed on traditional insurers were imposed on public risk pools, the increased costs would eliminate the option for some public entities to pool.

Department has limited authority—In addition to the minimal financial requirements associated with public risk pools, the Department has limited jurisdiction over public risk pools. Under the State's hazardous financial condition rule, the Department can place controls on traditional insurers that are acting in a financially unsound manner. Such action is taken in an effort to avoid insolvencies. In contrast, the Department can only intervene in public risk pools when an insolvency has already occurred. Even then, the Department's role is limited to confirming the insolvency through an examination, providing recommendations to abate it and, if necessary, reporting the insolvency to the State's legislative and executive leadership.

Some Public Risk Pools Insolvent

There have been three public risk pools that have become insolvent in recent years, leaving some pool members liable for outstanding claims. Unlike traditional insurance companies, members of public risk pools remain responsible for the liabilities of their pool even in the event of an insolvency.

Three public risk pools have experienced financial trouble—Three public risk pools have become insolvent in recent years, leaving some pool members liable for their own claims. From fiscal years 1992 through 1997, 3 out of the 13 public risk pools that existed during this time period have become insolvent. Table 3 (see page 25), provides specific information on each insolvency. One pool had to cease operations because it did not have sufficient assets to satisfy outstanding claims, leaving participating public entities responsible for their own claims. Specifically, the Arizona Public Agency Employee Benefit Trust, comprised of 13 various public entities and providing health coverage to approximately 1,250 employees, became insolvent in 1992 and ceased operations in 1994 with a deficit of over $830,000. Due to the closure, pool members were left to pay their own claims**.**

As Table 3 indicates, the other two insolvent pools continue to operate. With the Department's assistance, both pools devised "workout plans" to assist them in addressing their insolvency. The Arizona Municipal Risk Retention Pool was able to maintain sufficient cash flow to pay existing claims while it recovered from its insolvency and has

been solvent since November 1994. The Arizona School Alliance for Workers' Compensation Pool is in the process of obtaining sufficient assets to address the insolvency and, to date, has had sufficient cash flow to pay existing claims.

Table 3

Public Risk Pools That Have Become Insolvent
Years Ended June 30 or December 31, 1992 through 1997[1]
(Unaudited)

	Arizona Municipal Risk Retention Pool	Arizona Public Agency Employee Benefit Trust	Arizona School Alliance for Workers' Compensation
Type of coverage	Property and Liability	Life and Health	Workers' Compensation
Policyholders	57 municipalities	13 public entities[2]	15 school districts
Employees covered	N / A[3]	Approximately 1,250	Approximately 2,000
Insolvency date	Calendar year 1992	Fiscal year 1992	Fiscal year 1997
Insolvency amount	$2,273,801[4]	$834,140	$778,378[4]
Current status	Operating and now solvent	Ceased operations	Operating but remains insolvent

1 Insolvency dates were reported by either fiscal or calendar year.

2 This pool had varied types of members such as public hospitals, cities, and school districts.

3 Because the pool provides property and liability insurance coverage for municipalities, it does not apply to individual employees.

4 These amounts are based on Arizona Department of Insurance examinations as of December 31, 1992, and December 31, 1997, respectively.

Source: Auditor General staff analysis of correspondence and financial documents maintained by the Arizona Department of Insurance financial documents.

Pool members/taxpayers are ultimately responsible for claims—Members of public risk pools remain liable for their claims even in the event a pool ceases to exist. In contrast to traditional insurance companies, public risk pools require their members to take an ownership interest in the program. This "ownership interest" results from an "assessable policy," meaning pools can assess their members an additional premium not to exceed the amount of each member's annual contribution to the pool in the event costs exceed premiums charged during a covered period of time. This provision provides a source of additional monies for pools should they experience financial trouble and also distributes any financial hardship among all members. However, assessable policies do not always provide a mechanism to cure insolvencies. For example, if the insolvency is larger than the allowable aggregate assessment charged and the pool has insufficient assets to pay existing claims, the pool may be forced to close its doors, leaving its members responsible for the liabilities. If these public entities lack adequate resources to pay the assessment or cover claims, the liabilities ultimately become the taxpayers' responsibility.

In contrast, the State's guaranty funds protect traditional insurance policyholders in the event an insurance company becomes insolvent.[1] These funds exist to pay outstanding claims of insolvent insurers. However, these guaranty funds do not protect public risk pool members.

[1] Guaranty fund coverage does not exceed $100,000 for property and casualty claims; $100,000 for cash value or annuity claims; or $300,000 for all life and disability benefits, including cash values and annuity claims as well as death benefits, with respect to any one life.

SUNSET FACTORS

In accordance with A.R.S. §41-2954, the Legislature should consider the following 12 factors in determining whether the Department of Insurance should be continued or terminated.

1. The objective and purpose in establishing the Department.

The Department was established in 1913 to regulate the insurance industry in Arizona. As provided in the Arizona State Constitution, all companies selling insurance within the State shall be subject to licensing, control, and supervision by a department of insurance. Further, Title 20 authorizes the Arizona Department of Insurance to license insurance companies and agents, provide consumer assistance, investigate complaints from the public, review insurance forms and rate filings, monitor the financial status of insurers, oversee guaranty funds, and collect premium taxes and other fees. Laws 1980, Chapter 230, §1 and Laws 1990, Chapter 38, §1, define the Department's objectives as:

- To administer state insurance laws
- To protect the citizens of this State who purchase insurance
- To provide a better response to the needs of persons who purchase insurance
- To stimulate the insurance market by encouraging competition
- To protect the public from unregulated insurers and to represent insurance consumers' interests

2. The effectiveness with which the Department has met its objective and purpose and the efficiency with which it has operated.

The Department has been generally successful in meeting its objectives as stated above. For example, during fiscal year 1997, the Department issued 12,173 new and 19,888 renewal licenses and monitored over 2,000 insurers. In addition, the Department initiated 41 market conduct exams to identify any unfair trade or claim settlement practices in which insurers may be engaging, and completed 116 financial examinations. However, auditors' review revealed that the De-

partment's Rates and Regulation Division could improve its efficiency and increase the consumer protection it provides. Specifically, the Department should revise its current approach of regulating insurance rates by limiting review activities to identifying unfairly discriminatory rates and monitoring competition within various insurance markets (see Finding I, pages 9 through 16).

3. The extent to which the Department has operated within the public interest.

The Department has operated within the public interest in a variety of ways. For example, the Department conducts and publishes automobile and homeowners' premium comparisons to assist consumers in obtaining coverage for the best price. In addition, the Department helps protect the public by imposing financial requirements and monitoring those requirements. Examples of this include verifying that insurers maintain the required capital and surplus, routinely examining insurer financial information to identify potential solvency problems, conducting market conduct examinations of insurers, and requiring insurers to disclose certain material information to prospective policyholders prior to selling policies.

4. The extent to which rules and regulations promulgated by the Department are consistent with the legislative mandate.

According to the Governor's Regulatory Review Council (GRRC), the Department has complied with A.R.S. §20-143, which authorizes the Director to adopt rules and is on schedule in repealing and amending its rules according to the five-year review approved by GRRC on February 3, 1998. In addition, GRRC indicated that the Department provides an outstanding example of timeliness and quality of rulemaking in its interaction with GRRC and its staff.

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

The Department ensures adequate public input on proposed rules and regulations. The Department publishes a notice of proposed rulemaking activities in the *Arizona Administrative Register,* as required by law. Furthermore, when the Department anticipates taking action on a proposed rule, it first solicits input from members of the industry who have an insurance background or who are likely to be affected by the proposed rule. The Department also publishes press releases and circular letters to announce important actions, changes to insurance-related laws, and rules and procedures, as well as its interpretation of insurance-

related laws. With regard to the operations of its boards, the Department conducts public meetings and posts notices for the Guaranty Fund board meetings. These boards oversee the operations of the Arizona Life and Disability Guaranty Fund and the Arizona Property and Casualty Guaranty Fund.

Auditors did find that the Secretary of State's Office does not have the Department's meeting locations on file. While the Department provided documentation indicating it filed this information in 1992, the Department should update its filing with the Secretary of State's Office to ensure compliance with open meeting law requirements.

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

The Department has been able to investigate and resolve most consumer complaints it receives in a timely manner. However, it takes the Department slightly longer than its internal goal of 60 calendar days to resolve complaints. According to the Department's complaint database, it took the Department an average of 71 days to resolve complaints in fiscal year 1997.[1] The Department acknowledges that it has difficulties responding to all complaints within its internal goal of 60 days and it is currently taking steps to reduce its workload by disseminating information to consumers to enable certain complaints to be resolved without substantial Department involvement.

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

The Attorney General has the authority to prosecute actions on behalf of the Department. Specifically, A.R.S §20-152 authorizes the Attorney General to prosecute Title 20 violations and prosecute or defend all actions resulting from enforcement of Title 20 provisions. Furthermore, A.R.S. §20-401.04 provides that the Attorney General may enforce the order of the director in any court proceeding. The Department entered into a Collection Enforcement Revolving Fund agreement with the Attorney General's Office. Under this agreement, the Attorney General's Office provides the legal services necessary to collect outstanding civil

[1] This figure is based on complaints that were opened and closed within fiscal year 1997.

penalties and other debts owed to the Department. Lastly, under A.R.S. §20-466(F), the Attorney General's Office and the appropriate County Attorney have the authority to prosecute insurance fraud.

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

The Department has actively addressed deficiencies in the insurance statutes over the years. From fiscal years 1992 through 1997, the Department proposed 25 laws affecting the Department and the insurance industry. Many of the changes specifically updated the enabling statutes to allow the Department to adequately regulate the continually changing insurance field. For example, in fiscal year 1996, the Department proposed insurance solvency regulation, which updated the laws to correspond with the requirements of the National Association of Insurance Commissioners (NAIC), allowing the Department to maintain its official NAIC accreditation.

In addition, in fiscal year 1997, the Department proposed legislation to clarify various aspects of its authority to take over and administer the affairs of insolvent insurers. Finally, for the last two legislative sessions, the Department sought legislation that would grant peace officer status to investigators. According to Department officials, peace officer status would allow the Fraud Unit, among other things, to serve search warrants and make arrests, without the assistance of other law enforcement agencies, thus allowing it to take more swift action in suspected fraud cases.

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

This review did not reveal any changes needed in the laws for the Department to adequately comply with the factors listed in the sunset laws.

10. The extent to which the termination of the Department would significantly harm the public health, safety, or welfare.

Regulating the insurance industry is necessary to protect the public in transactions that can significantly affect their financial welfare. Pursuant to federal law, regulation of the insurance business rests exclusively with the states. Accordingly, all 50 states regulate the insurance industry to varying degrees. If the Department were terminated, another state agency would be needed to regulate the

insurance industry for consumer protection purposes. Should the Legislature decide to terminate the Department, a constitutional amendment will be necessary.

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

Auditors' work suggests that the current level of regulation is generally appropriate.

12. The extent to which the Department has used private contractors in the performance of duties and how effective use of private contractors could be accomplished.

Arizona Revised Statute §20-148(B) provides the Department authority to utilize contractor services. As such, the Department uses private contractors to perform several functions. For example, the Department uses private contractors for prelicense testing and to conduct financial and market conduct examinations of insurers. Although the use of private contractors in these areas appears appropriate, a 1995 special investigation of the Insurance Examiners' Revolving Fund (IERF) by our Office found that the billings of these contractors were not adequately monitored by the Department. Since that report was issued, the Department has converted 21 supervisory, administrative, and clerical IERF contractor positions to Departmental positions to improve contract enforcement and oversight. According to the Department, it continually reviews its programs to privatize when it is cost-effective and appropriate, and to eliminate the use of contractor services if this is not the case.

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Agency Response

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CHARLES R. COHEN
Acting Director of Insurance

November 2, 1998

Mr. Douglas R. Norton
Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

Dear Mr. Norton:

The Arizona Department of Insurance ("Department") appreciates the opportunity to respond to the report of the performance audit conducted by the Office of the Auditor General.

FINDING I

Recommendation 1: The Division should obtain information from its Corporate and Financial Affairs Division to assist it in targeting those companies which are at greatest risk for insolvency should they charge inadequate rates. In addition to using this information, the Division should identify and use other factors to target filings for inadequate rate review, such as:

- ***Targeting filings of companies showing significant increases in market share;***
- ***Targeting filings of certain lines of insurance; and***
- ***Targeting filings submitted by new and/or small companies.***

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

The Department agrees that its process for detecting inadequate and unfairly discriminatory rates should be improved, and we will endeavor to convert from a review of each rate filing to a targeted approach. However, we do not agree with all of the report's underlying analysis of the issue, and we believe the report's specific recommendations must be refined to be practical and effective.

The Department disagrees that "market forces are the primary regulator of rates under Arizona's 'open competition law'," as stated repeatedly in the report. We agree that under an open competition system the marketplace is intended to be the primary regulator against

excessive rates, and the Department's role, with respect to regulation of excessive rates, is to monitor whether a reasonable degree of price competition does not exist in the marketplace based on the relevant tests of competition pertaining to market structure, market performance, and market conduct set forth in A.R.S. § 20-383(B)(1) through (4). However, even under an open competition system, the Department is the primary regulator against inadequate and unfairly discriminatory rates. This role is crucial to the protection of consumer interests, and crucial to the success of an open competition system because inadequate and unfairly discriminatory rates are the insidious by-products of a highly competitive marketplace for insurance. If unchecked, they ultimately threaten continued competitiveness. Competition itself naturally prevents excessive rates, but may lead to predatory pricing and other forms of unfair competition which may cause some competitors to withdraw from the market, and may cause others to falter or fail financially. As competition breaks down, certain classes of insurance products may become unaffordable or even unavailable. Thus, the Department's role in regulating against inadequate and unfairly discriminatory rates is as integral to the ultimate success of an open competition rate regulatory system as a competitive marketplace.

The Department acknowledges that it has not "formally disapproved" Article 4.1 rate filings based on grounds of inadequacy. However, the Department is not unable or unwilling to find rates inadequate. Both the Department and insurers appreciate the considerable difficulty, expense, and inconvenience attendant to a contested rate disapproval proceeding. The Department must also consider the practical difficulties associated with initiating contested proceedings concerning complex, technical rate-making issues wherein the State will be matched against an insurer's considerable technical, legal, and expert witness resources. Insurers on the other hand, must consider the adverse publicity that can result from such proceedings. Consequently, the Department and the affected insurer have generally negotiated a mutually satisfactory resolution when a rate is found to be inadequate. On many occasions, insurers have voluntarily amended their rates to avoid the possibility of a formal rate disapproval proceeding.

The report suggests that the Department has continued to review Article 4.1 rate filings for excessiveness, notwithstanding the legal presumption that the market is competitive and therefore rates are not excessive. We wish to make it clear that the Department does not review Article 4.1 rate filings for excessiveness; our review is limited to seeking evidence of inadequate and unfairly discriminatory rates. The report also omits any discussion of the importance of detecting unfairly discriminatory rates, and omits any recommendation to enforce this standard by targeted rate filing review or any other method. Unfairly discriminatory rates are potentially disastrous to consumers. The Department is required to enforce this important standard as well, and any consideration of the feasibility of targeted review and the appropriate targeting criteria must take this into account.

The Department respectfully submits that the report's analysis and recommendations are heavily reliant on the misconception that rate regulation is mostly a tool to detect evidence of specific insurers' future insolvency. The prohibition against inadequate rates is intended to

generally deter insurer insolvency, among other things. However, the regulation of inadequate rates and the regulation of insurer solvency, while related, are different programs with different objectives.

The objective of the Department's solvency regulation programs is to monitor insurers' financial condition to identify present or potential insolvency or financial weakness and to take appropriate corrective actions. An insurer's insolvency may result from various causes, including inadequate rates relative to past policy periods. The objective of the prohibition against inadequate rates is not to monitor insurer solvency or correct insolvency, but to generally deter future insolvency, unfair competition, and the ultimate unavailability and unaffordability of insurance.

The requirement of adequate rates ensures that at the time an insurer issues a particular insurance product it receives income (i.e., the amount of premium produced by the rate) sufficient to cover the projected losses and expenses attributable to that particular class of product. A.R.S. § 20-383(C). In this way, the issuance of that product does not pose a threat to the insurer's future solvency, nor to the continued existence of fair competition for products of that class. Article 4.1 does not permit insurers to adopt "loss leader" marketing strategies whereby insurers intentionally accept excessive losses on one class of product in order to more aggressively compete in the marketplace for that product. Nor are they permitted to underprice one class of product based on speculation that exceptional profits will be realized from another class of product. Therefore, the report's conclusion that review of rates for inadequacy is ineffective to regulate insurer solvency because all an insurer's rates must be considered together to determine impact on solvency erroneously confuses rate and solvency regulation.

The Department believes that making rate filing review dependent on evidence of an insurer's financial weakness will be of limited effectiveness. For example, each state is the primary regulator of its domestic insurers' financial condition. However, each state is the sole regulator of the rates of all insurers, domestic and foreign, doing business in that state. Therefore, this Department will be intimately familiar with the financial condition of only a fraction of the insurers whose rates it regulates. As of September, 1998, there were 38 domestic and 749 foreign property and casualty insurers authorized to transact insurance in Arizona. This Department has little control over the quality of financial regulation exercised by other states. Additionally, if evidence of financial weakness is present, it is more likely indicative of past inadequate rates than present inadequate rates because income adequacy has a prospective effect on financial condition. An insurer which is already manifesting signs of financial weakness may actually increase its rates in an attempt to increase long term income. An insurer that decreases rates as a result of financial weakness is one that is looking for a short term infusion of cash at the expense of long term financial health. In that scenario, it is more likely that rate levels will be evidence of financial problems rather than the other way around.

For the above reasons, the provisions of Article 4.1 establish the sound legislative policy of this state that each rate filed under the open competition system is prohibited from being inadequate or unfairly discriminatory, not just those filed by insurers which present detectable evidence of current or future solvency problems. See A.R.S. § § 20-383, 20-385, and 20-388. The report fails to give due consideration to the ongoing marketplace dynamics that justify the general proscription against any inadequate or unfairly discriminatory rates, even when filed by unquestionably financially sound insurers. The Department accepts the recommendation to adopt a targeted approach to enforcement of Article 4.1. However, we differ from the report in that we believe the point of targeting must be to identify insurers that are more likely to have inadequate or unfairly discriminatory rates, not those more likely to be or become insolvent. The latter, while obviously of critical importance, is the function of the Department's separate solvency regulation program.

The Report (page 11) states "other states that have enacted open competition laws do not review every rate filing in detail. Auditors contacted 13 states that have an open competition law and found that, in practice, 10 limit their detailed reviews to those rates that are of unique concern to that particular state." The 13 states are identified in the report. The Department respectfully suggests that a more in-depth review of this comparison is useful. Notwithstanding that the report characterizes all 13 states as having "open competition" laws, some of the identified states have different rate laws than Arizona's "use and file" law. For example, three of the states have laws which do not require rate filings at all. Comparison to the practices of those states is unavailing. Of the remaining ten states, only five have "use and file" laws similar to Arizona's. Of those five, one state "targets" filings for review by exercising its legal authority to exempt certain lines of insurance from any filing requirement. This Department does not have that power. Of the other four, only two target rate filings for in-depth review based on discretionary criteria. It does not appear that any of the five "use and file" law states target rate filings for review by using solvency information in the manner suggested by the report.[1]

We disagree that the point of Article 4.1 is to achieve administrative cost savings at the Department by reducing the amount of analyst time spent reviewing rate filings. The cost of analyst review by the Department is nominal considering the volume of insurance premium affected by Article 4.1. We believe the true cost saving element of Article 4.1 is the inherent cost savings available to insurers and consumers under an open competition system (i.e., insurers' ability to quickly adjust rates or offer new products and consumers' rapid access to new prices and products). The Department's review of rate filings to detect inadequate or unfairly discriminatory rates does not defeat these inherent cost savings, and we believe Article 4.1 plainly contemplates that the Department will perform that function. Further,

[1] The report states that there are two primary approaches to rate regulation, "prior approval" and "open competition", and that workers' compensation and title insurance rates are subject to prior approval in Arizona. This is technically incorrect. Workers' compensation and title insurance rates are subject to A.R.S. § 20-341, et seq. (Article 4) which provides a "file and use" system wherein the rates must be filed at least fifteen days before they take effect, and may be summarily disapproved by the Department before they take effect. Article 4 rate filings do not require the Department's prior approval to take effect, which distinguishes Article 4 from a true "prior approval" system.

implementing a targeted approach to rate filing review will require unique resources, such as computer hardware and software, computer programmer time, and insurance analyst time to oversee the continuing compilation, input and analysis of data. Therefore, we disagree that failure to realize administrative cost savings is a significant deficiency of our current process, or that significant administrative cost savings will be achieved through a shift to targeting. We believe the issue is whether the change would enable the Department to be more effective at enforcing the rate making standards. We agree to make the change because we agree that the backlog of Article 4.1 rate filings and resulting lack of timely review impairs the effectiveness of the review.

The Department has implemented a pre-review/prioritization procedure to attempt to more timely review those rate filings which contain a "program" rate change and/or obvious unfairly discriminatory rates/rating rules. However, we agree that with current levels of rate analyst staffing, a targeted approach to rate filing review based on criteria that identifies those rate filings more likely to present inadequate or unfairly discriminatory rates and more likely to have significant market impact would be more effective than untimely review of most rate filings. We note that there is no statutory guidance as to appropriate criteria for targeting inadequate and unfairly discriminatory rate review, and the Department must therefore exercise discretion to develop such criteria.

Recommendation 2: The Division should expand its current market monitoring program by:

a. Compiling and analyzing, at a minimum, data on the four economic indicators listed in statutes for all personal lines of insurance. The Division should also compile and analyze data for those commercial lines of insurance that are conducive to market monitoring such as commercial auto and general and professional liability.

b. Developing a database on which it can maintain the economic indicator data and track trends for determining shifts in market behavior.

The finding of the Auditor General is agreed to and the recommendations will be implemented.

The Department accepts the recommendation that we should expand our market monitoring program by assuring that we compile data on the economic indicators identified by statute, by identifying and compiling additional information that is necessary or useful to the monitoring, and by developing a database and programs to meaningfully analyze that data to identify trends bearing upon market competitiveness. We agree that this market monitoring

activity will be useful in targeting rate filings for review for inadequate or unfairly discriminatory rates. We also agree that implementing these recommendations will require additional resources. The Department was appropriated the resources for Fiscal Year 1998-99 to obtain and install the necessary computer hardware and the basic operating system and office software. We will determine what additional resources, such as programming and analyst personnel and specialized software, are needed to fully implement the recommendations.

The Department questions whether it is practical, reasonable, or cost effective to expand its monitoring activities to the commercial lines marketplace due to the immense number of independent commercial lines programs filed by insurers, within which there is an extremely wide distribution of coverage and rate variables for each line and each class of business. It may be prohibitively difficult to obtain among insurers like data for the purpose of making a meaningful comparison. Further the data compilations, programming, and analysis required may be prodigious. Therefore, while we agree to attempt to monitor certain commercial lines markets for competitiveness to the extent we determine it is appropriate and feasible, we cannot agree to monitor any specific commercial lines to any specific extent at this time.

FINDING II

The report reflects the improvements the Department has made in its fight against insurance fraud including the dramatic increases in cases annually referred for prosecution, the number of indictments, and the rate of indictments and convictions. As the report indicates, the Fraud Unit has benefited from the recruitment and retention of investigators with extensive prior experience in law enforcement, and from strong, stable management. The Unit has funded prosecutor services from its inception in 1994. However, commencing with Fiscal Year 1998, the Unit has included in its intergovernmental agreements with prosecuting agencies the requirement that the funding be applied to designated personnel dedicated to prosecution of Fraud Unit cases. Additionally, the Legislature appropriated additional funds to the Unit for prosecutorial services, commencing in Fiscal Year 1998. The additional funds enabled the Unit to fund dedicated prosecutorial personnel at both the Attorney General's and Maricopa County Attorney's Offices. These improvements significantly increased the number of successful prosecutions resulting from Fraud Unit referrals.

As the report reflects, in its early stages, the Fraud Unit attempted to address both the civil and criminal aspects of insurance fraud to roughly equal degrees. There are certainly significant potential civil violations and corresponding remedies arising out of insurance fraud. However, the Department quickly realized that meaningful impact by a relatively small Fraud Unit requires a sharp focus on criminal cases. Implementation of that strategic objective improved the Unit's measurable impact.

The Department is committed to continuously improve Fraud Unit performance and impact, to achieve the Fraud Unit's destiny to lead the fight against insurance fraud in Arizona, and to ultimately see its efforts manifest in the rates charged by insurers.

Recommendation 1: The Department should revise the Fraud Unit's referral form to capture an insurance company's unique identifier (i.e., NAIC number) and enter this number in the fraud referral database. This will allow the Unit to identify those companies that have not made reports of suspected fraud.

The finding of the Auditor General is agreed to and the recommendation will be implemented**.**

We agree with the report's finding that the fraud referral form and the Unit's database should be refined to include an insurer's NAIC number as a unique identifier. We also agree this will allow the Unit to better identify those insurers that have not made referrals to the Unit. The Department's Information Services Division has already developed this improvement, which was implemented in early October 1998. We have also already developed revised referral forms which prompt the insurer to provide its NAIC number. At the end of each fiscal year, the Department will determine which insurers have not made fraud referrals to the Department and will follow-up with insurers that have not made referrals or have made what appears to be a disproportionately small number of referrals, and will offer assistance in correcting any fraud reporting deficiencies. Additionally, our Market Conduct Division will continue to ascertain referral frequency as part of its preparation to examine an insurer, and will reinforce the referral requirement as part of the examination process.

Recommendation 2: The Fraud Unit should enact formal procedures to inform and educate insurance companies regarding case referrals.

The finding of the Auditor General is agreed to and the recommendation will be implemented**.**

We agree that having a formal set of procedures to inform and educate insurance companies is important. The Fraud Unit already provides training seminars every six months to assist in educating insurance company special investigation unit staff in current crime trends, fraud detection methods and investigation techniques. The Unit also provides ad hoc consultation and information to insurance companies upon request. The Unit participates in monthly meetings of the Arizona Association of Special Investigations Units at which the Unit shares valuable information on crime trends and Department activities while encouraging members to file fraud cases.

We also agree it is important to keep insurers informed of the status of cases they refer to us, and to explain why cases are closed without referral for prosecution. Commencing in late 1996, the Unit adopted the practice of notifying the designated representative of an insurer, usually by telephone, each time a change occurs in the status of the referral. In 1997, that practice was added to the Unit's written policies and procedures manual. Department surveys of Fraud Unit clients suggest the Unit is successful at keeping insurance companies informed of the status of referrals. The Unit has now adopted the formal policy of accomplishing this notification by written form letter. This letter advises insurers that if the

referral was determined to be "unfounded," the case file, which contains explanatory information, is available for review through a public records request.

The Department issued Circular Letter 1998-11 dated October 6, 1998 which published the revised referral form, announced the referral status notification letter, and described the Department's procedures to monitor and encourage referral levels.

FOLLOW-UP ON PRIOR AUDITS

The Department has made significant progress towards maintaining an appropriate relationship with its independent contractors.

The Department has made significant progress in achieving appropriate relationships with its contract personnel. Since September 1995, the Department has created 31 appropriated and nonappropriated employee positions to provide services previously provided by contract personnel. These changes not only enable us to utilize employee personnel or services better suited to employees than contractors, they enable us to exercise dramatically improved internal control over contract services we continue to use. For example, some of the new employee positions have responsibilities for review of contractor billings, as described in your report.

The Department has recently completed conversion of the in-house market conduct examination staff from contractor to employee positions. All market conduct contract personnel are now assigned to field examination work. The only remaining contract personnel provided with office space, access to administrative support, computer equipment, and office supplies, as described in your report, provide financial analysis and examination services. The Department will continue to exploit any and all opportunities to further refine its relationship with its contract personnel in accordance with prevailing standards for distinguishing contract from employee personnel. However, the optimum effectiveness of our financial examination and analysis activities, and the maintenance of our accreditation by the National Association of Insurance Commissioners, requires our contract personnel to have ready access to the Department's records and automated data, as well as interaction with the Department's employee staff. It is for that reason, and not the contractors' benefit, that the Department provides office space, access to administrative support, computer equipment attached to the Department's LAN and AS/400 computer systems, and attendant supplies to a limited number of contractors engaged to provide complex financial analysis services.

The Legislature has specifically authorized the Department to utilize contract services for precisely the kind of highly technical and specialized functions performed by the financial analytical and examination personnel. A.R.S. § 20-148(B) provides:

> *The Director may from time to time contract for and procure, on a fee or part time basis, or both, such actuarial, technical and other professional services as he may require for the operation of his office*

The Legislature has also specifically authorized reimbursement of travel expenses for the Department's contract examiner personnel, A.R.S. § 20-159((B), and this reimbursement is a term of contracts which were duly procured for the Department by the Department of Administration in accordance with the State Procurement Code.

A diminishing number of investigation cases are awaiting prosecution by the Attorney General.

The Department has been working in partnership with the Office of the Attorney General to reduce the backlog of cases awaiting prosecution. During the latter half of 1997, the Department implemented the practice of requesting a quarterly status report from the Attorney General's Office on all pending referrals for administrative action. The Attorney General's Office has responded positively to these requests. This attention to the backlog has produced results. As of October 27, 1998, only six investigation cases (excluding Fraud Unit cases) were awaiting action by the Attorney General. All these cases are in an "active working stage" and are expected to be resolved within 60 days from October 27. During Fiscal Year 1998, the Attorney General required an average of 93 calendar days from the date a case was provided to the Attorney General's Office to when a notice of hearing was issued or another form of disposition was completed. Both the Department and the Attorney General's Office anticipate further reductions in backlog.

The Attorney General's Office notes that the administrative cases discussed in your report comprise less than 25% of all legal matters handled by Assistant Attorneys General for the Department. Other matters include license denial proceedings (which must be given priority due to statutory time-frame mandates), appeals challenging previous administrative decisions by the Department, and representation of the Department in discovery requests arising out of receivership cases.

The Department has reduced the amount of time necessary to resolve routine complaints.

The Department reduced the average calendar days required to respond to consumer complaints from 71 in Fiscal Year 1997 to 46 in Fiscal Year 1998, thereby meeting our internal goal of 60 days. The Department accomplished this goal by augmenting its informational literature available to consumers and by encouraging consumers to exhaust self help avenues prior to the Department's intervention on certain kinds of claims-related, non-regulatory issues. This reduced the total number of consumer complaint matters requiring the Department's active intervention, and enabled more efficient and expeditious handling of those matters. Additionally, the Department has requested an appropriation for an additional FTE in the Consumer Services and Investigations Division to increase personnel available to respond to public records requests, thereby freeing staff to concentrate on handling consumer complaints.

OTHER PERTINENT INFORMATION

We provide some observations to augment the report's discussion of public entity risk pools.

First, A.R.S. § 11-952.01(L) does not require the Department to notify the state's executive and legislative leadership unless the pool fails to comply with the Department's recommendations to abate the insolvency. Second, a pool is required to inform the Department of its existence, pursuant to A.R.S. § 11-952.01(G)(6). If a risk pool fails to notify the Department of its existence, we are unable to fulfill our responsibilities with respect to the pool. Third, pools are not required to provide to the Department, nor obtain our approval for, their financial feasibility or operating plans prior to commencing operations.

For example, the Department first learned of the existence of the Arizona Public Agency Employee Benefit Trust only after it had already ceased operations when a former member requested assistance in enforcing coverage. The Arizona Municipal Risk Retention Pool timely implemented the Department's recommendations to abate its insolvency. The Arizona School Alliance for Workers' Compensation is in the process of attempting to implement the Department's recommendations to abate its insolvency.

SUNSET FACTORS

With regard to Factor # 5, the report indicated the Secretary of State's Office did not have on file the location at which information concerning public meetings is posted. The Department has updated its filing with the Secretary of State's Office to ensure compliance with open meeting law requirements.

CONCLUSION

We would like to commend the Auditor General's staff for the courtesy and professionalism consistently demonstrated throughout the audit process. We found the review to be substantive, fair, and appropriate, and we genuinely appreciate the comments and recommendations in the report which enable us to further improve the quality of our planning and operations.

Sincerely,

Charles R. Cohen
Acting Director

CRC:sbg

AUDITOR'S NOTE

Although in agreement with our first finding, the Department of Insurance (Department) has taken lengthy exception to the underlying analysis for the finding. To ensure that the reader can place in the needed context the recommendation for the Department to "target" its rate reviews, we offer the following comments.

First, reasonable parties may disagree over the extent to which rates should be reviewed under an "open competition" system. Our observation that the Department can rely more extensively on competition to regulate rates is based on the literature and philosophy behind open competition. Contrary to the Department's claim, the literature is clear (including that produced by the NAIC) that under a competitive rating law, competition is the primary regulator of rates. According to the NAIC, reliance on fair and open competition to maintain reasonable insurance prices allows insurance departments to conserve resources for other important areas of public interest. As such, rather than reviewing thousands of individual rates, one of the most effective things the Department can do as a regulator is help ensure an effectively functioning marketplace.

Second, regardless of how strongly one takes a position for or against "open competition" as a means of regulating rates, it is clear that the Department does not need to review each rate as it has unsuccessfully attempted to do. Department officials concede there is no statutory requirement in Arizona to review each rate. In addition, literature indicates there is large variation in the levels of scrutiny applied to rate filings by states under an open competition system. As noted by the Department, 3 of the 13 states we contacted do not even statutorily require rates to be filed for review. Therefore, our recommendation to "target" reviews is not contrary to the Department's mandate and is actually a more conservative approach than that employed by some states. In addition, targeting reviews will likely help relieve the current backlog of rate filings and might eliminate the need for additional rate personnel as requested by the Department.

Finally, the Department expresses concern that we do not explicitly discuss reviewing rates for unfairly discriminatory provisions as a part of our targeted approach. We did not specifically discuss this aspect of rate review only because we know that the Department already reviews for these provisions, and we anticipated that it would continue to do so when reviewing rates under a targeted approach.