PERFORMANCE AUDIT
OF THE

MICHIGAN INSURANCE BUREAU

DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES

August 2000

63-115-99

EXECUTIVE DIGEST

MICHIGAN INSURANCE BUREAU

INTRODUCTION

This report, issued in August 2000, contains the results of our performance audit* of the Michigan Insurance Bureau, Department of Consumer and Industry Services.

AUDIT PURPOSE

This performance audit was conducted as part of the constitutional responsibility of the Office of the Auditor General. Performance audits are conducted on a priority basis related to the potential for improving effectiveness* and efficiency* .

BACKGROUND

The Michigan Insurance Bureau, under the direction of the Commissioner of Insurance, was responsible for regulating the insurance industry in Michigan and for administering operations of the Bureau as mandated by the Insurance Code of 1956 (Sections 500.100 - 500.8302 of the *Michigan Compiled Laws*) and related general insurance laws (Sections 550.1 - 550.1811 of the *Michigan Compiled Laws*). The Commissioner was appointed by the Governor, with the advice and consent of the Senate, for a four-year term.

Subsequent to our audit, Executive Order 2000-4, effective April 3, 2000, created the Office of Financial and Insurance Services as a type I agency within the Department of Consumer and Industry Services, to be

* *See glossary at end of report for definition.*

headed by a Commissioner of Financial and Insurance Services. The Executive Order transferred all authority, powers, duties, functions, and responsibilities of the Michigan Insurance Bureau and the Commissioner of Insurance to the Office of Financial and Insurance Services, and then abolished the Michigan Insurance Bureau and the Commissioner of Insurance.

The Bureau's responsibilities were divided among four offices: Office of the Commissioner, Office of Financial Evaluation, Office of Licensing and Enforcement, and Office of Policy and Consumer Services.

For fiscal year 1998-99, the Bureau had revenues and expenditures of $16,536,355 and $9,393,115, respectively. As of October 31, 1999, the Bureau had 110 permanent, full-time employees.

AUDIT OBJECTIVES, CONCLUSIONS, AND NOTEWORTHY ACCOMPLISHMENTS

Audit Objective: To assess the effectiveness of the Bureau's customer service efforts.

Conclusion: We concluded that the Bureau's efforts to provide customer service were generally effective. However, we noted reportable conditions* related to the consumer complaint process and the timeliness of insurer responses during complaint investigations (Findings 1 and 2).

Audit Objective: To assess the effectiveness and efficiency of the Bureau's licensing and regulation of the insurance and managed health care* industries.

** See glossary at end of report for definition.*

Conclusion: We concluded that the Bureau was generally effective in its licensing and regulation of the insurance and managed health care industries and generally performed these functions in an efficient manner. However, we noted reportable conditions relating to documentation of the health maintenance organization (HMO) licensure process, administration of receivership* proceedings, and contract monitoring (Findings 3 through 5).

Noteworthy Accomplishment: After the completion of our audit fieldwork, the Commissioner recommended to the Governor new and updated regulations for the State's HMOs. These recommendations resulted in reform packages being introduced in the Legislature that were designed to strengthen the HMO financial requirements. The recommendations, expected to be signed into law, set stricter solvency levels for HMOs that will be phased in over a period of time. One such recommendation increases the current HMO minimum net worth requirement of $250,000 to $1.5 million. That minimum threshold would increase over time as the number of clients served also increases so that the minimum threshold is always at least 5% of subscriber revenues.

Audit Objective: To assess the Bureau's compliance with applicable statutes, the *Michigan Administrative Code*, State procedures, and Bureau policies and procedures that could have a material effect on its operations.

Conclusion: We concluded that the Bureau was generally in compliance with applicable statutes, the *Michigan Administrative Code*, State procedures, and

* *See glossary at end of report for definition.*

Bureau policies and procedures that could have a material effect on its operations. However, we noted reportable conditions related to timeliness of HMO applications, relicensures, and financial examinations and contracting procedures (Findings 6 and 7).

AUDIT SCOPE AND METHODOLOGY

Our audit scope was to examine the program and other records of the Michigan Insurance Bureau focusing on the Office of Policy and Consumer Services and the Office of Licensing and Enforcement. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances.

Our methodology included examining the Bureau's records and activities for the period October 1, 1996 through October 31, 1999.

To accomplish our first audit objective, we conducted a preliminary review by interviewing key Bureau personnel, evaluating the Bureau's goals* and objectives, reviewing contracts for professional services, and reviewing various states' reports and selected national publications related to insurance regulation. In addition, we conducted a survey of individuals who had filed complaints with the Bureau.

To accomplish our second audit objective, we evaluated the Bureau's oversight and monitoring of the licensing and regulation processes, including related contractual services. We examined the minimum requirements for

** See glossary at end of report for definition.*

HMO licensure and evaluated the Bureau's efforts to ensure the financial viability of HMOs.

To accomplish our third objective, we obtained an understanding of the statutes, regulations, policies, and procedures that were integral to the Bureau's operations and conducted tests of the Bureau's compliance with those laws and regulations that could have a material effect on its operations.

AGENCY RESPONSES

Our audit report includes 7 findings and 7 corresponding recommendations. The Bureau's preliminary response indicated that it generally agreed with our recommendations and has initiated action to implement them.

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August 16, 2000

Ms. Kathleen M. Wilbur, Director
Department of Consumer and Industry Services
G. Mennen Williams Building
Lansing, Michigan
and
Mr. Frank M. Fitzgerald, Commissioner
Office of Financial and Insurance Services
Ottawa Building
Lansing, Michigan

Dear Ms. Wilbur and Mr. Fitzgerald:

This is our report on the performance audit of the Michigan Insurance Bureau, Department of Consumer and Industry Services.

This report contains our executive digest; description of agency; audit objectives, scope, and methodology and agency responses; comments, findings, recommendations, and agency preliminary responses; description of survey and summary of survey responses, presented as supplemental information; and a glossary of acronyms and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agency's response subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a formal response within 60 days after release of the audit report.

We appreciate the courtesy and cooperation extended to us during this audit.

AUDITOR GENERAL

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GLOSSARY

Description of Agency

The Michigan Insurance Bureau, under the direction of the Commissioner of Insurance, was responsible for regulating the insurance industry in Michigan and for administering operations of the Bureau as mandated by the Insurance Code of 1956 (Sections 500.100 - 500.8302 of the *Michigan Compiled Laws*) and related general insurance laws (Sections 550.1 - 550.1811 of the *Michigan Compiled Laws*). The Commissioner was appointed by the Governor, with the advice and consent of the Senate, for a four-year term.

Subsequent to our audit, Executive Order 2000-4, effective April 3, 2000, created the Office of Financial and Insurance Services as a type I agency within the Department of Consumer and Industry Services, to be headed by a Commissioner of Financial and Insurance Services. The Executive Order transferred all authority, powers, duties, functions, and responsibilities of the Michigan Insurance Bureau and the Commissioner of Insurance to the Office of Financial and Insurance Services, and then abolished the Michigan Insurance Bureau and the Commissioner of Insurance.

The Bureau's responsibilities were divided among four offices:

a. The Office of the Commissioner provides assistance to the Commissioner and Bureau staff in the areas of budget, financial control, personnel, office services, and procurement. Also, the Office plans and manages the Bureau's information system.

b. The Office of Financial Evaluation is primarily responsible for monitoring the financial condition of insurance companies and for conducting on-site financial examinations and compliance audits. The Bureau regulates approximately 160 domestic companies*, 8 alien companies*, and 1,358 foreign companies*.

c. The Office of Licensing and Enforcement is primarily responsible for the examination and licensure of insurance agents, collection of license-related fees, and maintenance of license records. All examinations are administered by a

* *See glossary at end of report for definition.*

private contractor. This office is also responsible for investigating allegations of wrongdoing by licensed individuals and for prosecuting enforcement cases.

d. The Office of Policy and Consumer Services assists customers who have experienced difficulties or have questions regarding insurance. The Bureau receives approximately 4,700 written complaints and 25,000 telephone inquires per year. Also, this section examines and investigates the rates, benefit contracts, and provider contracts used by prepaid health plans. These health plans include Blue Cross and Blue Shield of Michigan and health maintenance organizations.

For fiscal year 1998-99, the Bureau had revenues and expenditures of $16,536,355 and $9,393,115, respectively. As of October 31, 1999, the Bureau had 110 permanent, full-time employees.

Audit Objectives, Scope, and Methodology and Agency Responses

Audit Objectives

Our performance audit of the Michigan Insurance Bureau, Department of Consumer and Industry Services, had the following objectives:

1. To assess the effectiveness of the Bureau's customer service efforts.

2. To assess the effectiveness and efficiency of the Bureau's licensing and regulation of the insurance and managed health care industries.

3. To assess the Bureau's compliance with applicable statutes, the *Michigan Administrative Code*, State procedures, and Bureau policies and procedures that could have a material effect on its operations.

Audit Scope

Our audit scope was to examine the program and other records of the Michigan Insurance Bureau focusing on the Office of Policy and Consumer Services and the Office of Licensing and Enforcement. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances.

Audit Methodology

Our audit procedures were performed between May and October 1999 and included examining the Bureau's records and activities for the period October 1, 1996 through October 31, 1999.

To accomplish our first audit objective, we obtained an understanding of the Bureau's operations and conducted a preliminary review. This included interviewing key Bureau personnel regarding their functions and responsibilities, evaluating the Bureau's goals and objectives, and reviewing contracts for professional services. We obtained and reviewed various states' reports and selected national publications related to insurance regulation.

In addition, we conducted a survey of individuals who had filed complaints with the Bureau. We included a summary of the survey responses in this report as supplemental information.

To accomplish our second audit objective, we obtained an understanding of the Bureau's operations related to licensing and regulation of the insurance and managed health care industries. We evaluated the Bureau's oversight and monitoring of the licensing and regulation processes, including related contractual services. We examined the minimum requirements for health maintenance organization (HMO) licensure and evaluated the Bureau's efforts to ensure the financial viability of HMOs.

To accomplish our third objective, we obtained an understanding of the statutes, regulations, policies, and procedures that were integral to the Bureau's operations and conducted tests of the Bureau's compliance with those laws and regulations that could have a material effect on its operations.

Agency Responses

Our audit report includes 7 findings and 7 corresponding recommendations. The Bureau's preliminary response indicated that it generally agreed with our recommendations and has initiated action to implement them.

The agency preliminary response which follows each recommendation in our report was taken from the Department's and the Bureau's written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and Department of Management and Budget Administrative Guide procedure 1280.02 require the Department of Consumer and Industry Services to develop a formal response to our audit findings and recommendations within 60 days after release of the audit report.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

EFFECTIVENESS OF CUSTOMER SERVICE EFFORTS

COMMENT

Audit Objective: To assess the effectiveness of the Michigan Insurance Bureau's customer service efforts.

Conclusion: We concluded that the Bureau's efforts to provide customer service were generally effective. However, we noted reportable conditions related to the consumer complaint process and the timeliness of insurer responses during complaint investigations.

FINDING

1. Consumer Complaint Process

The Bureau's Consumer Services Section (CSS) should improve its management oversight of the complaint process to help ensure that complaint investigation decisions are properly documented and that complaints are investigated in a timely manner.

CSS acts as an intermediary between insurance purchasers and insurance agents or companies (insurers). CSS analysts are responsible for the initial review of consumer complaints, which are usually generated from telephone calls or written inquiries. When CSS analysts determine that violations of the Michigan Insurance Code may exist, the complaints are referred to the Bureau's Investigation Division or the Code Enforcement Division. CSS had four analysts and one regulation manager responsible for investigating consumer complaints. During calendar year 1998, 4,668 new complaint files were opened and 4,723 complaint files were closed.

We reviewed 20 consumer complaint cases opened during the period January 1 through June 30, 1999. Our review disclosed:

a. Formal management approval of analysts' decisions to close complaint cases was not always evident.

Bureau procedures allowed analysts to investigate and close cases with only informal reviews by management. These informal reviews were not documented or performed consistently. CSS allowed analysts to close cases and then reopen them for further investigation when or if the complainant submitted additional correspondence. From our sample, analysts closed 3 (15%) cases in favor of the insurers without requesting evidence to support the insurers' responses. One of these cases was subsequently reopened when the complainant provided additional correspondence. After a thorough investigation, the analyst referred the insurer named in the complaint to the Investigations Division for possible Michigan Insurance Code violations.

b. The form letters sent to complainants informing them that CSS had closed their cases in favor of the insurer did not uniquely pertain to each complaint and did not assure the complainants that CSS had addressed their specific concerns.

Rather, these form letters included general statements that CSS had considered statutory requirements, policy language, and industry standards in its analysis. The form letters concluded that the insurer's position appeared reasonable and did not violate the statutes or policy language.

c. CSS did not investigate all complaints in a timely manner.

In one case that originally came to the Bureau on July 28, 1998, an informal investigation was initiated by upper management level staff in the Office of Policy and Consumer Services. Minimal documentation existed to support this initial investigation, and it was not tracked on the Bureau's automated computer system. CSS initiated a formal case file for this complaint on February 23, 1999, after the staff who had initially investigated the complaint left the Bureau and after the complainant submitted a third copy of the

complaint. Correspondence to the complainant detailing CSS's position was dated May 25, 1999, at which time the case was closed in favor of the insurer.

In two other cases, CSS did not enforce due dates for requested information, which caused significant delays in processing the complaints. At the time of our review, the cases had been open 151 and 85 days (Finding 2).

CSS's implementation of a methodology to approve analysts' decisions when closing complaint cases would help ensure the thoroughness of complaint investigations. Premature decisions to close cases could allow insurers to continue undesirable practices, thus putting consumers at risk. It also prevents consumers from being awarded monetary claims that may have otherwise been obtained after a thorough CSS investigation. Also, requiring analysts to document specific reasons in personal closing letters to complainants may reduce the risk that cases are closed prematurely and reduce the number of complainant requests to reopen cases. In addition, the processing of complaints by appropriate CSS staff would help ensure sufficient complaint oversight and timely resolutions.

CSS management informed us that it initiated the use of personal closing letters to complainants that address their specific concerns. However, this change occurred after our testing was completed.

RECOMMENDATION

We recommend that CSS improve its management oversight of the complaint process to help ensure that complaint investigation decisions are properly documented and that complaints are investigated in a timely manner.

AGENCY PRELIMINARY RESPONSE

The Bureau agreed with this recommendation and informed us that it had identified these same issues prior to the audit. Improvement measures, which began in spring 1999, had not been fully implemented before the end of the audit period. Some measures became effective during the audit period, some immediately following the audit period, and others are still being implemented.

The Bureau informed us that a case investigation audit sheet is now used to provide a review of the handling of all consumer files. In addition, the CSS

manager randomly reviews complaint files. The Bureau has implemented a policy of having the analyst use a personal closing letter to complainants that is specific to their concern. The receipt of incoming consumer correspondence has been centralized and a log system has been implemented to track consumer correspondence received in other areas of the Bureau. All such correspondence is being tracked on the Bureau's management information system.

The Bureau informed us that it believes that these procedural improvements will provide effective management oversight of the complaint process.

FINDING

2. Timeliness of Insurer Responses During Complaint Investigations

CSS should initiate appropriate referrals to the Code Enforcement Division when insurers repeatedly fail to respond in a timely manner during Bureau investigations into consumer complaints.

Section 500.438(3) of the *Michigan Compiled Laws* requires insurers to promptly respond in writing to each Bureau inquiry. Also, Section 500.438(5) allows for a civil penalty of not less than $1,000 or more than $5,000, and an additional $50 for every day after a specified date that the insurer fails to reply to a Bureau inquiry. When insurers fail to respond in a timely manner, analysts can refer them to the Code Enforcement Division for compliance action. The Code Enforcement Division staff draft settlement agreements that include terms that must be met in order to close the enforcement case against the insurer. In addition to requiring that the insurers deliver the requested information by a specified date, it is common for the Code Enforcement Division to include a "market conduct" monetary penalty as one of the terms of the agreement. By signing the agreement, the insurers avoid further enforcement action by the Bureau and avoid the statutorily allowed civil penalty.

We reviewed 20 consumer complaint cases opened during the period January 1 through June 30, 1999. Our review disclosed 5 instances from 2 (10%) cases in which the Bureau did not receive the insurers' responses within the allowed 45 days or by the due dates specified by the analysts. One of the 2 cases had been open for 151 days at the time of our review. Within those 151 days, the responses

received subsequent to 4 separate Bureau requests were received a total of 39 days late. Two of the 4 untimely responses did not provide the information requested but rather asked for additional time to respond. The second case had been open a total of 85 days at the time of our review, during which time only one response had been received from the insurer. The response was 36 days late and did not provide the information requested, but rather asked for additional time to respond to the Bureau's initial inquiry. Neither of the two insurers were referred to the Code Enforcement Division.

CSS management informed us that a new procedure to refer insurers to the Code Enforcement Division for failure to respond to Bureau inquiries was implemented in July 1999. As of August 27, 1999, CSS had referred 17 insurers to the Code Enforcement Division for failing to respond to Bureau inquiries in a timely manner, thus resulting in market conduct fines totaling $5,000. Two of the 5 untimely responses that we documented occurred after the implementation of this procedure.

The failure to enforce timely insurer responses caused significant delays in the investigations of consumer complaints, thus hindering analysts' ability to provide the consumers with timely resolutions. Also, these delays resulted in the continuance of potentially unfavorable practices by insurers and delayed any necessary enforcement action against the insurers.

CSS management subsequently informed us that, effective September 15, 1999, insurers will be allowed only 21 days to respond to analysts' initial inquiries. This policy's effectiveness will depend on the Bureau's efforts to ensure insurers' timely responses.

RECOMMENDATION

We recommend that CSS initiate appropriate referrals to the Code Enforcement Division when insurers repeatedly fail to respond in a timely manner during Bureau investigations into consumer complaints.

AGENCY PRELIMINARY RESPONSE

The Bureau agreed with this recommendation and informed us that it has implemented a 21-day response requirement from insurance companies and will continue to document any delays.

The 21-day response requirement is not required by law or rule. The Bureau has discretion to extend the time frame a company is given to respond to an inquiry before the matter is referred for compliance action for failure to respond. The extension or length of time a company is given to bring resolution to a file is made on a case-by-case basis and is based on the particular facts of the compliant. If a company can prove that an investigation is ongoing and that it is actively pursuing information to bring closure to the file, the Bureau will use its statutory discretion to grant a reasonable amount of additional time. In complaints that involve facts under dispute in a civil and/or criminal court, a complaint may be left open for a considerable length of time pending the outcome of the court proceedings.

EFFECTIVENESS AND EFFICIENCY OF INSURER LICENSING AND REGULATION

COMMENT

Background: The Bureau's Office of Financial Evaluation and Office of Licensing and Enforcement are primarily responsible for licensing and regulating the various insurance and managed health care companies. At the time of our audit, the Bureau regulated approximately 1,525 companies.

Health maintenance organizations (HMOs) are a specific type of insurance company designed to deliver health care services to enrollees under the terms of specified contracts. They provide these services through contracted providers in exchange for a fixed, prepaid sum or a per capita prepayment, without regard to frequency, extent, or type of health care services rendered. Within Michigan, there are 21 licensed HMOs serving approximately 2.7 million enrollees.

During our audit, Section 333.21034 of the *Michigan Compiled Laws* contained Michigan's initial HMO licensure requirements, such as net worth of $100,000, deposits

of $100,000, and working capital of $250,000. These financial requirements had remained in effect since December 24, 1982. This Section also contained Michigan's renewal or insolvency prevention requirements for these same financial categories. These initial and renewal financial requirements were significantly lower than the requirements for most other insurance companies licensed in Michigan.

The financial information for Michigan's 21 HMOs as presented in their 1998 annual financial statements disclosed that 5 (24%) did not have sufficient working capital to meet Michigan's minimum renewal requirement of $250,000. These 5 HMOs had negative working capital ranging from $354,400 to $8,874,000. At the time of our audit, these HMOs were not due for renewal. The Bureau identified the HMOs' financial condition in a timely manner and required them to file corrective plans of action.

Audit Objective: To assess the effectiveness and efficiency of the Bureau's licensing and regulation of the insurance and managed health care industries.

Conclusion: We concluded that the Bureau was generally effective in its licensing and regulation of the insurance and managed health care industries and generally performed these functions in an efficient manner. However, we noted reportable conditions relating to documentation of the HMO licensure process, administration of receivership proceedings, and contract monitoring.

Noteworthy Accomplishment: After the completion of our audit fieldwork, the Commissioner recommended to the Governor new and updated regulations for the State's HMOs. These recommendations resulted in reform packages being introduced in the Legislature that were designed to strengthen the HMO financial requirements. The recommendations, expected to be signed into law, set stricter solvency levels for HMOs that will be phased in over a period of time. One such recommendation increases the current HMO minimum net worth requirement of $250,000 to $1.5 million. That minimum threshold would increase over time as the number of clients served also increases so that the minimum threshold is always at least 5% of subscriber revenues.

FINDING

3. Documentation of the HMO Licensure Process

The Bureau had not sufficiently documented its HMO licensure process. As a result, we could not locate many documents needed to support the completeness of the Bureau's efforts in approving HMOs for licensure.

The Department of Community Health (DCH), with the concurrence of the Bureau, grants licensure to HMOs. To coordinate the functions necessary to grant licensure, DCH and the Bureau have developed an Interagency Agreement. DCH regulates the health delivery aspects of HMO operations. The Bureau regulates the business and financial aspects of HMO operations to ensure that the HMOs are financially sound and follow acceptable business practices. From the Interagency Agreement, DCH and the Bureau have developed procedures which assign various licensure approval responsibilities to appropriate divisional levels. Within the Bureau, these responsibilities are principally allocated to the Office of Financial Evaluation and the Health Plans Unit.

To evaluate the Bureau's licensure approval process, we reviewed 10 HMO applications: 4 initial licensure applications, 4 renewal applications, and 2 applications from HMOs that were granted temporary licenses prior to their permanent licenses. We reviewed 16 categories of exhibits for documentation supporting the analysts' and supervisors' approval of the information submitted with the application. These categories included approvals of provider contracts, subscriber contracts, marketing plans, accounting procedures, management information systems, and financial plans. We determined that all 10 application files lacked documentation supporting the analysts' and/or supervisors' approvals within 13 of the 16 categories.

Documentation of the Bureau's licensure approval process should be maintained to facilitate and support licensing-related decisions. The Bureau's lack of uniform HMO approval processes within all divisions involved with HMO licensure may have contributed to the lack of documentation maintained by the various divisions.

RECOMMENDATION

We recommend that the Bureau sufficiently document its HMO licensure process.

AGENCY PRELIMINARY RESPONSE

The Bureau agreed with this recommendation and informed us that in mid-1999, it instituted a uniform process for documenting the analysis of and actions on HMO licensure and relicensure applications. Analysts from various areas of the Bureau working on any portion of an HMO application now document their recommendations in a central worksheet that resides on a shared computer drive. In addition, one employee now coordinates the actions of the various units of the Bureau and maintains a central file of documentation on these applications.

FINDING

4. Administration of Receivership Proceedings

The Bureau could have more efficiently administered its receivership proceedings.

The Insurance Commissioner has the authority to initiate delinquency proceedings against financially troubled insurance companies. These proceedings can result in 1 of 4 different kinds of receiverships: supervision, seizure* , rehabilitation, or liquidation. A court order from the Ingham County Circuit Court is needed to authorize the Commissioner to seize, rehabilitate, or liquidate a financially troubled company. Such an order authorizes the Commissioner to take possession of and control the assets of the company under the Court's general supervision. The Commissioner is empowered by statute to appoint a deputy receiver(s) to act as the Commissioner's agent and to employ counsel, clerks, and assistants as may be necessary to administer a receivership.

The Commissioner filed an Order of Seizure and was directed to take possession and control of all property, books, accounts, documents, and other records of a failing company. Two consultants were contracted to assist in managing this receivership. Our review of the ensuing proceedings disclosed numerous instances in which the company failed to fully cooperate with the Bureau's evaluation of its financial condition. This lack of cooperation forced the Bureau to modify the consultants' contracts numerous times. In written correspondence, the Bureau repeatedly referred to delays by the company as the reason for these

* *See glossary at end of report for definition.*

contract modifications. As shown in the accompanying tables, the Bureau committed additional financial resources totaling $442,528 for such modifications:

Contract A

	Contract Price	Additional Cost
Original Contract	$108,000	$
Modification		
1/1/99 - 3/31/99	198,000	90,000
3/31/99 - 9/30/99	No additional cost	
no extension in time	213,000	15,000
no extension in time	230,000	17,000
10/1/99 - 6/30/2000	270,000	40,000
Total Costs	$270,000	$162,000

Contract B

	Contract Price	Additional Cost
Original Contract	$34,472	$
Modification		
1/1/99 - 3/31/99	135,000	100,528
4/31/99 - 9/30/99	225,000	90,000
no extension in time	240,000	15,000
no extension in time	315,000	75,000
10/1/99 - 10/31/99	No additional cost	
Total Costs	$315,000	$280,528

Section 500.8106(4) of the *Michigan Compiled Laws* states that a person who fails to cooperate with the Commissioner, or a person who obstructs or interferes with the Commissioner in the conduct of a delinquency proceeding, may be sentenced to pay a fine not exceeding $10,000 or imprisonment for a term of not more than one year, or both. As of September 30, 1999, the Bureau had not initiated enforcement action against this company.

Initiating enforcement action against an insurer in receivership status could encourage cooperation with the Bureau. Cooperation between this company and the Bureau is imperative because, at the Bureau's discretion, the Bureau has paid

for all costs associated with the company's receivership proceedings. The Bureau's past practices were to charge such costs to the insurer.

RECOMMENDATION

We recommend that the Bureau more efficiently administer its receivership proceedings.

AGENCY PRELIMINARY RESPONSE

The Bureau agreed to improve upon the efficiency with which the receivership proceedings are administered.

However, the Bureau informed us that initiating a criminal proceeding under Section 500.8106(4) of the *Michigan Compiled Laws* may not always be applicable or warranted. Criminal proceedings may be:

a. Unwarranted in that the failure to produce documents and data on a timely basis was not a deliberate attempt to thwart the Bureau's efforts. The failure was, instead, largely a product of inadequacies in staffing, data, and data systems at the company. Bureau management, under the direction of the Commissioner, has addressed all of these problems.

b. Wasteful in that the proceeding would require extensive testimony by accountants and actuaries for both sides. Conservatively, it would have cost the Bureau $27,200 and the company $49,200. The State would have lost several days of time of an assistant attorney general who could be used for other purposes.

c. Counterproductive in that the last thing this financially troubled company needed was additional expenses of $50,000. Even worse, the negative publicity of a criminal proceeding could be devastating to its retention of business and threaten the company's survival.

FINDING

5. Contract Monitoring

The Bureau had not fully monitored contractor performance for services related to administering and processing insurance agent continuing education courses. As a result, the Bureau's monitoring lacked reconciliations of continuing education revenue, on-site course monitoring, and summarized results of contractor performance.

The Bureau contracted with an outside vendor to the services of administering and processing insurance agent license examinations and continuing education courses. The contract, including extensions, was effective for the period January 1, 1995 through September 30, 1999. The contract's cost was approximately $4,008,275. During our audit, the Bureau rebid these services through March 31, 2005 for an estimated cost of $5,775,000. The contract's cost is primarily paid through agents' examination and continuing education fees. Our review of the Bureau's administration of the contract disclosed:

a. The Bureau had not reconciled the continuing education fees with the Bureau's automated information system and with the licensee completed course credit report.

   The contractor collected the fees associated with the recording of continuing education credits. Per the contract, the contractor collected $1.00 per continuing education credit hour from the course provider. The contractor remitted to the Bureau the total revenue collected, an invoice for the contractor's services, a continuing education fee detail report, and a licensee completed course credit report. The Bureau then paid the contractor $0.22 per continuing education credit hour processed and retained the $0.78 per credit hour. The Bureau's share amounted to an estimated $1,404,000 over the life of the contract.

   However, the Bureau had not reconciled the continuing education fee detail with the Bureau's automated information system to verify the accuracy of the contractor's invoice and related agent information. We compared 542 credit hour transactions from the June 1999 continuing education fee detail report

with the Bureau's automated information system and noted more than 100 inconsistencies, including:

(1) Overstated, understated, and omitted continuing education credit hours.

(2) Incorrect agent information, such as name and social security number.

(3) Incorrect continuing education course information.

(4) Incorrect time periods for when the course was provided.

In addition, we compared the June 1999 continuing education fee detail report with the June 1999 licensee completed course credit report and noted that the two reports did not correspond. The agents listed on one report as taking particular continuing education courses were not supported by the other report. As a result of significant inconsistencies, we could not determine whether the revenue collected by the Bureau was correctly stated.

b. The Bureau did not ensure that the continuing education courses were in accordance with Bureau policies and procedures, statutory requirements, and approved course syllabuses.

Each licensed agent is required to earn 30 continuing education credit hours every two years. As of September 20, 1999, there were 72,699 active agents and 3,550 active classroom and self-study courses that had been provided. The Bureau recently added the responsibilities of reviewing and approving the continuing education courses' contents to the contract. The Bureau intends to monitor the contractor's fulfillment of these responsibilities by reviewing the course applications and submitted materials on a test basis.

However, the Bureau did not conduct on-site monitoring through classroom visits or third-party confirmations to verify that the courses corresponded to the information submitted and that the instructors met all applicable requirements. Without such verification, the Bureau could not determine that the continuing education program fulfilled the qualifications and requirements

of Bureau policies and procedures, statutory requirements, and approved course syllabuses.

c. The Bureau had not summarized its monitoring results of the contractor who administered the license examination and continuing education processes. Such summaries would help determine whether expectations associated with a contracted service were fulfilled in a responsible manner and help identify opportunities to improve the level of service.

In addition, the Department of Management and Budget Administrative Guide procedure 0510.08 requires that the agency contract administrator (1) review, at the time of project completion, the contractor's products, including progress reports, to determine whether all terms of the contract have been met and (2) write post-project reviews and evaluations.

The minutes of the Education Advisory Council disclosed the insurance industry's concerns with the contractor's consumer relations. Documentation of the Bureau's monitoring and final evaluations should be maintained to facilitate and support contractor-related decisions.

RECOMMENDATION

We recommend that the Bureau fully monitor contractor performance for services related to administering and processing insurance agent continuing education courses.

AGENCY PRELIMINARY RESPONSE

The Bureau agreed with this recommendation and informed us that it has, under the new contract with the contractor covering the period October 1, 1999 through March 31, 2005, implemented some corrective action.

The Director of the Licensing Enforcement Division has worked with the contractor to develop a new procedure in documenting revenues. On October 1, 1999, the contractor began submitting revenue reports and amounts will be reconciled monthly throughout the life of the new contract.

Early in the continuing education implementation cycle, the Bureau conducted on-site audits. In March 2000, the Bureau began formal audits of continuing education courses. This was possible because the new contract transfers the labor-intensive process of reviewing providers and courses to the contractor.

The Licensing Section has developed a list of contract requirements that will be used every six months to evaluate the requirements of the contract. The Bureau conducted the first such evaluation of October through March 2000 performance this spring. At the end of the current contract, the six-month evaluations will be a complete determination of the contractor's performance.

COMPLIANCE WITH LAWS AND REGULATIONS

COMMENT

Audit Objective: To assess the Bureau's compliance with applicable statutes, the *Michigan Administrative Code*, State procedures, and Bureau policies and procedures that could have a material effect on its operations.

Conclusion: We concluded that the Bureau was generally in compliance with applicable statutes, the *Michigan Administrative Code*, State procedures, and Bureau policies and procedures that could have a material effect on its operations. However, we noted reportable conditions related to timeliness of HMO applications, relicensures, and financial examinations and contracting procedures.

FINDING

6. Timeliness of HMO Applications, Relicensures, and Financial Examinations

The Bureau did not consistently complete HMO applications, relicensures, and financial examinations in a timely manner. As a result, the Bureau was not in compliance with various statutorily mandated requirements and departmental agreements.

Our review of timeliness related to the Bureau's approval of HMO applications, relicensure of HMOs, and financial examinations of HMOs disclosed:

a. The Bureau exceeded the 120-day (90 days plus a 30-day extension) period allowed for assessing HMO applications for licensure. Section R 325.6240 of the *Michigan Administrative Code* requires that the Bureau issue or deny a license within 90 calendar days of the application's filing, unless the Bureau notifies the applicant that the review was extended for 30 days.

   Four (67%) of the 6 license applications that we reviewed exceeded the 120-day period allowed. The Bureau exceeded the allowed review period from 94 to 258 days for an average of 173.5 days per HMO. These 4 companies received their licenses within the period July 1996 through November 1998. Bureau personnel informed us that some of these delays resulted from the applicants requesting extensions rather than receiving denials of their applications because of incomplete or questionable data. However, the *Michigan Administrative Code* does not provide for such extensions. Also, these extensions may add to the Bureau's work load and, thus, contribute to delays in the accomplishment of other responsibilities.

b. The Bureau did not consistently grant HMO renewal licenses in a timely manner. Thus, several HMOs operated with licenses that exceeded their expiration dates.

   HMO licenses are granted for a maximum of three-year periods. However, 11 (52%) of Michigan's 21 HMOs significantly exceeded the three-year period before receiving renewal licenses. The time period after the expiration dates of these 11 HMOs' licenses until the granting of their renewal licenses ranged from 3.4 years to 6.8 years, with an average of 5.3 years.

   The Bureau and DCH, who jointly regulate HMOs, relied on a section of the Administrative Procedures Act (Section 24.291 of the *Michigan Compiled Laws*) for the continuance of these HMO licenses until relicensure action was taken by the Bureau and DCH. The Act states that when a licensee makes timely and sufficient application for renewal of a license, the existing license does not expire until the agency makes a final decision on the application.

However, Section R 325.6245 of the *Michigan Administrative Code* states that an HMO renewal applicant shall file its application with the Bureau 90 days prior to the license's expiration date. Two HMOs did not submit their renewal applications within the 90-day requirement. These HMOs submitted their applications only 60 and 81 days prior to their license expiration dates. Also, we question whether the issuance of renewal licenses from three to six years after the expiration of the existing licenses is within the intent of the Administrative Procedures Act.

c. The Bureau had not consistently conducted financial examinations of HMOs within the time intervals specified in the Interagency Agreement between the Bureau and DCH.

The Bureau conducts on-site financial examinations of HMOs and other insurance companies. These examinations determine whether insurers are financially sound and reliable, are entitled to public confidence, and are in compliance with all relevant statutes. When these examinations identify financially troubled insurers, the Bureau's policy is to initiate action to protect Michigan's policyholders. The Interagency Agreement specifies that the Bureau shall conduct financial examinations of each HMO no less than once every three years.

Our review disclosed that the Bureau did not conduct 8 (31%) of 26 financial examinations within the required time frame during the period October 1, 1996 through October 31, 1999. The time frame between examinations for these 8 HMOs ranged from 3.2 to 4.6 years. As of the end of audit fieldwork, there were two additional HMOs whose most recent financial examinations occurred more than three years ago.

The Bureau should closely monitor all aspects of HMO operations, including their application, relicensure, and financial examination processes.

RECOMMENDATION

We recommend that the Bureau consistently complete HMO applications, relicensures, and financial examinations in a timely manner.

AGENCY PRELIMINARY RESPONSE

The Bureau agreed with this recommendation regarding consistent completion in a timely manner of various activities (HMO applications, relicensures, and financial examinations) related to the regulation of HMOs.

HMOs submit annual, quarterly, and, in some cases, monthly financial statements to the Bureau, supplemented by CPA audits and actuarial evaluations. The Bureau continuously reviews the financial condition of HMOs as well as the rates, contracts, and provider agreements they use.

The Bureau informed us that legislation currently being considered will change the future of licensure for HMOs. This legislation will consolidate the function of licensure under a single agency. Relicensure will be eliminated and timely handling of application promoted.

FINDING

7. Contracting Procedures

The Bureau's written procedures for contracting with consultants for assistance in managing insurer receiverships did not conform with Statewide contracting guidelines.

The Department of Management and Budget Administrative Guide procedure 0510.13 outlines specific procedures that agencies must follow when procuring consultant services. These procedures include obtaining competitive bids for contracts and obtaining approvals from the agency's department, the Department of Civil Service, and the State Administrative Board, if applicable.

Our review of the Bureau's written procedures disclosed that they did not require:

a. Competitive bids when contracts were executed with professional firms listed in the National Association of Insurance Commissioner's directory of professional services firms providing legal, accounting, and consulting services.

b. The appropriate approvals of the Department of Consumer and Industry's procurement services office, Department of Civil Service, and the State Administrative Board when contract amounts exceed $250,000.

The Bureau contracted with two consultants to help manage the receivership proceedings against an HMO that was placed under a court-ordered seizure. Bureau staff informed us that originally the HMO, not the Bureau, would pay for all associated costs of the seizure. Beginning in 1998, the Bureau made a "public policy" decision that it would pay for all costs of supervisions and seizures as a matter of customer service to the policyholders and creditors of troubled insurers. However, the Bureau's procedures did not address the possibility that the Bureau may be responsible for paying the consultants' bills. As a result, it was necessary for the Bureau to obtain the approvals of the procurement services office and the Department of Civil Service after executing engagement letters with the consultants and after services were provided.

RECOMMENDATION

We recommend that the Bureau revise its procedures for contracting with consultants for assistance in managing insurer receiverships to conform with Statewide contracting guidelines.

AGENCY PRELIMINARY RESPONSE

The Bureau agreed with this recommendation and informed us that written procedures will be implemented to conform with Statewide contracting guidelines, which will include the following requirements:

(a) Competitive bids when contracts are executed with professional firms listed in the National Association of Insurance Commissioner's directory of professional services firms providing legal, accounting, and consulting services.

(b) The appropriate approvals of the Department of Consumer and Industry Services' Procurement Services Office, Department of Civil Service, and the State Administrative Board when contract amounts exceed $250,000.

SUPPLEMENTAL INFORMATION

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Description of Survey

In August 1999, we sent surveys to 100 consumers who had filed written complaints with the Michigan Insurance Bureau during the period January 1, 1999 through March 31, 1999 (population 1). Also, we sent surveys to 100 consumers who had filed written complaints with the Bureau during the period April 1, 1999 through June 30, 1999 (population 2) for a total population of 200 consumers. We received 46 responses from population 1 and 44 responses from population 2 for a response rate of 45%.

Following is a copy of the survey that includes the number of responses received by population for each item. The total number of responses for each item may not agree with the number of responses reported above because some consumers provided more than one response to an item and other consumers did not respond to all of the items.

MICHIGAN INSURANCE BUREAU
Department of Consumer and Industry Services
Summary of Survey Responses

Background Information

1. How did you become aware of the Michigan Insurance Bureau's regulatory role in handling complaints against insurance companies?

	Insurance company or insurance agent		Telephone directory		Secretary of State or other government agency	
	Number	Percent	Number	Percent	Number	Percent
Population 1	8	20%	4	10%	6	15%
Population 2	11	25%	2	5%	3	7%

Telephone Contact

2. When you contacted the Bureau by telephone, you were greeted pleasantly.

	Strongly Agree		Agree		Disagree	
	Number	Percent*	Number	Percent*	Number	Percent*
Population 1	12	38%	18	56%	0	
Population 2	7	21%	21	64%	3	9%

3. If your call was transferred, did you consider the number of transfers to be:

	Appropriate		Excessive		No opinion	
	Number	Percent*	Number	Percent*	Number	Percent*
Population 1	9	56%	3	19%	4	25%
Population 2	17	74%	2	9%	4	17%

4. If you were put on hold, did you consider the length of time you spent on hold to be:

	Appropriate		Excessive		No opinion	
	Number	Percent*	Number	Percent*	Number	Percent*
Population 1	12	60%	5	25%	3	15%
Population 2	11	58%	2	11%	6	32%

5. When you contacted the Bureau, did the person(s) you spoke with adequately explain the assistance process?

	Yes		No		No opinion	
	Number	Percent	Number	Percent	Number	Percent
Population 1	25	76%	6	18%	2	6%
Population 2	23	70%	9	27%	1	3%

This schedule continued on next page.

Elected official		Attorney		Other		Total Responses
Number	Percent	Number	Percent	Number	Percent	
2	5%	4	10%	16	40%	40
5	11%	3	7%	20	45%	44

Strongly disagree		Not applicable as I have not contacted the Bureau by telephone			Applicable Responses	Total Responses
Number	Percent*	Number	Percent			
2	6%	10	24%		32	42
2	6%	9	21%		33	42

Not applicable as my call was not transferred					Applicable Responses	Total Responses
Number	Percent					
17	52%				16	33
10	30%				23	33

Not applicable as I was not put on hold					Applicable Responses	Total Responses
Number	Percent					
13	39%				20	33
13	41%				19	32

						Total Responses
						33
						33

MICHIGAN INSURANCE BUREAU
Department of Consumer and Industry Services
Summary of Survey Responses
Continued

Complaint Processing

6. From the time that you first contacted the Bureau by telephone with your complaint, how long was it before you received a complaint form?

	1 to 5 business days		6 to 10 business days		11 to 20 business days	
	Number	Percent*	Number	Percent*	Number	Percent*
Population 1	11	41%	11	41%	2	7%
Population 2	7	29%	13	54%	4	17%

7. From the time that you submitted your complaint in writing, how long was it before the Bureau acknowledged receipt of your complaint?

	1 to 5 business days		6 to 10 business days		11 to 20 business days	
	Number	Percent	Number	Percent	Number	Percent
Population 1	3	8%	15	38%	14	35%
Population 2	5	13%	11	28%	16	40%

8. Did the Bureau adequately explain the assistance process in its response?

	Yes		No		No opinion	
	Number	Percent	Number	Percent	Number	Percent
Population 1	28	65%	13	30%	2	5%
Population 2	31	74%	9	21%	2	5%

9. Did the Bureau update you on actions taken in relation to your complaint?

	Yes		No		No opinion	
	Number	Percent	Number	Percent	Number	Percent
Population 1	27	63%	14	33%	2	5%
Population 2	25	63%	13	33%	2	5%

10. Did the Bureau provide you with the insurance company's response?

	Yes		No		Not applicable as there was no response from the insurance company	
	Number	Percent*	Number	Percent*	Number	Percent
Population 1	35	85%	6	15%	1	2%
Population 2	32	84%	6	16%	2	5%

11. How satisfied were you with the Bureau's processing of your complaint?

	Very satisfied		Somewhat satisfied		No opinion	
	Number	Percent	Number	Percent	Number	Percent
Population 1	16	37%	9	21%	2	5%
Population 2	10	25%	12	30%	3	8%

This schedule continued on next page.

More than 20 business days		Not applicable as I initially submitted my complaint in writing.		Applicable Responses	Total Responses
Number	Percent*	Number	Percent		
3	11%	9	25%	27	36
0		8	25%	24	32

More than 20 business days		The Bureau did not acknowledge receipt of my complaint.			Total Responses
Number	Percent	Number	Percent		
7	18%	1	3%		40
8	20%	0			40

					Total Responses
					43
					42

					Total Responses
					43
					40

				Applicable Responses	Total Responses
				41	42
				38	40

Somewhat unsatisfied		Very unsatisfied			Total Responses
Number	Percent	Number	Percent		
7	16%	9	21%		43
4	10%	11	28%		40

MICHIGAN INSURANCE BUREAU
Department of Consumer and Industry Services
Summary of Survey Responses
Continued

12. Has your complaint been resolved?

	Yes		No, my complaint is still open.	
	Number	Percent	Number	Percent
Population 1	30	73%	11	27%
Population 2	20	51%	19	49%

Complaint Resolution

13. How satisfied were you with the resolution of your complaint?

	Very satisfied		Somewhat satisfied		No opinion	
	Number	Percent	Number	Percent	Number	Percent
Population 1	16	39%	6	15%	2	5%
Population 2	8	25%	4	13%	3	9%

14. If your complaint was not resolved in your favor, did the Bureau help you to understand why?

	Yes		No	
	Number	Percent	Number	Percent
Population 1	8	33%	16	67%
Population 2	5	29%	12	71%

15. Did the Bureau address all of your concerns?

	Yes		No	
	Number	Percent	Number	Percent
Population 1	20	57%	15	43%
Population 2	16	59%	11	41%

16. Did the Bureau require the insurance company to justify its position?

	Yes		No	
	Number	Percent	Number	Percent
Population 1	18	58%	13	42%
Population 2	17	65%	9	35%

17. Could the Bureau have done more to help you?

	Yes		No		No opinion	
	Number	Percent	Number	Percent	Number	Percent
Population 1	18	49%	15	41%	4	11%
Population 2	19	51%	8	22%	10	27%

* Percent of Applicable Responses

				Total Responses
				41
				39

Somewhat unsatisfied		Very unsatisfied		Total Responses
Number	Percent	Number	Percent	
6	15%	11	27%	41
2	6%	15	47%	32

				Total Responses
				24
				17

				Total Responses
				35
				27

				Total Responses
				31
				26

				Total Responses
				37
				37

Glossary of Acronyms and Terms

alien company	An insurance company that uses Michigan as a port of entry into the United States.
CSS	Consumer Services Section.
DCH	Department of Community Health.
domestic company	An insurance company incorporated in the State of Michigan.
effectiveness	Program success in achieving mission and goals.
efficiency	Achieving the most outputs and outcomes practical for the amount of resources applied or minimizing the amount of resources required to attain a certain level of outputs or outcomes.
foreign company	An insurance company incorporated in a state other than Michigan.
goals	The agency's intended outcomes or impacts for a program to accomplish its mission.
HMO	health maintenance organization.
managed health care	Systems that combine the financing and delivery of health care services to patients by arranging with providers to provide patient services.
performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or

	function to improve public accountability and to facilitate decision making by parties responsible for overseeing or initiating corrective action.
receivership	The state of being under control of the Insurance Commissioner for the purpose of taking possession and control of an insurance company. Receivership is initiated by the Commissioner through a court order.
reportable condition	A matter coming to the auditor's attention that, in his/her judgment, should be communicated because it represents either an opportunity for improvement or a significant deficiency in management's ability to operate a program in an effective and efficient manner.
seizure	The action taken as a result of a court order requested by the Insurance Commissioner to take possession and control of all or part of an insurance company while also prohibiting the insurer, or others on its behalf, from disposing of the insurer's property or from transacting business, except with the Commissioner's written consent.