California State Auditor

BUREAU OF STATE AUDITS

Department of Insurance:

It Needs to Make Improvements in Handling Annual Assessments and Managing Market Conduct Examinations

June 2004
2003-138

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CALIFORNIA STATE AUDITOR

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June 15, 2004 2003-138

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee (audit committee), the Bureau of State Audits presents its audit report concerning the Department of Insurance's (Insurance) effectiveness in improving consumer services and reducing organized automobile fraud activity as a result of the additional funding it received through Chapter 884, Statutes of 1999 (SB 940), and Chapter 885, Statutes of 1999 (AB 1050). This report concludes that Insurance lacks adequate data to determine how much it should have received since the enactment of these two bills. Using unaudited data from the Department of Motor Vehicles, we estimate the possible loss of as much as $7 million in assessments for fiscal year 2002-03 alone. Further, Insurance has not made sufficient efforts to follow up on most of the discrepancies in insurers' payments that it identified in a May 2003 analysis.

Insurance has used some of the SB 940 funds to increase its outreach and communication efforts to consumers related to several automobile insurance programs. However, Insurance needs to improve tracking the use of SB 940 funds; for example, the Legal Division cannot easily demonstrate that it used $9.4 million it received only for allowable activities. Further, Insurance used some AB 1050 funds to work on cases that do not meet the criteria in state law. Finally, Insurance does not monitor the use of AB 1050 funds by either the district attorneys or the Department of the California Highway Patrol, as state laws and regulations require.

The audit committee also requested that we examine the functions of Insurance's bureaus that perform market conduct examinations. Based on our analysis, it appears unlikely that Insurance could gain increased efficiencies, including time and cost savings for insurers, by combining the three bureaus that currently conduct market conduct examinations. However, Insurance may be able to realize some cost savings by combining some of these bureaus' administrative functions. Further, because the Market Conduct Division does not fully utilize Insurance's database, it cannot report on the time and cost associated with its examinations or measure the efficiency of its market conduct operations.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

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SUMMARY

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Our review of the Department of Insurance's (Insurance) effectiveness in improving consumer services and reducing organized automobile fraud activity through the use of SB 940 and AB 1050 funds and its market conduct examinations found that:

- ☑ ***Insurance lacks adequate data to know how much it should have received from insurers since the enactment of SB 940 and AB 1050. Unaudited data from the Department of Motor Vehicles indicate that Insurance is collecting revenues for far less than the number of registered vehicles in the State, resulting in the possible loss of as much as $7 million in assessments for fiscal year 2002–03 alone.***
- ☑ ***Insurance has not made sufficient efforts to verify that insurers are remitting all revenues due, even though it identified discrepancies in the number of insured vehicles reported by them.***

continued on next page. . .

RESULTS IN BRIEF

Since 1989, state law has required insurers doing business in California to pay an annual assessment of $1 for each vehicle they insure. In 1999, the Legislature enacted two statutes designed to provide additional funding to the Department of Insurance (Insurance) for activities related to automobile insurance: Chapter 884, Statutes of 1999 (SB 940) adds 30 cents per insured vehicle to fund consumer operations and Chapter 885, Statutes of 1999 (AB 1050) adds up to 50 cents per insured vehicle to target the prosecution and elimination of organized automobile fraud activity.

Because it lacks adequate data to determine how many vehicles are insured in California, Insurance does not know how much it should have received since the enactment of these two bills. Unaudited data from the Department of Motor Vehicles indicate that Insurance is collecting revenues for far less than the number of registered vehicles in the State, resulting in the possible loss of as much as $7 million in assessments for fiscal year 2002–03 alone. Insurance has not made sufficient efforts to verify that insurers are remitting all revenues due, even though it identified discrepancies in the number of insured vehicles reported by them. Of the 349 insurers its Budget and Revenue Management Bureau analyzed in May 2003, 230 failed to make one or more quarterly payments between 1998 and 2002. Further, 73 insurers paid annual assessments for fewer total vehicles in 2002 than the number of private passenger vehicles they reported insuring to Insurance's Statistical Analysis Division. As of April 15, 2004, Insurance had followed up on only nine of these insurers to determine whether additional assessments are due. Insurance acknowledges that it lacks adequate data to verify the accuracy of the assessments it receives from insurers and is considering regulatory changes that will enable it to capture more specific information from insurers about the number of vehicles they insure.

Further, during fiscal year 2001–02, Insurance changed its revenue collection methodology for how insurers are to calculate and remit the annual assessments before analyzing the effect this change would have, and revenues dropped dramatically

in that fiscal year. Had it conducted sufficient analysis before making this change, it could have timed the change to avoid all or part of the resulting $11 million revenue loss.

- ☑ ***Despite reducing the backlog of cases in its Investigation Division by 51 percent, Insurance can improve how it reviews and assigns cases to ensure they are not outstanding for long periods of time.***

Insurance has used some SB 940 revenues to reduce the backlog of cases in its Investigation Division by 1,580 cases, or 51 percent. Despite this, it can make improvements in how it reviews and assigns cases to avoid their being open for long periods of time. Insurance spent other SB 940 funds to increase public awareness of the services it provides, and its Legal Division used $9.4 million in SB 940 funds. However, because the Legal Division's case tracking system is not linked to the time reporting system, Insurance cannot easily demonstrate that these expenditures were only for allowable activities.

- ☑ ***Insurance cannot easily demonstrate that its Legal Division used SB 940 funds for allowable activities only.***

- ☑ ***Insurance could not demonstrate that all AB 1050 expenditures were for allowable activities. Specifically, Insurance spent $22,000 on cases that do not meet the criteria in state law.***

Insurance's use of AB 1050 funds includes working on 446 organized automobile insurance fraud cases since the program's inception, which resulted in 432 arrests. Nonetheless, Insurance could not demonstrate that all AB 1050 expenditures were for allowable activities. We identified 20 cases that do not meet state law criteria for which the department used approximately $22,000 in AB 1050 funds. Insurance does not transfer the expenditures charged to AB 1050 funds to the regular automobile fraud program when it identifies cases that do not meet the criteria in state law. Insurance also needs to ensure that it follows laws and regulations for monitoring the use of AB 1050 funds by district attorneys and the Department of the California Highway Patrol (California Highway Patrol). For example, although required to do so, the California Highway Patrol does not submit annual reports on its expenditures to Insurance.

- ☑ ***Insurance does not ensure that it follows state laws and regulations for monitoring district attorneys' and the California Highway Patrol's use of AB 1050 funds.***

- ☑ ***Its Market Conduct Division does not fully utilize Insurance's database. Therefore, Insurance cannot report on the time and cost associated with its examinations or measure the efficiency of its market conduct operations.***

Based on our analysis of the department's market conduct examination system, it appears unlikely that Insurance could gain increased efficiencies, including time and cost savings for insurers, by combining the three bureaus that currently perform market conduct examinations. Market conduct examinations are reviews of insurers' compliance with California laws and regulations, and Insurance conducts two main examinations: claims examinations and rating and underwriting examinations. The objectives of the two examinations are separate and distinct, and examiners need differing expertise and experience to conduct them. Insurance may be able to realize some cost savings, however, by combining some of the three bureaus' administrative functions. Finally, the Market Conduct Division does not fully use Insurance's database, which can collect and track data on insurers, accounts receivable, and examinations.

Consequently, Insurance cannot report on the time and cost associated with its examinations or measure the efficiency of its market conduct operations.

RECOMMENDATIONS

To ensure that it receives all assessments due, Insurance should do the following:

- Move forward in its efforts to make regulatory changes that will result in it capturing more specific data from insurers about the number of vehicles they insure.

- Follow up on the discrepancies identified in the Budget and Revenue Management Bureau's analysis.

Insurance should perform sufficient analysis of the impact of future changes to its regulations before implementing them.

To improve its service to consumers and provide appropriate oversight of SB 940 funds, Insurance should do the following:

- Revise its Investigation Division's policies and procedures to ensure that cases are not outstanding for long periods of time. For example, Insurance should assign cases to an investigator as soon as they are received and establish a goal that investigators take no more than a year from the date they receive a case to complete their investigations, barring extenuating circumstances.

- Link its Legal Division's case tracking system to its time reporting system to better document the use of SB 940 funds.

To ensure that it uses AB 1050 funds appropriately, Insurance should do the following:

- Transfer expenditures it charges to AB 1050 from its organized automobile fraud program when it transfers cases to the regular automobile fraud program.

- Follow state laws and regulations governing the oversight of the district attorneys and the California Highway Patrol's use of AB 1050 funds.

To determine whether it could generate savings from combining the administrative tasks of the three bureaus that perform market conduct examinations, Insurance should prepare an analysis and quantify possible savings.

To assess the performance of its market conduct operations, including the average time and cost of examinations, Insurance should develop a plan to fully use its database.

AGENCY COMMENTS

Insurance agreed with our recommendations and stated that it has already begun implementing several of the recommendations in our report. ■

INTRODUCTION

BACKGROUND

States have the primary responsibility for regulating the insurance industry in the United States. The Department of Insurance (Insurance) oversees most of the insurance industry in the State, including automobile, homeowner, and workers' compensation insurance.[1] It regulates the rates and practices of insurers that sold more than $102 billion in insurance premiums in 2002. Insurance oversees the industry by licensing agents and brokers (also known as producers).[2] Additionally, it enforces state laws and regulations and investigates and arrests those who commit insurance fraud. An elected insurance commissioner oversees the activities and functions of the various units within Insurance that carry out these tasks.

ANNUAL ASSESSMENTS RECEIVED FROM AUTOMOBILE INSURERS

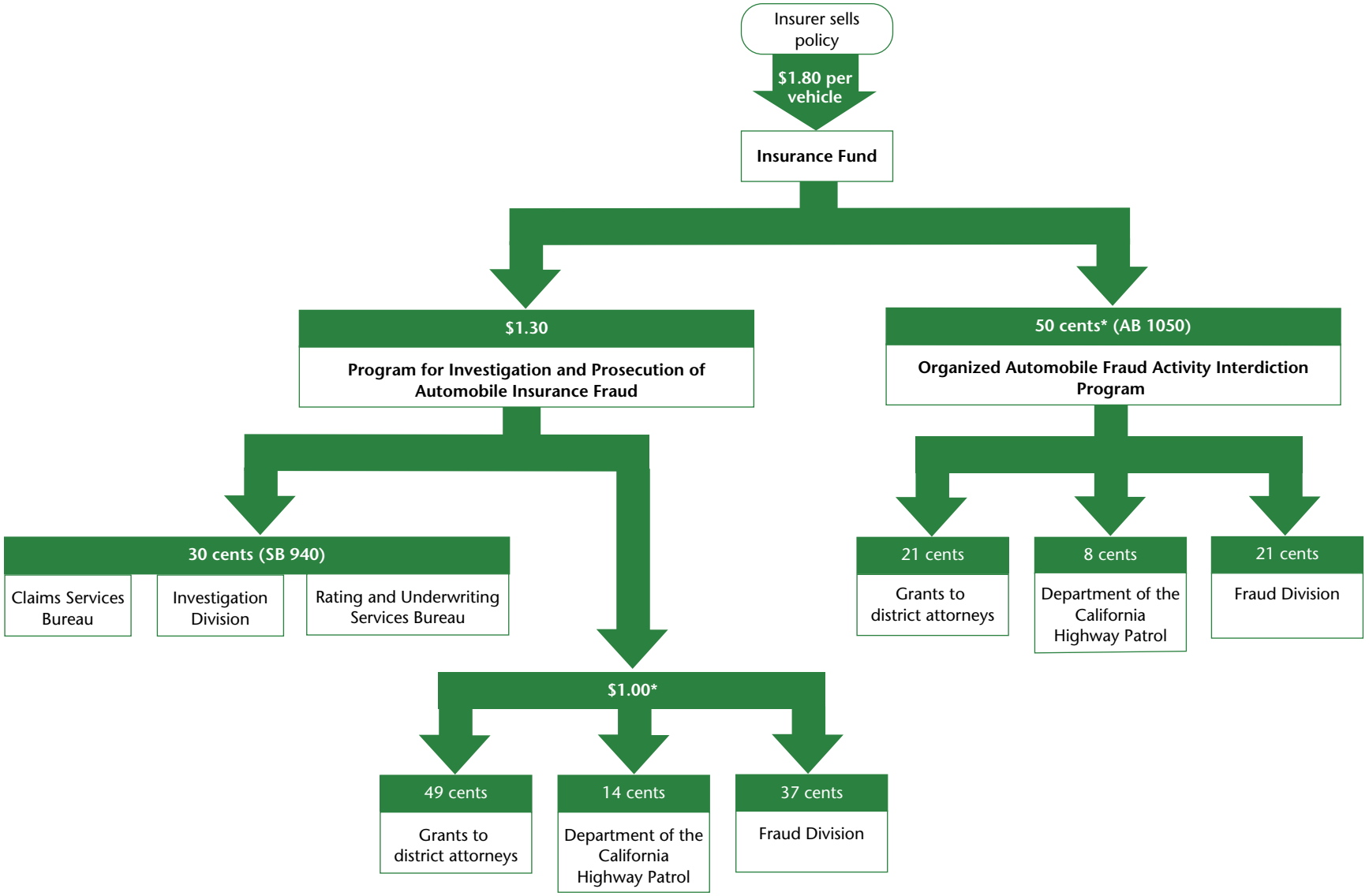
Since 1989, state law has required insurers doing business in California to pay an annual assessment for each vehicle they insure. The insurance commissioner has set this assessment at the maximum allowed under state law—$1 per insured vehicle. State law requires Insurance to use these funds to increase investigation and prosecution of fraudulent automobile insurance claims and economic automobile theft. State law defines economic automobile theft as automobile theft perpetrated for financial gain, including theft of a motor vehicle or reporting that a motor vehicle has been stolen for the purpose of filing a false insurance claim. Figure 1 on the following page shows Insurance's and other entities' use of the various assessments it receives from automobile insurers.

[1] Insurance is responsible for overseeing almost all types of insurance in California with the exception of those regulated by the Department of Managed Health Care, such as health maintenance organizations and some preferred provider organizations.

[2] See Appendix A for definitions of commonly used terms.

FIGURE 1

Use of the Annual Assessments Mandated by Law



Source: Insurance Code, sections 1872.8, 1872.81, and 1874.8.

* We computed the amounts distributed to the various entities using percentages presented in state law.

Senate Bill 940 Activities

In 1999, the Legislature enacted Chapter 884, Statutes of 1999 (SB 940), which requires insurers to pay Insurance an annual assessment of 30 cents for each vehicle they insure to fund certain consumer operations relating to automobile insurance. For fiscal years 1999–2000 and 2000–01, Insurance had to use 20 cents of the assessment to improve service to consumers, with its highest priority dedicated to eliminating the backlog of complaints related to automobile insurance policies and insurers, agents, and brokers selling those policies. Insurance could use the remaining 10 cents to improve such activities as its ability to respond to consumer complaints and information requests through its toll-free telephone number and its ability to offer information about automobile insurance rates to the public. After fiscal year 2000–01, Insurance could use the entire 30-cent annual assessment to continue to fund its consumer operations until January 1, 2007, when the law is repealed.

Two of Insurance's bureaus that can spend SB 940 funds—the Claims Services Bureau and the Rating and Underwriting Services Bureau—are within its Consumer Services Division. The Claims Services Bureau investigates consumer allegations of improper claims handling by insurers, such as the wrongful denial of a claim, reductions in claim payments, and delays in processing claims. The Rating and Underwriting Services Bureau is responsible for investigating, evaluating, and resolving complaints such as the cancellation or nonrenewal of insurance policies, refusal to insure, billing problems, and agent misrepresentation and mishandling of policies. Staff in these bureaus generally resolve complaints by communicating through letters, e-mail, or telephone calls with insurers, producers, and complainants. When warranted, they will forward cases to Insurance's Fraud, Investigation, or Legal divisions for additional action or investigation. The Investigation Division relies on SB 940 funds to minimize crimes committed by businesses and individuals related to automobile insurance. The scope of the Investigation Division's cases can begin with the sale of the policy and can typically include premium theft, senior citizen abuse, and consumer abuse by automobile insurance agents and claims adjusters.

The Consumer Communications Bureau and the External Affairs Office use SB 940 funds to improve community outreach related to automobile insurance. For example, the Consumer Communications Bureau maintains a toll-free hotline to provide

consumers immediate access to information such as agents' or brokers' licensing status or answers to questions relating to insurance claims and underwriting practices.

Assembly Bill 1050 Activities

Chapter 885, Statutes of 1999 (AB 1050) requires insurers doing business in California to pay an annual assessment of up to 50 cents for each vehicle they insure.[3] Insurance must use these revenues to fund a coordinated grant program, the Organized Automobile Fraud Activity Interdiction Program, which is targeted at the successful prosecution and elimination of organized automobile fraud activity (see text box). The grants may only be awarded to district attorneys.

Organized automobile fraud activity occurs when two or more persons conspire, aid and abet, or in any other manner act together to engage in economic automobile theft or to violate any of several state laws relating to automobile insurance claims.

Source: Insurance Code, Section 1874.8(g).

State law requires the insurance commissioner to give funding priority to those grant applications with the potential to have the greatest impact on organized automobile insurance fraud activity. Figure 1 on page 6 shows that 21 cents, or 42.5 percent, of the assessments Insurance receives from AB 1050 must fund these grants. Additionally, 8 cents, or 15 percent, goes to the Department of the California Highway Patrol (California Highway Patrol) and 21 cents, or 42.5 percent, goes to Insurance's Fraud Division, both of which must use these assessments to fund their investigators who coordinate their activities with the district attorneys. Insurers must continue to pay the 50-cent annual assessment until January 1, 2007, when the law is repealed.

MARKET CONDUCT EXAMINATIONS

Insurance also provides consumer protection through its market conduct examinations. The goal of market conduct examinations is to reduce the frequency and severity of insurance practices that are unfair to policyholders and claimants, and to evaluate insurers' compliance with laws and regulations. Because no generally accepted standards exist that stipulate how often, or even how, regulators should examine insurers, market conduct examination policies and practices vary widely from state to state. In California, Insurance conducts two main examination types: claims examinations and rating and

[3] The insurance commissioner set the annual assessment at 25 cents for calendar year 2000 and 50 cents for all subsequent years.

underwriting examinations. State law requires Insurance to carry out both types of examinations for every company licensed in the State at least once every five years.

Proposition 103, enacted by voters in November 1988, changed California from an "open competition" system of regulation where rates were set by insurers without approval from the insurance commissioner to a system where any rate changes must be approved by the insurance commissioner before they can take effect. Additionally, among other items, Proposition 103 does the following:

- Makes the insurance commissioner an elected, rather than an appointed, official.
- Requires automobile insurance rates to be determined primarily by four factors (in decreasing order of importance): (a) the driver's safety record; (b) the number of miles driven annually; (c) the number of years of driving experience; and (d) any other factors the insurance commissioner adopts by way of a regulation that have a substantial relationship to risk of loss.

Source: Insurance Code, sections 1861.01 to 1861.16; Proposition 103 text; and the Personal Insurance Federation of California Web site.

Three bureaus within Insurance's Market Conduct Division conduct these examinations. The Field Claims Bureau examines the claims payment practices of all licensed California insurers, focusing on compliance with state law and California's Fair Claims Settlement Practices regulations. This bureau's examinations include tests designed to identify claim payment delays and improper claim denials. Two Field Rating and Underwriting bureaus examine insurers' rating and underwriting practices. They focus on insurers' advertising and sales materials, compliance with prior approval and other rating laws, consistency within the adopted rating processes, and overall conformity of insurers' rating, underwriting, policy issuance, and termination procedures with state law. These bureaus also conduct reviews of insurers' compliance with Proposition 103 (see text box). Insurance's staff perform examinations at the insurers' offices. State law requires insurers to pay for the examination costs. However, all costs attributable to Proposition 103 examinations are built into an annual assessment paid by each insurer.

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (audit committee) requested that we assess Insurance's effectiveness in improving consumer services and its Fraud Division activities as a result of the additional funding it received through SB 940 and AB 1050. In addition, the audit committee requested that we examine the functions of Insurance's bureaus that perform market conduct examinations to determine the efficiency and necessity of having more than one examination bureau.

To obtain an understanding of the insurance industry and Insurance's role in regulating this industry, we reviewed applicable state laws and regulations and Insurance's policies and procedures. We also consulted staff at the National Association of Insurance Commissioners (NAIC) and three insurance regulatory agencies: the Florida Department of

Financial Services-Office of Insurance Regulation, the New York State Insurance Department, and the Texas Department of Insurance. We reviewed reports issued by the NAIC and the United States General Accounting Office as well.

To obtain an understanding of the amount of revenues it has received and spent under SB 940 and AB 1050, we reviewed Insurance's accounting records. We also reviewed information it submitted to the Office of Administrative Law to request a change to its regulations for collecting these revenues and its subsequent analysis of the effect of this change.

To evaluate Insurance's progress in reducing the backlog of cases in its Investigation Division, we compared the number of cases outstanding before the inception of SB 940 (December 31, 1999) to those cases outstanding as of December 31, 2003. We also analyzed Insurance's reports showing the number of consumer inquiries to determine the impact of its use of SB 940 funds for education and outreach activities. To determine whether Insurance restricted its use of AB 1050 funds to allowable activities, we reviewed grant agreements, payments to district attorneys, and payments to the California Highway Patrol, as well as Insurance's monitoring efforts. We also selected and reviewed 25 cases to determine if they met the criteria outlined in AB 1050.

To evaluate whether Insurance is receiving all automobile fraud assessments due from insurers, we requested information from Insurance on the number of insured vehicles in the State. However, state law requires insurers to only report to Insurance certain data on lightweight commercial vehicles that are not part of a group of five or more vehicles owned as part of a fleet. Thus, Insurance's data for commercial vehicles are incomplete. Because state law requires owners of vehicles to establish financial responsibility at the time they renew their vehicle registration with the Department of Motor Vehicles (DMV), we used DMV's unaudited data on the number of registered vehicles to estimate the number of insured vehicles. However, DMV's data have certain limitations. State law allows owners to provide evidence of financial responsibility in forms other than liability insurance policies, such as certificates of self-insurance issued by DMV or cash deposits. DMV data include vehicles where the owner provided evidence other than a liability insurance policy at the time of renewing the registration, but DMV could not

identify the number of vehicles affected. The information we present in this report is our best attempt to estimate the amount of funds that Insurance is not collecting from insurers.

To determine whether it would be efficient or beneficial to combine Insurance's Field Claims and Field Rating and Underwriting bureaus, we reviewed state laws governing each bureau's examinations and their policies and procedures. We also interviewed key staff about the job functions and qualifications Insurance requires its examiners to have. We attempted to calculate the average time and cost of the two market conduct examinations, but Insurance does not maintain its data in a manner that would allow us to do so. Finally, we contacted representatives from the three states previously mentioned. Appendix B presents a comparison of California's market conduct procedures to those of these states. ■

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CHAPTER 1

The Department of Insurance Does Not Ensure That It Receives All Annual Assessments Due

CHAPTER SUMMARY

The Department of Insurance (Insurance) does not have sufficient data to ensure that amounts insurers remit to it for annual assessments are all amounts due under state law. Consequently, it could be missing out on assessment revenues, as much as $7 million for fiscal year 2002–03 alone. Additionally, Insurance does not make sufficient efforts to oversee collection of these assessments. Also, it has yet to follow up on most of the discrepancies in insurers' payments identified by its Budget and Revenue Management Bureau in its May 2003 analyses to determine whether some insurers actually underpaid and to collect additional amounts due. Finally, Insurance did not adequately plan the change it made to its methodology for how insurers are to remit payments for the annual assessments; as a result, it experienced a decrease of almost $11 million, or 24 percent, in its assessment revenues during fiscal year 2001–02.

INSURANCE HAS NO WAY OF KNOWING IF IT RECEIVES ALL ASSESSMENTS

Insurance lacks adequate data to verify that the amounts insurers remit to it for the three annual automobile assessments constitute all amounts due. Currently, it does not collect complete data on the number of insured vehicles in the State. State law only requires insurers to report data on family-owned private passenger motor vehicles and lightweight commercial vehicles used for specific purposes that are not part of a fleet of five or more vehicles. Therefore, insurers do not report data on many larger commercial vehicles owned as part of a fleet, although they are responsible for paying assessments on these vehicles. Moreover, Insurance believes that the different types of commercial policies for fleets make it difficult for insurers to track data on each vehicle. Lacking complete information on the number of insured vehicles in the State means that Insurance does not know how much it should have received

since the enactment of Chapter 1119, Statutes of 1989 (regular automobile fraud program), Chapter 884, Statutes of 1999 (SB 940), and Chapter 885, Statutes of 1999 (AB 1050).

Using the unaudited data of the Department of Motor Vehicles (DMV), we found that Insurance collects revenues for far fewer than the total number of registered vehicles. As Table 1 shows, in fiscal year 2002–03 Insurance received assessments from insurers for about 22.5 million vehicles, which represented roughly 85 percent of the 26.4 million registered vehicles.

TABLE 1

Total Number of Registered Vehicles Versus Those for Which the Department of Insurance Received Annual Assessment Payments

	Fiscal Year		
Revenue Source	2000–01	2001–02	2002–03
Number of registered vehicles in the State *	25,276,473	26,043,725	26,440,451
Number of vehicles for which Insurance received assessment payments†	26,211,486	19,022,644	22,503,737
Difference in the vehicle counts (number)	935,013	(7,021,081)	(3,936,714)
Difference in the vehicle counts (percent)	4%	(27%)	(15%)
Potential lost revenues	($1,566,147)	$12,637,946	$7,086,085

Source: Department of Insurance remittance reports for the period October 2000 through January 2004 and Department of Motor Vehicles' unaudited data on registered vehicles.

* Total number of registered vehicles in the State is as of June 30 and includes automobiles, commercial vehicles, and motorcycles, but does not include planned nonoperational vehicles, off-highway vehicles, or fee-exempt vehicles and trailers.

† Although we excluded trailers from the number of registered vehicles in the State, the number of vehicles for which Insurance received assessment payments may include trailers that require insurance, such as those owned by household goods carriers. Additionally, for fiscal year 2000–01, the number of vehicles for which Insurance received assessment payments has been adjusted to reflect an increase from 25 cents to 50 cents for the Organized Automobile Fraud Interdiction Program (AB 1050) fees, effective January 1, 2001.

The Legislature enacted the regular automobile fraud program, SB 940, and AB 1050 to help reduce crimes related to automobile insurance and intended Insurance to collect these assessments on all insured vehicles. State law requires every owner of a motor vehicle to establish financial responsibility for the vehicle at the time he or she renews a DMV registration. However, as we stated in the Introduction, evidence of financial responsibility can be other than a liability insurance policy, such as a

certificate of self-insurance issued by DMV or a cash deposit. If the owners of almost four million registered vehicles in the State for which Insurance did not receive an assessment use other than a liability insurance policy to show financial responsibility and do not have insurance, then Insurance received the correct amounts. However, if any or all of these vehicles did carry insurance for at least part of the year, then Insurance should have received up to $1.80 for each vehicle and thus could have missed out on up to roughly $7 million in additional revenues for fiscal year 2002–03 alone.

INSURANCE LACKS SUFFICIENT OVERSIGHT FOR COLLECTING ASSESSMENTS

Insurance has many procedures to ensure that the assessments it receives from insurers are deposited and recorded correctly in its accounting system. However, it has not made sufficient efforts to verify that the amounts insurers remit are based on the actual number of vehicles they insure. As of April 15, 2004, Insurance has verified that the amounts remitted are correctly calculated and constitute all revenues due for only nine insurers.

Insurers pay the three annual assessments on an honor system. Insurance sends an invoice and requires each insurer to certify under penalty of perjury that the number of insured vehicles reported is correct. However, as discussed earlier, Insurance lacks complete information on the total number of insured vehicles in the State. Therefore, it cannot easily verify the accuracy of insurers' payments. Moreover, Insurance does not follow up when it identifies discrepancies in the number of insured vehicles for which insurers remit assessments.

A Department of Insurance analysis shows that, among other discrepancies, 73 insurers paid annual assessments for fewer total vehicles in 2002 than the number of private passenger vehicles they reported having insured.

In May 2003, Insurance's Budget and Revenue Management Bureau analyzed annual assessments received from 349 insurers between 1998 and 2002.[4] The analyses found that 230 companies failed to make one or more quarterly payments over the five-year period and that 73 paid annual assessments for fewer total vehicles in 2002 than the number of private passenger vehicles they reported having insured to Insurance's Statistical Analysis Division.

[4] The bureau selected insurers with an annual assessment in 2002 of more than $1,000 for analysis.

Although its Budget and Revenue Management Bureau identified these and other discrepancies, Insurance has yet to follow up with most of these insurers to determine whether they actually underpaid their assessments, and if so, to collect additional amounts that may be due. A supervising insurance examiner in the Field Examination Division stated that Insurance's intent was to have Field Examination Division teams within the Financial Surveillance Branch use these analyses as a place to begin their reviews of insurers.[5] However, as of April 15, 2004, Insurance has completed examinations of only nine of the 349 insurers in the year since it did the analyses. Although in most instances insurers either overpaid their assessments or the discrepancy was immaterial, Insurance also discovered that two of the nine insurers underpaid their assessments by a total of $126,000.

Our comparison of written premiums to assessments paid found that the written premiums for 17 of 50 insurers increased from 2001 to 2002, but the amount of their annual assessments decreased.

For 50 of the 349 insurers analyzed by the Budget and Revenue Management Bureau, we compared their written premiums to the assessments they paid and found additional discrepancies. For example, although the written premiums for 17 insurers increased from 2001 to 2002, the amount of their annual assessments decreased. In one instance, the insurer's written premiums increased by $24 million to more than $518 million, but its annual assessment paid to Insurance decreased by almost $300,000 to about $1.4 million. Four insurers paid no assessments in 2001 and 2002, even though they reported to Insurance they had written premiums. We believe it would be beneficial for Insurance to conduct a similar review of all insurers and investigate any unusual trends to ensure that it receives all assessments due.

Finally, in January 2004, Insurance's Fraud Division conducted a survey of 701 insurers to verify the methodology they used to calculate and remit assessments during the last quarter of 2003. Of the 66 insurers responding to the survey as of May 2004, seven reported they had incorrectly calculated assessments in previous quarters and either reimbursed Insurance for the underpayments or planned to adjust future assessments for these errors. For example, one insurer remitted $28,300 to Insurance for its underpayment of assessments in 2002 and 2003. Furthermore, our review found that responses from 10 insurers indicated that the methodology they were using was inconsistent with

[5] The Financial Surveillance Branch is responsible for overseeing the financial condition of the insurance industry to ensure it can provide the benefits and protection promised to California policyholders. As part of this branch, the Field Examination Division is responsible for examining the business and affairs of every admitted insurer to determine its financial condition and compliance with applicable laws.

state regulations. For example, one insurer reported that it uses a formula based on written premium to approximate a vehicle count for its policies that did not identify the specific vehicles. Further follow-up with insurers to clarify its methodology could, again, give Insurance more assurance that it is collecting all amounts due. Insurance acknowledges that it lacks adequate data to ensure the accuracy of the assessments it receives from insurers. It is considering regulatory changes that will enable it to capture more specific information from insurers about the number of vehicles they insure.

INSURANCE DID NOT ADEQUATELY PLAN FOR A CHANGE TO ITS ASSESSMENT CALCULATION METHODOLOGY

Had Insurance conducted sufficient analysis, it may have been able to better time its change and thus could have avoided a drop in revenue of roughly $11 million.

Concerned that its revenue collection methodology was causing an inconsistent cash flow to fund its operations, during fiscal year 2001–02 Insurance changed the methodology for how insurers were to calculate and remit payments for the three annual assessments. However, it did not conduct any analysis of the effect this change would have before implementing it. As a result, assessment revenues dropped dramatically during that fiscal year. Had Insurance conducted sufficient analysis, it may have been able to better time its change and thus avoided losing roughly $11 million, the amount by which its revenues declined that year.

State laws require insurers doing business in California to pay annual assessments totaling $1.80 for each vehicle they insure. Insurance collects these amounts by sending invoices to insurers on a quarterly basis. Before April 2002, during the first quarter of each calendar year, Insurance required insurers to calculate assessments due on all vehicles for which they had a policy in force as of January 1 plus any newly insured during the quarter. For each of the remaining quarters in the calendar year, Insurance required insurers to calculate the assessment due for all vehicles newly insured during those quarters. Under this methodology, insurers paid the majority of their assessments in the first quarter of each calendar year.

Effective April 1, 2002, Insurance notified insurers that beginning with the first quarter of 2002, they were to calculate the assessments due for each quarter by multiplying one-fourth of the $1.80, or 45 cents, by the number of vehicles insured as of the first day of each quarter plus any newly insured during the quarter.

However, Insurance did not perform any analysis to fully study the impact this change would have on its revenues. It did not complete such an analysis until December 2002 and concluded that implementing the new methodology would likely decrease assessment revenues between 16.2 percent and 18.5 percent for fiscal year 2001–02. However, as Table 2 shows, the decrease was greater than 18.5 percent.

TABLE 2

Dollars Received From the Annual Assessments Fiscal Years 2000–01 Through 2002–03

Assessments	Fiscal Year 2000–01	2001–02	2002–03
30 cents*	$ 7,863,446	$ 5,706,793	$ 6,751,121
50 cents†	10,928,541	9,511,322	11,251,869
$1‡	26,211,486	19,022,644	22,503,737
Annual assessment totals	$45,003,473	$34,240,759	$40,506,727
Change from prior year (dollars)	—	($10,762,714)	$ 6,265,968
Change from prior year (percent)	—	(24%)	18%

Source: Department of Insurance remittance reports from October 2000 through January 2004. Because these reports do not detail amounts received for each of the three assessments, we calculated the separate amounts Insurance should have received for each.

* Chapter 884, Statutes of 1999 (SB 940).

† Chapter 885, Statutes of 1999 (AB 1050).

‡ Chapter 1119, Statutes of 1989, Program for the Investigation and Prosecution of Automobile Insurance Fraud (regular automobile fraud program).

As the table shows, Insurance's revenues from the three annual assessments dropped by almost $11 million, or 24 percent, from fiscal years 2000–01 to 2001–02. Revenues increased in fiscal year 2002–03 but did not return to the same levels as before the change was made. Had Insurance analyzed the effect of the change to its methodology before making the change, it would have been able to avoid this large drop in revenue by postponing its implementation date until after the first quarter of the calendar year.

RECOMMENDATIONS

To ensure that it receives all assessments due, Insurance should do the following:

- Move forward in its efforts to make regulatory changes that will result in capturing more specific data from insurers about the number of vehicles they insure.

- Compare the number of private passenger vehicles insurers report on their assessment invoices to the number they report to its Statistical Analysis Division annually and investigate discrepancies.

- Direct its Field Examination Division to follow up on the discrepancies identified in the Budget and Revenue Management Bureau's analysis.

- Periodically perform analytical reviews of insurers' data, such as comparing changes in written premiums to changes in the assessments insurers remit, and investigate unusual trends.

- Direct its Fraud Division to follow up on the calculation and remittance discrepancies identified as a result of the January 2004 survey of insurers.

Insurance should perform sufficient analysis of the impact of future changes to its regulations before implementing them. ■

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CHAPTER 2

The Department of Insurance Has Spent Some Annual Assessment Funds on Inappropriate Activities

CHAPTER SUMMARY

Although the Department of Insurance (Insurance) has not received all assessments that may be due, it has been able to use the funds it has received to make some improvements in services related to automobile insurance. Insurance reduced the backlog of cases in its Investigation Division with the additional funds provided by Chapter 884, Statutes of 1999 (SB 940), but it did not reduce the amount of time that cases remain open. Insurance also used SB 940 funds to increase consumer public awareness of automobile insurance, particularly the low-cost automobile insurance pilot programs. However, it may be able to improve how it tracks the use of some of these funds. Insurance's Legal Division used $9.4 million in SB 940 funds, but because its case tracking system is not linked to its time reporting system, it cannot easily demonstrate whether it used the funds for allowable activities.

Insurance also received additional funding through Chapter 885, Statutes of 1999 (AB 1050). This funding has allowed district attorneys, Insurance, and the Department of the California Highway Patrol (California Highway Patrol) to work on 446 cases involving organized automobile insurance fraud since the program's inception. However, Insurance used AB 1050 funds to work on some cases that do not meet the criteria established in state law. Finally, Insurance does not properly oversee district attorneys' or the California Highway Patrol's use of AB 1050 funds; consequently, it is unable to ensure that they are using AB 1050 funds only for allowable activities.

ALTHOUGH INSURANCE HAS MADE IMPROVEMENTS TO CONSUMER SERVICES, IT CANNOT DEMONSTRATE THAT IT SPENDS ALL SB 940 FUNDS ON ALLOWABLE ACTIVITIES

Between October 2000 and January 2004, Insurance received almost $26 million in SB 940 revenues. The additional staff and resources provided through these revenues allowed it to reduce the backlog of open cases in its Investigation Division by 1,580 cases, or 51 percent. Insurance can, however, improve how it reviews and assigns these cases to ensure shorter processing time. Additionally, Insurance used SB 940 funds to increase its outreach and communication efforts related to several automobile insurance programs, and in doing so, it may have increased public awareness of the services it provides. Insurance does need to improve tracking the use of SB 940 funds; for example, the Legal Division cannot easily demonstrate that it used the $9.4 million it received only for allowable activities.

Insurance Used SB 940 Funds to Reduce the Investigation Division's Backlog, but It Could Make Further Improvements

SB 940 required Insurance to dedicate 20 cents of its additional revenues for fiscal years 1999–2000 and 2000–01 to improving service to consumers, with its highest priority dedicated to eliminating the backlog of consumer complaints. SB 940 also directed Insurance to develop and submit a plan for the use of these funds to the committees on insurance in both the Assembly and Senate. In its March 2000 plan to the committees, Insurance noted that it did not have a backlog of complaints but rather a backlog of cases in its Investigation Division. Insurance therefore planned to use $2.5 million of the SB 940 funds annually to pay for the costs of adding 53 positions in its Investigation Division and compliance bureaus within its Legal Division to reduce this backlog and to assist with consumer-protection programs.

The Investigation Division focuses on allegations of suspected violations of state laws and regulations that arise when the policy is sold by agents, brokers, and insurers.

Examples of cases investigated include the following:

- Anti-consumer practices.
- Bogus insurers.
- Insurance company insider fraud.
- Premium theft.
- Senior citizen insurance abuse.

Source: Department of Insurance, Investigation Division.

We determined that Insurance significantly reduced this backlog between December 31, 1999—just prior to the start of the SB 940 program—and December 31, 2003. As shown in Table 3, the total number of open cases in the Investigation Division dropped from 3,116 to 1,536, a reduction of 1,580 cases, or 51 percent. According to the Investigation Division's policy and procedures manual, supervisors are to direct and encourage their staff to average

six months from the date they receive a complaint to the date they close a major case. To be considered major, a case must be important to Insurance or be considered a potential risk of serious harm to the public. The Investigation Division was able to resolve 3,818 of the 5,841 cases it closed in 2000 through 2003 within six months of the date it assigned the case.

TABLE 3

Number of Open Cases for 2000 Through 2003

	2000	2001	2002	2003
Open cases as of January 1	3,116	2,762	2,135	1,438
New cases added during the year	1,323	1,103	916	919
Cases closed during the year	(1,677)	(1,730)	(1,613)	(821)
Open cases as of December 31	2,762	2,135	1,438	1,536

Source: Department of Insurance's Investigation Division case tracking system.

However, Insurance has not reduced the length of time some of the cases in its Investigation Division remain open. As of December 31, 1999, 2,178 cases, about 70 percent of all open cases, had been open more than six months. As of December 31, 2003, 1,161 cases, 76 percent of all open cases, had been open more than six months. Moreover, 656 cases, or 43 percent of those open cases, still were not assigned to an investigator. The Investigation Division chief stated that supervisors are expected to review the unassigned cases periodically. If unassigned cases are three years old, supervisors are expected to assign or close them, unless there is a reason to keep the cases open longer, such as a request from another agency. However, supervisors are to make their final determination to assign or close any case within four years of the alleged misconduct to allow time for Insurance to investigate and file charges.

Insurance's policy regarding unassigned cases is unreasonable and does not promote consumer protection. In fact, our review of various state laws applicable to several departments found that state law requirements for investigating complaints range from 15 days to one year. For example, state law requires the

Contractors State License Board within the Department of Consumer Affairs to set as a goal that an average of no more than six months elapse from the receipt of a complaint to the completion of an investigation and that investigations of complaints involving complex fraud or contractual arrangements take no more than one year. Insurance acknowledges that prompt and effective investigations are critical to its overall law enforcement program. Its Investigation Division chief told us that he plans to reevaluate the current review process. Insurance told us that it is in the process of hiring two investigators and has requested five investigative positions to eliminate the backlog relating to SB 940, but it believes it will take six years to eliminate the remaining backlog of unassigned cases. Until Insurance revises its policy and reevaluates its approach to eliminating the backlog, suspected violations of insurance laws and regulations by agents, brokers, and insurers will continue to remain unresolved longer than necessary.

Insurance Used Some SB 940 Assessments to Increase Consumer Awareness of Automobile Insurance

State law allows Insurance to use SB 940 funds to improve its ability to offer information about automobile insurance rates to the public. In its March 2000 plan, Insurance stated that it would use $1.5 million in SB 940 funds each fiscal year to establish an education and awareness program for underserved communities and for consumers. This program includes educating consumers in Los Angeles and San Francisco counties about the State's low-cost automobile insurance pilot programs that offer annual rates as low as $300 to $450 to people who meet criteria such as living in a household with a gross income that does not exceed 250 percent of the federal poverty level.

Insurance used SB 940 funds to educate consumers and increase public awareness of its low-cost automobile insurance pilot programs, among other things.

Between July 2000 and March 2004, Insurance paid a public relations firm roughly $2.9 million in SB 940 funds to educate consumers and increase their public awareness about its mission, the low-cost automobile insurance pilot programs, its toll-free consumer hotline, and automobile insurance requirements. Insurance's External Affairs Division also incurred costs totaling $524,000 from fiscal years 2000–01 to 2002–03 relating to its low-cost automobile insurance pilot programs.

Insurance believes that its education and awareness efforts help to increase the number of inquiries it receives about the low-cost automobile insurance pilot programs, the number of visits to its Web site, and the number of consumer complaints. For example,

according to Insurance's unaudited data, consumer inquiries about its low-cost automobile insurance pilot programs increased from 3,619 in 2000 to a total of 61,000 between 2001 and 2003. Insurance's unaudited data also show a steady increase in visits to its Web site, from almost 212,000 during fiscal year 1999–2000 to more than 905,000 in fiscal year 2002–03.

Insurance's Legal Division Cannot Demonstrate That It Only Used SB 940 Funds for Allowable Activities

State law does not expressly allow Insurance's Legal Division to use SB 940 funds. However, according to our legal counsel, such use of these funds would be reasonable to the extent the Legal Division's services support the purpose of SB 940. The Legal Division assists the Consumer Services Division and Investigation Division by preparing and filing pleadings in connection with disciplinary actions against insurers and producers. Cases referred by the Investigation Division represent 95 percent of the caseload of the Legal Division's compliance bureaus.

Insurance could not easily demonstrate that the roughly $9.4 million in SB 940 funds it used to pay for expenses related to the Legal Division's assistance to the Investigation Division was accurate or for allowable activities.

State law requires Insurance to adopt an accounting system that will allow it to accurately identify costs by regulatory activities and to link the costs to the fees collected for those activities. In July 1994, Insurance implemented its Time Activity Reporting System (time reporting system), which tracks expenditures by program, unit, program cost account code, activity, and task. The Legal Division also uses a case tracking system to monitor the status of its cases. However, unlike the tracking systems of other divisions or bureaus within Insurance, the Legal Division's case tracking system does not link to its time reporting system. Without this link, we could not readily identify the cases worked on by staff in the Legal Division's compliance bureaus. Therefore, Insurance could not easily demonstrate that the roughly $9.4 million in SB 940 funds it used to pay for expenses related to the Legal Division's assistance to the Investigation Division was accurate or for allowable activities. The Legal Division's assistant chief counsel stated that Insurance intends to relate the two systems by September 2004.

INSURANCE NEEDS TO SIGNIFICANTLY IMPROVE ITS OVERSIGHT OF AB 1050 FUNDS

Insurance has received about $39 million in AB 1050 funds since the law went into effect; however, it cannot demonstrate that it is using the money only for allowable activities. Some of its

expenditures appear to be for unallowable activities. To ensure appropriate use of this funding for the most benefit possible, Insurance should better review the expenditures made by district attorneys and the California Highway Patrol.

AB 1050 Revenues Have Funded Coordinated Efforts to Fight Automobile Insurance Fraud

The Legislature enacted AB 1050 to fund a coordinated grant program, the Organized Automobile Fraud Interdiction Program (organized automobile fraud program), to target the successful prosecution and elimination of organized automobile fraud activity. State law requires Insurance to award three-year grants from AB 1050 funds to between three and 10 district attorneys. For the period of July 1, 2000, through June 30, 2003, it awarded grants totaling almost $14.5 million to eight counties—Alameda, Los Angeles, Riverside, San Bernardino, Sacramento, San Diego, San Francisco, and Santa Clara. For fiscal year 2003–04, Insurance awarded $4.5 million to nine counties—the eight counties that previously received grants plus Fresno. District attorneys have been able to use these grants to dedicate additional staff, such as prosecutors, investigators, and clerical support, to the organized automobile fraud program. Each grantee enters into a memorandum of understanding with Insurance's Fraud Division and the California Highway Patrol. The agreement establishes a chief investigator from the Fraud Division as the regional coordinator responsible for administering and managing investigative resources.

Insurance awarded grants based on a variety of needs outlined by the district attorneys in their applications. In some instances, these needs had the potential to affect not only the county applying for the funds but also neighboring counties. For example, in its grant application Alameda's district attorney outlined a problem with "chop shops" operating in Alameda that are dismantling vehicles stolen in neighboring counties. Los Angeles County's district attorney noted that investigators have traced organized accident rings to Southern California gangs, making Los Angeles County the core of the automobile insurance fraud problem. In their applications, the district attorneys outlined a variety of plans to use grant funds to address these issues.

Since its inception, the AB 1050 program has supported a joint approach to investigating 446 organized automobile fraud activity cases, which have led to 432 arrests.

Since its inception, the AB 1050 funds have supported a joint approach to investigating a number of organized automobile fraud activity cases. Insurance reports that it has used these funds to work on 446 cases, resulting in 432 arrests. Among the successes reported by district attorneys was Sacramento County's 19 convictions, including nine defendants who were ordered to pay restitution totaling more than $145,000. Los Angeles County's district attorney reported using AB 1050 funds for 137 arrests between October 1, 2001, and June 6, 2003, estimating overall losses from fraudulent claims for two of the arrests alone at over $35 million.

Insurance Used Some AB 1050 Funds for Inappropriate Activities

We reviewed case files for 25 of the 446 cases billed to AB 1050 funds since the inception of the organized automobile fraud program and found four that involved only one suspect working alone to commit economic automobile theft. The organized automobile fraud program is aimed at investigating cases involving more than one person. We also reviewed case descriptions for all 446 cases. Based on these descriptions and discussions with department staff, we identified an additional 16 cases that did not meet the criteria in state law. According to Insurance's unaudited data, it used roughly $22,000 in AB 1050 funds to work on these 20 cases.

The deputy commissioner of Insurance's Administration and Licensing Services Branch stated that the decision to classify an investigation as an organized automobile fraud case, making it eligible for AB 1050 funds, is generally made by a supervisor when entering it into the case tracking system. Although the organized automobile fraud program may initially investigate them, some cases are transferred to Insurance's Program for Investigation and Prosecution of Automobile Insurance Fraud (regular automobile fraud program) once investigators make the determination that the case does not meet the criteria in state law for AB 1050 funds. Because state law requires it to limit the expenditures of AB 1050 funds to specific activities, Insurance's accounting records should be sufficient to demonstrate that the funds are spent on allowable activities only. However, the Fraud Division does not transfer the expenditures it has already incurred on these cases to the regular automobile fraud program. Until it establishes procedures to do so, it will continue to inappropriately use AB 1050 funds.

Insurance Lacks Proper Oversight of the District Attorneys' and the California Highway Patrol's Use of AB 1050 Funds

State regulations require district attorneys to submit audited financial reports to Insurance annually, and Insurance's grant guidelines state that failure to submit the annual report shall affect its subsequent funding decisions. Two of the eight district attorneys receiving AB 1050 grants in the first grant award period, fiscal years 2000–01 to 2002–03, had failed to submit one or more reports as of April 2004, yet Insurance did not modify or withdraw these counties' funding. Insurance told us that it has contacted the two counties and requested that they comply with the reporting requirement, but its inability to review these reports in a timely manner diminishes Insurance's effectiveness in overseeing AB 1050 funds.

Insurance does not follow state regulations that require it to perform a fiscal audit of each county at least once every three years, and has completed audits of only two of the eight counties that received AB 1050 funds.

Additionally, Insurance does not follow state regulations that require it to perform a fiscal audit of each county at least once every three years. Since Insurance began disbursing funds to the counties in May 2001, it has completed only two audits of the eight counties that received AB 1050 funds. Insurance stated that because no additional funding was provided for staff to audit AB 1050 and other grants to district attorneys, it has been unable to comply with the three-year audit requirement. However, Insurance found questionable and unallowable expenditures in the two audits it completed since May 2001 for the AB 1050 funds, demonstrating the need for the audits to guarantee that funds are spent properly.

Moreover, although state law and regulations require it to perform an annual review of the counties' performance under the organized automobile fraud program grant, Insurance does not do so. It should review the number of arrests, prosecutions, convictions, and dollar savings resulting from the counties' efforts. Insurance acknowledges that it should conduct these reviews and plans to do so at the end of each fiscal year beginning with fiscal year 2003–04.

Finally, state law requires Insurance to distribute 15 percent of all AB 1050 assessments to the California Highway Patrol to fund investigators who are assigned to work solely in conjunction with district attorneys who have been awarded organized automobile fraud program grants. State law requires the California Highway Patrol to report annually to Insurance its use of AB 1050 funds. This report should include information on the salaries and benefits of the California Highway Patrol's investigators. State law also requires Insurance to report to

the Legislature on or before January 1, 2005, the results of the organized automobile fraud program, including the California Highway Patrol's use of AB 1050 funds.

However, since the inception of the organized automobile fraud program, Insurance has neither requested nor received annual reports from the California Highway Patrol. According to the Fraud Division chief, he does not feel it is a large problem because the California Highway Patrol's investigators report to and work in the same office as Insurance's investigators. Nevertheless, without the annual reports, Insurance cannot ensure that the California Highway Patrol is accurately charging the salaries and benefits of those investigators working on allowable activities under AB 1050.

RECOMMENDATIONS

To improve its service to consumers and provide appropriate oversight of SB 940 funds, Insurance should do the following:

- Revise its Investigation Division's policies and procedures to ensure that cases are not outstanding for long periods of time. For example, Insurance should assign cases to an investigator as soon as they are received and establish a goal that investigators take no more than a year from the date they receive a case to complete their investigations, barring extenuating circumstances.

- Review its open cases, both assigned and unassigned, to determine whether any should be closed.

- Eliminate the Investigation Division's backlog of unassigned cases by requiring staff to work a reasonable amount of overtime or seeking additional staff.

- Link its Legal Division's case tracking system to its time reporting system to better document the use of SB 940 funds.

To ensure that it uses AB 1050 funds appropriately, Insurance should do the following:

- Transfer the hours and billable expenses it charges to AB 1050 from its organized automobile fraud program when it transfers cases to the regular automobile fraud program.

- Follow state laws and regulations governing fiscal and performance audits of counties to ensure that the district attorneys use AB 1050 funds only for allowable activities and in the most effective and efficient manner.

- Require the California Highway Patrol to submit annual reports of its expenditures as state law requires. ■

CHAPTER 3

Opportunities Exist for the Department of Insurance to Improve Management of Its Market Conduct Examinations

CHAPTER SUMMARY

The Department of Insurance (Insurance) has three bureaus within its Market Conduct Division—the Field Claims Bureau and two Field Rating and Underwriting bureaus—that perform two types of examinations: claims examinations and rating and underwriting examinations. The differing nature and scope of the two examinations leave little room to achieve efficiencies, including time and cost savings for examined insurers, by combining the three bureaus. The Field Claims Bureau focuses on claim payments, whereas the two Field Rating and Underwriting bureaus focus on rating and underwriting issues, such as conduct related to the issuance of policies or potential discrimination against selected insurable populations in the State. However, Insurance may be able to gain some efficiencies and cost savings by studying whether any of the administrative tasks shared by these bureaus can be combined.

In addition, the Market Conduct Division does not take full advantage of Insurance's database and does not adequately capture or tally the time or costs associated with its market conduct examinations; thus, it cannot measure the efficiency of its operations. However, linking various modules in its database would allow it to obtain data that meets its reporting needs.

COMBINING THE MARKET CONDUCT DIVISION'S BUREAUS WOULD NOT LIKELY RESULT IN INCREASED EFFICIENCIES

Combining Insurance's Field Claims and two Field Rating and Underwriting bureaus would not greatly reduce either the time or cost to perform market conduct examinations. Market conduct examinations are reviews of insurers' compliance with insurance laws and regulations. The goal of these examinations is to reduce the frequency and severity of insurance practices that are unfair to policyholders and claimants. However, the

objective of each of the two examinations—claims examinations and rating and underwriting examinations—is separate and distinct. Further, the claims examiners and the underwriting examiners possess separate expertise and experience. Thus, combining the three bureaus would not substantially reduce costs to insurers, who must pay for the examinations.

The three bureaus report to the chief of the Market Conduct Division and are located in Los Angeles, Sacramento, and San Francisco. Both types of examiners are housed in all three locations and receive assignments based on factors such as their proximity to the examination site and their experience. As shown in Table 4, the examinations conducted by the three bureaus have different objectives, focuses, and sample selection methods. The Field Claims Bureau examines the claim payment practices of all licensed California insurers. The Field Rating and Underwriting bureaus, on the other hand, focus on insurers' rating and underwriting practices, such as their compliance with state requirements relating to advertising and sales material, policy issuance, and policy termination.

Because of the different objectives of the two examinations, bureau examiners possess different expertise and experience. Insurance typically hires Field Claims Bureau examiners who have prior experience investigating, evaluating, negotiating, and settling claims as claims adjusters for insurance companies. It hires examiners for its Field Rating and Underwriting bureaus who have prior experience as underwriters determining acceptability, coverage, and appropriate rating plans for insurance companies. According to Insurance, none of its 26 Field Claims Bureau examiners have underwriting experience, and none of its 14 Field Rating and Underwriting bureaus' examiners have claims experience. Therefore, combining the three bureaus would require all examiners to become knowledgeable of both types of examinations. Insurance believes that this would require it to provide substantial initial and ongoing training. Further, Insurance stated that it is already faced with the challenge of training examiners on information relating to their existing areas of expertise.

Insurers would not benefit substantially if Insurance were to combine the market conduct examinations. However, Insurance may be able to realize some savings by combining administrative tasks such as timekeeping, scheduling and coordinating examinations with insurers, and preparing reports.

Insurers also would not benefit substantially if Insurance were to combine the examinations. Insurance companies typically have separate departments for claims and underwriting functions. Therefore, combining the bureaus would not eliminate the need for Insurance's examiners to perform the same amount of work they currently perform in the various offices of insurers to fulfill

the objectives shown in Table 4. State law requires insurers to pay for the examination costs, and they would still face essentially the same costs if Insurance were to combine the three bureaus.

TABLE 4

Comparison of Activities of the Field Claims Bureau and Field Rating and Underwriting Bureaus

	Field Claims Bureau	Field Rating and Underwriting Bureaus
Objective of the examinations	Verify insurers' compliance with state laws, regulations, and policies and procedures relating to handling claims.	Verify insurers' compliance with state laws, regulations, and policies and procedures relating to customer selection, sales, marketing, and pricing.
Areas of focus	Claim. File notes. Correspondence. Investigative material. Documentation of damage or loss. Payments. Any other documentation, such as the insurer's claim procedure manual, needed to support the insurer's compliance with state requirements.	Underwriting guidelines, policy forms, and policy files. Service standards relating to insurers' issuance of quotes, policies, and renewals. Insurer's disclosure of correct and legal information to potential and actual consumers on its Web site, advertising materials, quotations, and policy forms. Insurer's compliance with the Insurance Information Privacy and Protection Act. Insurer's compliance with Proposition 103, if applicable. Insurer's cancellation, non-renewal, and declination of policies.
Basis for selecting classes of insurance to be reviewed*	Homeowner and private passenger auto classes of insurance are always reviewed. However, review of other classes of insurance depends on factors such as Insurance's priorities, current concerns, and the number of consumer complaints.	Review of premium written by class of insurance by insurer's branch or home office.
Sample size	Statistically based on the number of claims within each class of insurance.	Generally, a minimum of 50 policies for each class of insurance to be reviewed.
Examination time allocation	Varies depending on factors such as the size of the sample, complexity of the issues, cooperation from the insurer, and the number of examiners assigned.	Generally, 20 days for each class of insurance.

Source: Department of Insurance procedures manuals and interviews with Market Conduct Division staff.

* The Department of Insurance uses the terms "classes of insurance" and "lines of insurance" interchangeably. We use the term "classes of insurance" in this report.

Insurance acknowledges it may be able to realize some savings by combining administrative tasks such as timekeeping, scheduling and coordinating examinations with insurers, and preparing reports. However, it also believes that combining the bureaus would reduce the efficiency and effectiveness of the Market Conduct Division as a whole. Nevertheless, it could benefit from preparing an analysis to quantify savings that could be generated by combining administrative tasks.

California's use of multiple bureaus to conduct the fieldwork portion of its examinations, which represent roughly 80 percent of its examination efforts, is not uncommon among states. For example, the state of New York focuses its market conduct examinations on the fair treatment of policyholders in areas such as insurers' operations, complaint handling, marketing, claims, rate and form filing, and policyholder service. New York uses three bureaus to examine insurers: its health, life, and property bureaus. New York's organizational structure focuses on types of insurers rather than California's approach of focusing on activities. Nonetheless, New York uses multiple bureaus to perform its examinations.

INSURANCE CANNOT REPORT ON KEY DATA NEEDED TO EVALUATE THE EFFICIENCY OF ITS MARKET CONDUCT EXAMINATIONS

Because its Market Conduct Division does not take full advantage of Insurance's database, Insurance cannot report on time and cost associated with a particular examination or the average time and cost for all market conduct examinations it performs, and as a result cannot measure the efficiency of its operations.

Insurance needs to improve its procedures for tracking examinations, including the number of examiners' hours and other billable costs such as travel expenses. The Joint Legislative Audit Committee requested that we determine the average length of time it takes Insurance to perform its market conduct examinations and the associated costs. Because the Market Conduct Division does not take full advantage of Insurance's database, Insurance cannot report on the time and cost associated with a particular examination or the average time and cost for all market conduct examinations it performs. As a result, it cannot measure the efficiency of its market conduct operations.

Insurance's database includes modules designed to capture data on insurers licensed to operate in California, including tracking examinations, staff hours, and how much to bill insurers. Based on user needs, Insurance's Information Technology Division can interrelate various tables and modules in the database so information can be shared. However, the Market Conduct Division has not taken full advantage of this database's capabilities. For example, if examiners perform an examination of an insurer that has multiple companies, they must enter data for each company using separate examination identification numbers. However, the examination tracking module can be configured to allow examiners to create one identification number for all companies included in a particular examination. Additionally, although the examination tracking module contains fields to track billable hours and costs, the Market

Conduct Division does not use these fields. Instead, as Figure 2 on the following page shows, examiners must enter their hours and other billable expenses into monthly time sheets and billing summaries that do not track data by the examination identification number. Without knowing all the insurer's companies that were part of a particular examination and the hours and other billable expenses charged by examiners to those companies, Insurance cannot aggregate the total hours and costs associated with its examinations.

The Market Conduct Division does not appear to comply with state law, which requires Insurance to examine every admitted insurer operating in California at least once every five years.

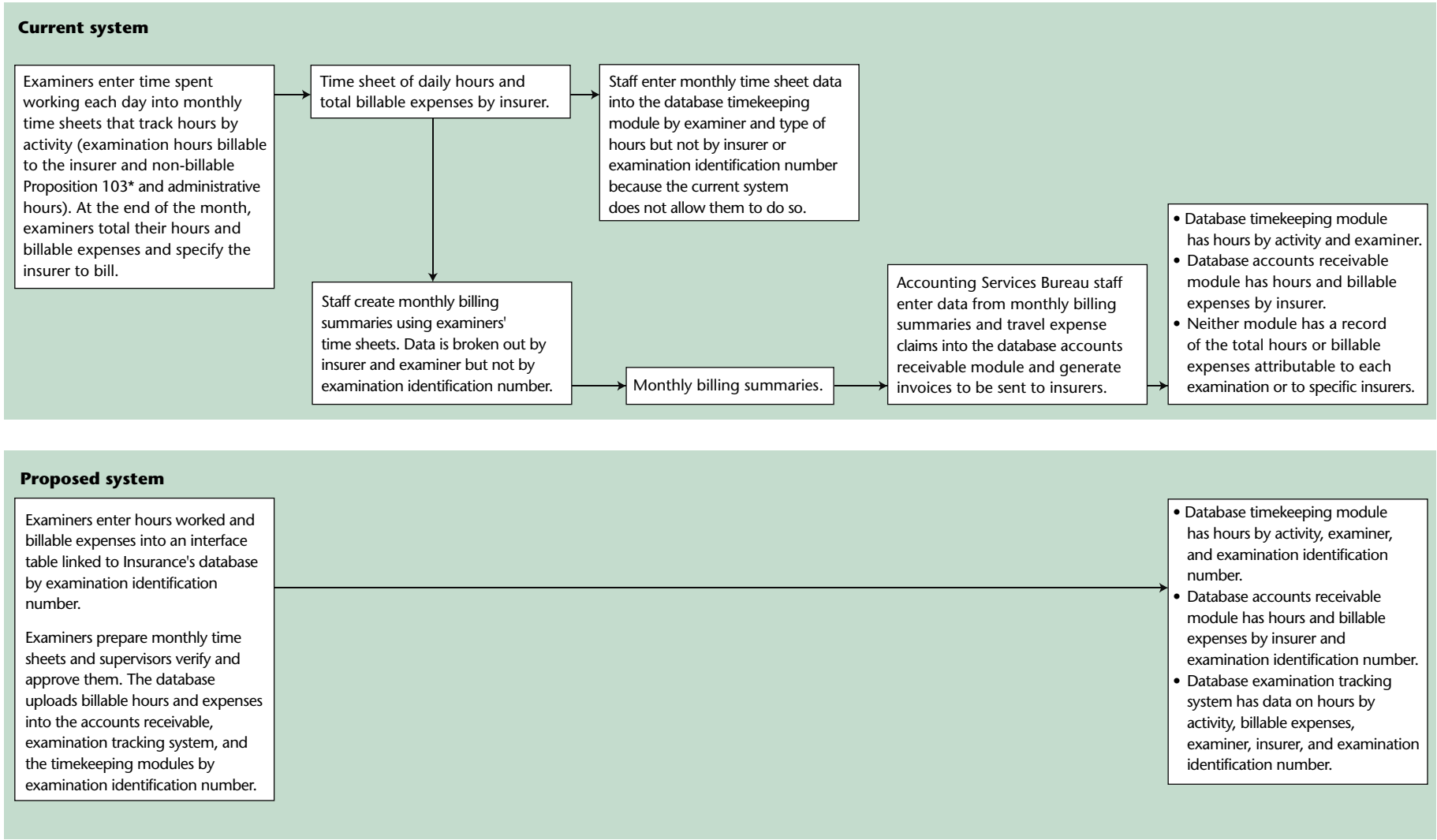
Measuring its operating efficiency is particularly important since the Market Conduct Division does not appear to comply with state law, which requires Insurance to examine every admitted insurer operating in California at least once every five years. According to one Field Rating and Underwriting Bureau chief, the two Field Rating and Underwriting bureaus may not review insurers with less than $10 million in annual written premium due to inadequate resources. Additionally, although the Field Claims Bureau chief believes claims examinations are occurring as state law requires, he acknowledges that some insurers may not be identified as requiring an examination using the current examination tracking process.

Insurance's database has an application that allows the Financial Surveillance Branch to track the financial examination status of active insurers. This application produces reports showing pending and overdue examinations that allow staff in the Financial Surveillance Branch to follow up on the status of examinations so they occur within the five years as state law requires. Even though it could take advantage of this application to track and schedule its examinations, the Market Conduct Division does not do so and thus lacks a way to ensure that it complies with state law.

The Market Conduct Division chief acknowledges that the division does not use Insurance's database to measure the efficiency or the time and cost of examinations, and hence the efficiency of the division's operations. The division chief also stated that he plans to meet with Information Technology Division staff to discuss modifications that will meet the Market Conduct Division's reporting needs. Until he does so, Insurance will continue to lack key data relating to its market conduct examinations.

FIGURE 2

Market Conduct Division's System for Recording Hours and Billable Expenses Versus a Proposed System



Source: Market Conduct Division policies and procedures manuals, database procedures manuals, and interviews with Insurance staff.

* Proposition 103 does not generally apply to claims examinations.

RECOMMENDATIONS

To determine whether it could generate savings from combining the administrative tasks of the three bureaus, Insurance should prepare an analysis and quantify possible savings.

To ensure that it has sufficient data to assess the efficiency of the Market Conduct Division, including an analysis of the average length of time and cost of its examinations, the division should work with Insurance's Information Technology Division to make full use of the existing database. At a minimum, Market Conduct Division plans should include the following:

- Modifying its examination tracking module to create an identification number that allows it to identify multiple companies that are under a particular examination using the existing company identification numbers.

- Eliminating the need for examiners to manually prepare monthly time sheets and billing summaries by allowing them to enter their hours directly into the timekeeping module.

- Linking its examination tracking, timekeeping, and accounts receivable modules using the examination identification number.

- Using the application developed for the Financial Surveillance Branch to track the financial examination status of active insurers.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: June 15, 2004

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APPENDIX A

Glossary of Commonly Used Terms

To provide context and definition to our report, we are presenting this glossary of commonly used terms for the aid of the reader.

Accident: An event causing loss that occurs unexpectedly or without design, usually specific in time and place.

Admitted Insurer: An insurer who has obtained a certificate of authority from the insurance commissioner that allows him or her to transact business within the State.

Agent: A licensed individual or organization authorized to sell and service insurance policies for an insurance company.

Automobile Insurance: A type of insurance that protects against losses involving automobiles. Automobile policies contain a variety of coverages that can be purchased depending upon the needs and wants of the policyholder. Liability for bodily injury and property damage, medical payments, uninsured motorist, comprehensive, and collision are some of the common coverages offered under an automobile insurance policy.

Broker: A licensed individual or organization that, on behalf of the person being insured, sells and services insurance policies.

Claim: Notice to an insurance company that a loss has occurred that may be covered under the terms and conditions of the policy.

Class of Insurance: General types of insurance as defined in sections 100 through 124 of the California Insurance Code, for example, fire, automobile, or liability insurance.

Coverage: The scope of protection provided by an insurance contract, which includes any of the listed benefits in an insurance policy.

Insurance: A mechanism for shifting a risk from a person, business, or organization to an insurance company in exchange for payment of premiums. The insurance company commits to being responsible for covered losses.

Insured: The policyholder(s) entitled to covered benefits in case of an accident or loss.

Insurer: The insurance company that issues the insurance and agrees to pay for losses and to provide covered benefits.

Policy: A contract that states the rights and duties of the insurance company and the policyholders.

Premium: The price paid to the insurance company for a policy.

Producer: A term used by the insurance industry to refer to agents and brokers.

Rating: The process of developing or applying classifications and statistical standards to a specific risk that will be covered by a policy to derive the appropriate premium.

Underwriting: The process of evaluating the insurance application and independent sources to verify the information provided and to determine the acceptability of risk.

Written Premium: The total premiums on all policies issued by an insurance company during a specified period.

APPENDIX B

State-to-State Comparison of Market Conduct Examinations

The Joint Legislative Audit Committee asked us, to the extent possible, to compare the average length of time it takes the Department of Insurance (Insurance) to perform its market conduct examinations and the average cost associated with those examinations to large insurance regulatory agencies in other states. Using the National Association of Insurance Commissioner's *2002 Insurance Department Resources Report*, we selected the states of Florida, New York, and Texas because their rank was similar to California in the size of their budgets, written premiums, and the number of market conduct examinations. However, as discussed in Chapter 3, California lacks data on the time and cost of its examinations. New York tracks the average length of time it takes to conduct its market conduct examinations, but not the average cost. According to the bureau chief of Market Investigations in the Office of Regulation, Florida's data are confidential in accordance with state law. Texas tracks the time and cost to conduct its market conduct examinations, but does not generally calculate an average cost or time to complete them. Hence, we are unable to provide information comparing the average time and cost of conducting market conduct examinations for California and the other states. Table B.1 on the following page depicts the structure of each state's market conduct examinations and highlights the differences from state to state.

TABLE B.1

Comparison of Market Conduct Examination Procedures in Four States

Comparison Factors	California	Florida	New York	Texas
Who is responsible for market conduct examinations?*	California Department of Insurance	Office of Insurance Regulation	New York State Insurance Department	Texas Department of Insurance
How many bureaus/divisions perform market conduct examinations?	Three bureaus (the Field Claims Bureau and two Field Rating and Underwriting bureaus)	One bureau (Bureau of Market Investigations)	Three bureaus	Five divisions
What types of market conduct examinations are performed?	Market conduct and some targeted examinations†	Targeted examinations	Combined, market conduct, and targeted examinations‡	Mostly targeted and some market conduct examinations
How are companies selected for examination?	State law requires the insurance commissioner to conduct an examination of every insurer operating in the State at least once every five years	Selection is based on a specific area of market concern or an individual insurer's practices	By state law, every insurer operating in the State must be examined at least once every three to five years	By state law, every insurer operating in the State must be examined annually for the first three years of operation and at least once every three years thereafter
What classes of insurance are reviewed?§	Almost all classes of insurance except those regulated by the Department of Managed Health Care, such as health maintenance organizations and some preferred provider organizations	All classes and products	Property and casualty, accident and health, non-profit health services, medical expense indemnity and dental expense indemnity corporations, health maintenance organizations, life insurers, public pension funds, fraternal benefit societies, retirement systems, charitable annuity societies, viatical settlement companies, and union welfare funds	All classes of insurance
How many examinations were completed in 2002?	207 claims market conduct examinations and 117 rating and underwriting market conduct examinations	112 targeted examinations	Four market conduct examinations, 115 targeted examinations, and 43 combined examinations	124 combined examinations and 33 targeted examinations
How many market conduct examiners does the state employ?	26 claims examiners and 14 rating and underwriting examiners	Florida uses only independent contracted examiners	209 financial examiners and 75 market conduct examiners	61 financial examiners and five market conduct examiners

Source: National Association of Insurance Commissioners *2002 Insurance Department Resources Report* and interviews with staff of California, Florida, New York, and Texas insurance regulatory agencies.

* Market conduct examinations review agent licensing issues, complaints, types of products sold by the company or agents, agent sales practices, rating practices, claims handling, and other market-related aspects of an insurer's operation.

† Targeted, or limited scope, examinations are conducted when deemed necessary by a state regulator. The examination may focus only on a specific area of concern, such as a company's investment portfolio or reinsurance agreements, or could be a complete financial or market conduct examination.

‡ Combined examinations combine market conduct examinations with financial examinations (which investigate a company's accounting methods, procedures, and financial statement presentation to verify and validate what is presented in the annual statement to ascertain whether the company is in good financial standing).

§ The Department of Insurance uses the terms "classes of insurance" and "lines of insurance" interchangeably. We use the term "classes of insurance" in this report.

Agency's comments provided as text only.

Department of Insurance
300 Capitol Mall, Suite 1700
Sacramento, California 95814

May 28, 2004

Ms. Elaine M. Howle*
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

RE: BSA 2003-138: Response to Final Report

Dear Ms. Howle:

The California Department of Insurance has reviewed the Bureau of State Audit's draft report entitled, "Department of Insurance: It Needs to Make Improvements in Handling Annual Assessments and Managing Market Conduct Examinations."

The audit included an extensive review of several aspects of the Department's operations related to the SB 940 and AB 1050 programs, including accounting functions, revenue and expenditure management, program cost accounting, time/activity systems, the Investigation Division, and the Fraud Division. We are pleased that, for the most part, the audit found the Department is properly accounting for and expending these dedicated resources. Additionally, we are pleased that the audit affirms that the structure of our Market Conduct Division allows for an efficient review of the claims handling and rating and underwriting processes that are two distinct functions of all insurance companies.

The audit supports a conclusion that I reached early in my administration. Specifically, that the Department lacks sufficient data upon which to determine whether or not insurance companies are complying with the vehicle assessment laws. As noted in the audit report, my Department has taken a number of actions to improve industry compliance and oversight of the assessment laws. We will continue to be vigilant in our efforts to ensure greater compliance.

The automobile fraud and consumer protection programs supported by AB 1050 (Wright, Chapter 885, 1999), and SB 940 (Speier, Chapter 884, 1999), respectively, have greatly improved the Department's anti-fraud and law enforcement efforts. As described in the audit report the

* California State Auditor's comments begin on page 53.

Department has significantly reduced the backlog of investigations and arrested hundreds of insurance fraud suspects. I look forward to working with the Legislature to continue these important programs beyond the scheduled sunset in January 2007.

I appreciate the thoroughness of the Bureau of State Audits report. As noted in the enclosed overview and response, we are already acting on several of the recommendations.

We look forward to describing our specific progress in making further changes over the next 12 months.

Sincerely,

(Signed by: John Garamendi)

JOHN GARAMENDI
Insurance Commissioner
Enclosure

California Department of Insurance

Response to the Bureau of State Audit Report 2003-138

Department of Insurance: It Needs to Make Improvements in Handling Annual Assessments and Managing Market Conduct Examinations

Response Overview

Handling of Annual Assessments

One of the first issues that Commissioner Garamendi confronted upon assuming office in January 2003 was a significant reduction in vehicle assessment revenue collected by the Department. The decline in this revenue was adversely impacting the Department's anti-fraud efforts because revenues were not sufficient to support the full level of spending authorized in the Governor's Budget for fighting automobile insurance fraud. Commissioner Garamendi instructed staff to determine the cause of the revenue decline, and to recommend a course of action to ensure that insurers pay all assessments that are due. As a result of that effort, it was determined that the revenue decline was caused primarily by a change in the methodology for calculating the assessment that was implemented by the previous insurance commissioner. Further, it was evident that the Department lacked adequate information to ascertain whether or not insurers were paying the full amount of assessments due.

In response, Commissioner Garamendi initiated the following actions:

- In February 2003 the Field Examination Division began auditing insurers for compliance with the vehicle assessment in conjunction with the regularly scheduled financial examination.
- In April 2003 the Department sent a bulletin to all property and casualty insurers to remind them of the proper methodology for calculating and reporting the assessment amount.
- In May 2003 the Budget and Revenue Management Bureau conducted an analysis of all insurers paying the $1.80 assessments and compared to previous years collections for the $1.00 assessment. The process included reviewing the estimated and actual number of vehicles reported and payments from the insurance companies. This data is provided to the Financial Examination Division for use in the insurer audits.
- In January 2004 the Department sent a survey to 701 insurance companies. The survey sought to collect information on the methodologies used by insurers to calculate the assessment, and whether any changes to the regulations were needed to make them more specific to prohibit using surrogate vehicle counting methods if those methods were not resulting in the collection of all assessments due.
- In April 2004 the Department held a pre-rulemaking workshop regarding the Department's proposed revision to the assessment regulations that would end the current practice of pro-rating the amount of the assessment and make explicit a requirement that insurers calculate the assessment based on a per policy, per vehicle, per year basis. Further requiring that the vehicle count be based on a vehicle specific identification rather than a surrogate; and that a database be maintained showing the specific vehicles for which an assessment has been paid for a given assessment period. The Department has drafted revised regulations which it intends to file with the Office of Administrative Law in June 2004.

The Department is confident that the revised regulations and continuation of the insurer audits will significantly improve industry compliance with the vehicle assessment laws.

However, the auditor's analysis embodied in Table 1 suggests that the Department could increase fees collected between $7 and $12.6 million dollars annually. In the Department's view, the estimates of potential lost revenues are too optimistic. The estimates rely on inappropriate assumptions that all registered vehicles remain insured after registration, and that a $1.80 assessment is collected on each of those vehicles.

- The Department cannot collect fees on uninsured vehicles

The Department has anecdotal evidence that many uninsured motorists purchase insurance to register their vehicle and then cancel the insurance for the remainder of the year. Current regulations allow insurers to pay the assessment $.45 per quarter. If a motorist cancels their insurance within one quarter, their insurer does not owe the Department an assessment in the other three quarters of the year. The Department's Statistical Analysis Division estimates the uninsured motorist rate at 6.1 percent (not including unregistered vehicles). The auditor's estimate of potential lost revenues assumes the Department could collect $1.80 for 6.1 percent of the registered vehicles, when it is much more likely the Department can only collect $.45. Hence, potential lost revenues could be about $2 million less in FY 2002-03 (26.4 million vehicles * .061 * $1.35).

- New vehicle sales occur throughout the year

A new vehicle sold on July 5 and insured that month will result in an assessment of $1.80 due to the Department in that fiscal year. A new vehicle sold the following May will result in an assessment of $.45. According to Department of Finance, 2.2 million new vehicles were sold in 2002. Assuming sales were evenly distributed over the year, .5 million vehicles would be sold each quarter, resulting in a total assessment due of $2.5 million. Since the BSA analysis uses the annual difference in registered vehicles, it assumes that the Department could collect $1.80 on all 2.2 million newly sold/registered vehicles, roughly $4.0 million. The difference, $1.5 million, is an overestimate of potential lost revenue.

The Department also disagrees with the auditor's assertion that the Department could have avoided the large drop in revenue from the regulations implemented on January 1, 2002. Shifting the date of implementation would have merely postponed the effect of allowing insurers to pro-rate their assessment on a quarterly basis to the following fiscal year.

Senate Bill 940 Activities

We are pleased that the audit findings recognize that the initial backlog of investigative cases that was the impetus for the passage of SB 940 has been substantially reduced with the expenditure of SB 940 funds.

We want to emphasize our commitment to eliminating the backlog, to fulfill the intent of SB 940. Although we had planned to fully eliminate the backlog in 2003, the prior administration directed a reduction of CDI staff including 13 limited term investigator positions. This of course slowed down our ability to fully eliminate the backlog. The Department remains committed to elimination of the backlog and will use available positions as well as evaluating other efficiency measures to achieve this goal.

The audit report concludes also that we have not reduced the average length of time needed to complete investigations. While we agree that the average time per case has not decreased much despite the reduction of the number of cases pending, we do not believe that the age of case is necessarily a good indicator of progress in reducing the backlog.

Our Investigation Division selects cases based on approved and articulated priorities, and the potential that reported misconduct will cause future harm to insurance buying people. Nothing about that selection process will reduce the average time frame per investigation. Instead, we have a formal goal setting and a monthly supervisory review process in place for the purpose of ensuring that investigations progress steadily and are completed appropriately. If we focused attention on the average time frames, we would devalue our consumer protection to satisfy a rote system that does not distinguish high intensity consumer frauds from technical licensing violations.

Nonetheless, the Department agrees that it is appropriate to have investigations assigned for handling as quickly as possible after receipt. However, the Investigation Division does not have enough staff to assign all cases when they are received. The Division is in the process of filling two current vacancies. In addition, we anticipate that we will receive five investigator positions in FY 2004-05 to specifically address SB 940 cases. The new investigators, once trained and able to investigate cases on their own, will contribute to reducing the unassigned cases and the amount of time cases are pending in the division. The pending caseload has always been significantly affected by factors outside of our control, especially new outbreaks of fraud and consumer abuse, the state of the economy, consumer and industry awareness of CDI, effectiveness of prosecution and the gain and loss of staff and positions. Assuming no significant change in such factors, we would expect to eliminate our pending unassigned caseload in approximately six years. Once that is accomplished, we will be able to perform investigations as soon as they are opened. Until that happens, our priority and control systems will continue to provide a proper focus and impetus for the completion of investigations.

It is important to note that the pending unassigned cases are not consumer complaints awaiting resolution. When consumer complaints are received in the Investigation Division, they are immediately and routinely sent to the Consumer Services Division for resolution. After handling the consumer issue, the file is referred back to the Investigation Division if a potential violation of law is noted.

Oversight of AB 1050 Funds

Assembly Bill 1050 (effective January 1, 2000) created the Organized Automobile Fraud Activity Interdiction Program ("AB 1050 Program"). The program is administered by the Fraud Division and provides grants and direct investigative support in the form of task forces, to District Attorneys who apply for the AB 1050 Program funding. For the first three-year grant funding cycle, eight counties were awarded grants under this program (Sacramento, Alameda, San Francisco, Santa Clara, San Bernardino, Riverside, San Diego, and Los Angeles). Additionally, the Fraud Division houses and supports the task forces for each of the participating grant counties. These task forces are comprised of peace officers from the Fraud Division, the California Highway Patrol (CHP), local District Attorneys (DA), and other allied agencies. For the Organized Automobile Fraud Activity Interdiction Program, the revenue source is based upon increased collections of fifty cents ($.50) per insured vehicle. The assessment fee generates approximately $11.1 million in revenue per year. Using this approximation, the Fraud Division receives $4.8 million, DAs an identical $4.8 million, and the CHP receives $1.5 million.

From its inception in January 2000 through June 2003, the AB 1050 Program has investigated a 533 cases, 397 cases have been submitted to District Attorneys statewide resulting in 305 cases being prosecuted, 438 arrests made, 189 convictions, and an additional 372 cases are currently under investigation. For fiscal year 2002-03, court ordered restitution in the amount of $5,905,852 of which $4,646,433 has been collected and returned to victims and the Insurance Fraud Fund.

Organized fraud rings/white collar crimes are recognized as the most difficult to successfully investigate and prosecute. Conspirators often include medical doctors, chiropractors, and attorneys who use the cover of their client relationships to provide the look of legitimacy to their activity. Given the complex characteristics of these cases and the cohesive nature of the perpetrators involved in this type of activity, the program has been highly successful.

The auditors report that they identified roughly $22,000 in expenditures that should not have been charged to the AB 1050 Program because the underlying cases did not meet the required criteria. While the Department of Insurance endeavors to ensure that every dollar of expenditures is charged to the appropriate program, we want to point out that that $22,000 is less than one-tenth of one percent of all expenditures incurred during the life of the AB 1050 Program.

Market Conduct Examinations

In general, the Bureau of State Audits (BSA) review of the Market Conduct Division (MCD) is a fair representation of the Division's market conduct functions and activities. The review affirms that the structure of the MCD is appropriate and, in fact, mirrors the insurance industry's own organizational structure. The MCD structure allows for the most comprehensive and efficient review of the claims handling and rating and underwriting functions that are two distinct functions (often housed in different locations) of all insurance companies.

The BSA audit accurately assessed the under-use of the Department's integrated database to electronically track the expenditures and duration for each exam, whether in-house or on-site at a company location. However, the review was mistaken in the premise that MCD could not determine the cost and time spent on each market conduct exam. Market Conduct tracks the number of hours and travel costs it expends on the examination of each insurer, by individual examiner, on a monthly basis. MCD bills the insurance entity accordingly, or charges the time and costs to the Proposition 103 assessment as appropriate. However, MCD does not currently use that information to calculate total costs per exam or to do average exam cost comparisons. MCD can do this now, by compiling the data manually. It would be a time consuming process but one that can be done if needed.

If it is possible to electronically collect the necessary data in sufficient detail, it would be useful to be able to evaluate and compare exam duration and costs for companies of different sizes, varying lines of insurance. Each exam is different in team make-up, exam locations, number of companies to be reviewed, and the lines of insurance to be examined. The number and extent of the exam findings impacts the amount of time and resources needed to resolve each examination. This data could help MCD to evaluate efficiency and make changes as appropriate.

Regarding the general recommendation of "combining the administrative tasks of time keeping, scheduling and coordinating examinations with insurers, and preparing reports," MCD will review its administrative responsibilities to identify possible areas for cost savings. MCD will certainly consider the BSA recommendation in this area and seek to improve efficiency wherever possible, as discussed further below.

Provided below are specific comments addressing each audit report recommendation:

Chapter One

To ensure that it receives all assessments due, Insurance should do the following:

Recommendation 1:

Move forward in its efforts to make regulatory changes that will result in it capturing more specific data from insurers about the number of vehicles they insure.

Response to Recommendation: The Department of Insurance concurs.

Recommendation 2:

Compare the number of private passenger vehicles insurers report on their assessment invoices to the number they report to its Statistical Analysis Division annually and investigate discrepancies.

Response to Recommendation: The Department of Insurance concurs.

Recommendation 3:

Direct its Field Examination Division to follow up on the discrepancies identified in the Budget and Revenue Management Bureau's analysis.

Response to Recommendation: The Department of Insurance acknowledges that further follow-up work is required to be performed on the discrepancies identified by the Budget and Revenue Management Bureau. Prior to redirecting our field examiners from their financial solvency examinations to conduct

a limited vehicle assessment review, the Budget and Revenue Management Bureau will aggressively pursue further information and perform additional data analysis by requiring insurers to submit additional documentation in support of the amounts remitted."

Recommendation 4:

Periodically perform analytical reviews of insurers' data, such as comparing changes in the insurers' written premiums to changes in the assessments they remit, and investigative unusual trends.

Response to Recommendation: The Department of Insurance concurs.

Recommendation 5:

Direct its Fraud Division to follow up on the calculation and remittance discrepancies identified as a result of the January 2004 survey.

Response to Recommendation: The Department of Insurance concurs: The request for verification issued by the Department in January 2004 was not designed solely for the purpose of identifying discrepancies in the insurer remittance of the assessment. However, the Department is and will continue its review of those responses and will follow-up on any actual and material discrepancies identified with the individual insurers.

Recommendation 6:

Insurance should perform sufficient analysis of the impact of future changes to its regulations before implementing them.

Response to Recommendation: The Department of Insurance concurs.

Chapter Two

To improve its service to consumers and provide appropriate oversight of SB 940 funds, Insurance should do the following:

Recommendation 7:

Revise its Investigation Division's policies and procedures to ensure that cases are not outstanding for long periods of time. For example, Insurance should assign cases to an investigator as soon as they are received and establish a goal that investigators take no more than a year from the date they receive the case to complete their investigations, barring extenuating circumstances.

Response to Recommendation: The Department of Insurance cannot assign all cases as they are received, until it has necessary additional resources. The Investigation Division (ID) has more cases than it can assign, given the current number of authorized positions. It uses its priority system and a review process to ensure the most egregious cases are assigned as soon as possible. ID selects and assigns cases based on approved and articulated priorities and the potential that reported misconduct will cause future harm to insurance buying people. ID bases the assignment of cases on the seriousness of the cases and the optimal caseload for investigators.

The auditor apparently bases the one year recommendation on standards and statutes related to other investigative agencies. The Contractors' State Licensing Board is specifically mentioned. A one year benchmark could lead to a process that assigns less complex investigations based on their shorter duration, rather than on potential for serious consumer abuse. ID has a formal goal setting and monthly supervisory review process in place for the purpose of ensuring that investigations progress steadily and are completed properly. Our experience is that some very significant cases will take more than one year to effectively investigate, due to high victimization, complexity and difficulty in obtaining evidence. Consumer protection would suffer if our system emphasized the assignment of cases with short average durations.

Recommendation 8:

Review its open cases, both assigned and unassigned, to determine whether any should be closed.

Response to Recommendation: The Department of Insurance concurs. The Division is revising its policy on the monitoring of reports of suspected violations to provide for more frequent reviews and to apply additional criteria consistent with the audit findings to enhance assignment or closing of Reports of Suspected Violations (RSVs) as soon as warranted. Although the auditors recommend that this determination be made based on age of file, it is our view that the proper criteria all relate to the potential viability of the prospective investigation.

The revised policy is expected to issue within two weeks.

Recommendation 9: Eliminate the Investigation Division's backlog of unassigned cases by requiring staff to work a reasonable amount of overtime or seeking additional staff.

Response to Recommendation: The Department of Insurance concurs with this recommendation subject to available funding and approval of additional staff.

Recommendation 10:

Link its Legal Division's case tracking system to its time reporting system to better document the use of SB 940 funds.

Response to Recommendation: The Department of Insurance concurs.

To ensure that it uses AB 1050 funds appropriately, Insurance should do the following:

Recommendation 11:

Transfer the hours and billable expenses it charges to AB 1050 from its Organized Automobile Fraud Program when it transfers cases to the regular automobile fraud program.

Response to Recommendation: The Department of Insurance concurs: The Fraud Division's time reporting and case management data system (FIDB) has the capacity to make the necessary adjustments between programs. The Fraud Division will continue to work closely with the Budget and Revenue Management Bureau to ensure that those adjustments are reflected in the correct program cost accounts.

Recommendation 12:

Follow state laws and regulations governing fiscal and performance audits of counties to ensure that the district attorneys use AB 1050 funds only for allowable activities and in the most effective and efficient manner.

Response to Recommendation: The Department of Insurance concurs. The Department will continue to communicate with the California District Attorney's Association Insurance Fraud Committee and provide all grantees with information and assistance to meet the mandates of the program. New training courses regarding grant management will be provided through the California District Attorney's Annual Insurance Fraud Conference. The Department will require timely reporting and performance measurements to assist in evaluating the grants to maximize the return on investment. In addition, the Department has reorganized its Internal Audits Unit to increase its efficiency in conducting financial and performance audits of the grantees and will evaluate existing staffing to determine if more resources are needed.

Recommendation 13:

Require the California Highway Patrol to submit annual reports of its expenditures as state law requires.

Response to Recommendation: The Department of Insurance concurs. The Department will work closely with the California Highway Patrol to provide assistance in complying with the Annual Informational Report regarding the expenditure of its funds pursuant to this program. The Department will also recommend to the CHP that their personnel assigned to the program utilize the Department's time reporting and case management system (FIDB) to provide accountability related to personnel time and expenditures related to this program.

Chapter Three

Recommendation 14:

To determine whether it could generate savings from combining the administrative tasks of the three bureaus, Insurance should prepare an analysis and quantify possible savings.

Response to Recommendation: The Department of Insurance concurs. The Market Conduct Division will conduct an analysis of the administrative tasks undertaken in the division. The overall purpose will be to identify those tasks which can be combined or eliminated, and implement all practical improvements.

To ensure that it has sufficient data to assess the efficiency of its Market Conduct Division, including an analysis of the average length of time and cost of its examinations, Insurance's Market Conduct Division should work with its Information Technology Division to make full use of Insurance's database. At a minimum, its plans should include the following:

Recommendation 15:

Modifying its examination tracking module to create an identification number that allows it to identify multiple insurers that are under examination using the existing company identifications numbers.

Response to Recommendation: The Department of Insurance concurs.

Recommendation 16:

Eliminating the need for examiners to manually prepare the monthly timesheets and billing summaries by allowing them to enter their hours directly into the timekeeping module.

Response to Recommendation: The Department of Insurance concurs.

Recommendation 17:

Linking its examination tracking, timekeeping, and accounts receivable modules using the examination identification number.

Response to Recommendation: The Department of Insurance concurs.

Recommendation 18:

Utilizing the application developed for the Financial Surveillance Branch to track the financial examination status of active insurers.

Response to Recommendation: The Department of Insurance will develop an enhanced exam tracking system similar to the one developed for the Financial Surveillance Branch.

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COMMENTS

California State Auditor's Comments on the Response From the Department of Insurance

To provide clarity and perspective, we are commenting on the Department of Insurance's (Insurance) response to our audit report. The numbers below correspond to the numbers we have placed in the margin of Insurance's response.

- Insurance is mischaracterizing our audit results. Specifically, on pages 15 through 17, we point out that Insurance has not made sufficient efforts to verify that the amount insurers remit in accordance with Chapter 1119, Statutes of 1989 (regular automobile fraud program), Chapter 884, Statutes of 1999 (SB 940), and Chapter 885, Statutes of 1999 (AB 1050) are based on the actual number of vehicles they insure. Moreover, Insurance does not follow up when it identifies discrepancies in the number of insured vehicles for which insurers remit assessments. Similarly on pages 25 through 29, we point out that Insurance could not easily demonstrate that the roughly $9.4 million in SB 940 funds it used to pay for expenses related to its Legal Division were accurate or for allowable activities, it used roughly $22,000 in AB 1050 funds for cases that do not meet the criteria in state law, and it lacks proper oversight of district attorneys' and the Department of the California Highway Patrol's use of AB 1050 funds. Thus, our report does not conclude that Insurance is properly accounting for and expending SB 940 and AB 1050 funds.

- Although Insurance believes that our estimates of potential lost assessment revenues rely on inappropriate assumptions, we believe that our methodology is sound and based on actual data, unlike Insurance's assumptions. Insurance's belief that many uninsured motorists purchase insurance and then cancel the insurance for the remainder of the year is, as they state in their response, based on anecdotal evidence only, and is not supported by any studies or actual data. Further, Insurance's assumptions related to new vehicles are similarly flawed. Specifically, Insurance is incorrect in stating that we used the year to year difference in registered vehicles. To calculate the potential lost revenue, as shown in Table 1 on page 14, we used the Department of Motor Vehicles' (DMV) unaudited data on actual total registered vehicles

in the State. Insurance's statement that we should discount the potential lost revenues for new vehicle sales assumes that no vehicles are entering California from other states and that purchasers of new vehicles did not own any vehicles prior to their purchases. Under Insurance's assumption, DMV's data on the number of registered vehicles would have to be steady or decline from month to month. However, as Table 1 shows, the total number of registered vehicles has increased every fiscal year between fiscal years 2000–01 through 2002–03.

- Insurance is mistaken. As we discuss on pages 17 and 18, under the old methodology, insurers paid the majority of their assessments in the first quarter of each calendar year. Had Insurance waited to implement the change to its methodology until after the first quarter of 2002, it would have avoided the large reduction of roughly $11 million, or 24 percent, for fiscal year 2001–02. Further, in its December 2002 analysis, Insurance concluded that implementing the new methodology would likely decrease assessment revenues between 16.2 percent and 18.5 percent for fiscal year 2001–02.

- We agree that the age of a case is not necessarily a good indicator of its progress in reducing the backlog, but we remain concerned with the large number of open and unassigned cases that are in Insurance's backlog. As we state on page 23, Insurance has 656, or 43 percent of its open cases, that have been open and unassigned for more than six months. Leaving these cases open and unassigned, especially in light of the fact that Insurance was able to close the majority of the cases it closed between 2000 and 2003 within six months of the date the case was assigned to an investigator, means that suspected violations of insurance laws and regulations by agents, brokers, and insurers are continuing to remain unresolved longer than necessary.

- Insurance is overstating its formal goal setting and monthly supervisory reviews. Specifically, as we discuss on page 23, Insurance's policy of setting goals for reviewing unassigned cases within three or four years is unreasonable and does not promote consumer protection. Further, its monthly supervisory review processes apply only to assigned cases and do not affect the open and unassigned cases, which can remain outstanding for long periods of time. Without a timely review of these unassigned cases, suspected violations of insurance laws and regulations by agents, brokers, and insurers will continue to remain unresolved longer than necessary.

- Insurance's figures are inconsistent with the data it provided to us. Specifically, as we report on page 27, Insurance has used AB 1050 funds to work on 446 cases from January 2000 through December 2003, which have led to 432 arrests.

- Insurance is correct that the $22,000 spent in AB 1050 funds on cases that do not meet the criteria in state law is not a large percentage of all funds expended for this program. However, as we discuss on page 8, state law is clear on how Insurance should spend these funds. Therefore, any noncompliance, whether material or not, is relevant to Insurance's administration of these funds.

- Insurance is incorrect that our premise is that the Market Conduct Division is unable to determine the cost and time spent on each market conduct examination. As we discuss on pages 34 to 36, Insurance's database includes modules designed to capture data such as examination time and cost. However, our point is that Insurance's Market Conduct Division needs to improve its management of its market conduct examination operations because it does not fully use this database and does not currently use information from other sources to calculate the total costs per exam or to do average examination cost comparisons—a conclusion Insurance agrees with in its response.

- We believe our recommendation on page 29 is reasonable. Insurance should assign cases to an investigator as soon as they are received and establish a goal that investigators take no more than a year from the date they receive a case to complete their investigations, barring extenuating circumstances. We acknowledge that in some instances, cases can take more than one year to investigate. However, we found it significant that, as we discuss on page 23, Insurance was able to resolve the majority—3,818 out of 5,841 cases closed in 2000 through 2003—within six months of the date it assigned the case.

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press