STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT
CONSUMER PROTECTION FUNCTIONS

PERFORMANCE AUDIT REPORT
AUGUST 2007

To The Fiscal Committee Of The General Court:

We have conducted an audit of the New Hampshire Insurance Department's (NHID) consumer protection functions, to address the recommendation made to you by the joint Legislative Performance Audit and Oversight Committee. We conducted our audit in accordance with the standards applicable to performance audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require we plan and perform the audit to provide a reasonable basis for our findings and conclusions. Accordingly, we have performed such procedures as we considered necessary in the circumstances.

The purpose of the audit was to assess if the NHID effectively fulfills its consumer protection functions. Our audit period includes State fiscal years 2001 through 2006.

This report is the result of our evaluation of the information noted above and is intended solely for the information of the NHID and the Fiscal Committee of the General Court. This restriction is not intended to limit the distribution of this report, which upon acceptance by the Fiscal Committee is a matter of public record.

Office Of Legislative Budget Assistant

August 2007

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ABBREVIATIONS

CHIS	Comprehensive Healthcare Information System
DAS	Department Of Administrative Services
DHHS	Department Of Health And Human Services
EDP	Electronic Data Process
EIC	Examiner In Charge
FAST	Financial Analysis Solvency Tool
HMO	Health Maintenance Organization
IRIS	Insurance Regulatory Information System
I-SITE	Internet-State Interface Technology Enhancement
LAH	Life, Accident, And Health
LPAOC	Legislative Performance Audit And Oversight Committee
NAIC	National Association Of Insurance Commissioners
NHID	New Hampshire Insurance Department
OAG	Office Of The Attorney General
P&C	Property And Casualty
PDF	Portable Document Format
RSA	Revised Statutes Annotated
SERFF	System For Electronic Rate And Form Filings
SFY	State Fiscal Year
UNH	University Of New Hampshire

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SUMMARY

Purpose And Scope Of Audit

This audit was performed at the request of the Fiscal Committee of the General Court consistent with the recommendation of the joint Legislative Performance Audit and Oversight Committee. It was conducted in accordance with generally accepted government auditing standards applicable to performance audits. The purpose was to assess if the New Hampshire Insurance Department (NHID) is effectively fulfilling its consumer protection functions.

Background

The NHID was formed in 1851 as the first insurance regulatory agency in the United States. Its duties are codified in RSAs 400-A through 420-K. The Insurance Commissioner is charged with all duties pertaining to enforcing and executing insurance laws of the State. The Commissioner has responsibility for collecting premium taxes and fees and regulating all segments of the insurance industry as it performs in the marketplace, particularly the treatment of policyholders and claimants. RSAs 412:19 and 415:2 allow the Commissioner to disapprove rates and forms found to be excessive, inadequate, unfairly discriminatory, or otherwise not in compliance with State statutes.

As of August 2007, the NHID had 80 authorized full-time positions with eight vacancies. The NHID, as currently organized, has eleven divisions. Our audit focused on operations in five operating units: Consumer Services, Financial Examinations, Property and Casualty Filings, Life and Health Filings, and the Enforcement Unit.

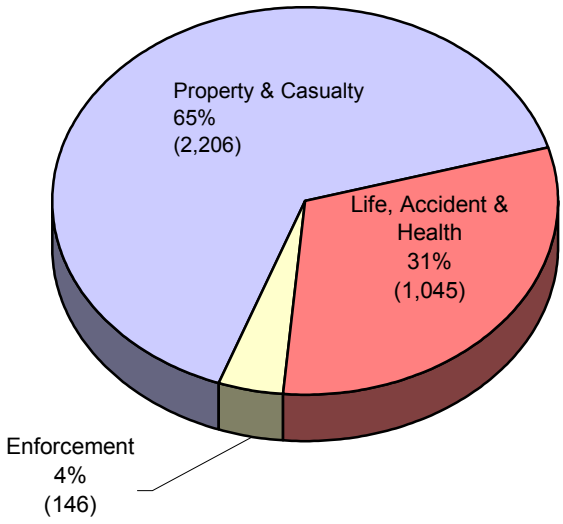
Prior to State fiscal year (SFY) 2002, the NHID was funded by assessments on domestic companies. Since SFY 2002, the NHID's general administrative operations have been funded by assessments on all insurance companies writing business in New Hampshire. Financial and market conduct examinations are funded through fees charged to the company under examination. The NHID also assesses a two percent premium tax on all insurers doing business in New Hampshire based on the company's gross premiums. Effective August 2006, the Legislature amended RSA 400-A:32 to incrementally reduce the insurance premium tax to one percent for most lines of insurance over a four-year period. From SFYs 2001 through 2006, the NHID expended approximately $32 million on NHID operations and collected approximately $520 million in revenue, $490 million of which was unrestricted general fund revenue.

The Consumer Services Division responds to consumer complaints and inquiries, as well as assists consumers in resolving their disputes with NHID licensees. The NHID defines inquires as any consumer-initiated contact with the NHID. Prior to 2003, the NHID did not have an electronic system for tracking complaints and inquiries. Between SFYs 2004 and 2006, the Division received 42,013 consumer-initiated contacts, some of which were related to new or existing complaints. During the same time period, consumers filed 3,397 complaints with the NHID, of which 14 resulted in consent orders against NHID licensees resulting in $11,500 in fines for violation of New Hampshire insurance laws or NHID rules, while three resulted in hearings. During this time, the Division assisted consumers in recovering approximately $3.6

million in relief from insurance companies. The Division has nine staff and as of August 2007, was fully staffed. Figure 1 illustrates the distribution of consumer complaints filed between SFYs 2004 and 2006.

Figure 1

Consumer Complaints Filed
State Fiscal Years 2004-2006



Source: LBA analysis of NHID consumer complaint data.

The Financial Examinations Division reviews the solvency of the State's 41 domestic insurance companies through quarterly and annual analyses of financial statements and on-site financial examinations. The Division also reviews applications for companies requesting a license to market insurance products in the State; grants, suspends, or revokes company licenses based on a company's financial condition; monitors business changes that require regulatory action such as mergers, ownership changes, rehabilitations, and liquidations; and regulates surplus (specialty or high risk) lines of insurance. Between SFYs 2001 and 2006, the Division completed 70 financial examinations and as of June 2006, licensed over 950 insurance companies to do business in New Hampshire.

The NHID charges the insurance company under examination for the cost of conducting financial and market conduct examinations. The Division's examiners perform most financial examinations. The NHID bills the company under examination monthly at an *estimated* per diem rate for each examiner, which as of November 2006, was $1,100 per day. Actual incurred expenses are also billed to the insurance company for reimbursement. The NHID also utilizes contract examiners on an as-needed basis. From SFYs 2003 through 2006, the NHID used 12

contracted examiners or examination firms to perform parts of 16 examinations. Approximately $6 million in examination fees were paid directly by insurance companies to contracted examiners and examination firms and not recorded or accounted for in the State accounting system.

The Rate and Form Compliance and Actuarial and Analytical Divisions review insurance forms and rates to ensure they meet the requirements of State law and rules. The Rate and Form Compliance Division is comprised of two functional areas, property and casualty, and life, accident, and health, both of which review all policy and endorsement forms to ensure they conform to State laws and rules prior to use. The Actuarial and Analytical Division mirrors the same two functional areas and reviews actuarial aspects of forms, rules, and rates to ensure that premium rates and rating plans are not excessive, inadequate, or unfairly discriminatory, and that premium rates conform to State law.

The NHID uses an on-line filing system developed by the National Association Of Insurance Commissioners called the System for Electronic Rate and Form Filing (SERFF), which allows insurers to submit their rate and form filings electronically. SERFF functions as a central clearinghouse and routes filings directly to each state's insurance department. SERFF allows companies to send and states to receive, comment on, and approve or reject insurance industry rate and form filings. Between SFYs 2003 and 2006, the divisions received 25,325 rate and form filings, 30 percent of which were filed through SERFF and 70 percent of which were filed in paper format. Since SFY 2003, the percentage of filings submitted through SERFF has increased from 12 percent to 46 percent in SFY 2006. Figure 2 illustrates the types of filings received from SFYs 2003 through 2006.

Results In Brief

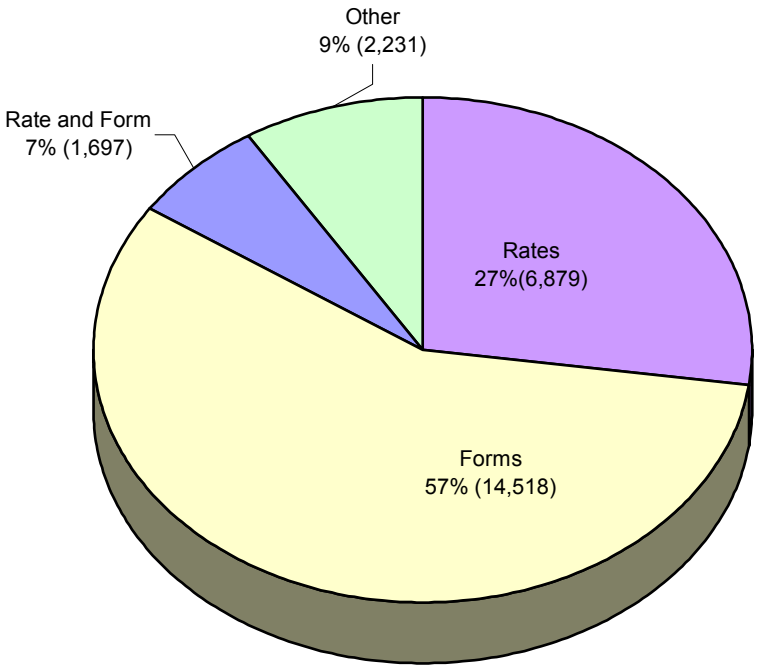
The NHID is responsible for regulating all segments of the insurance industry, particularly the treatment of policyholders and claimants. Our audit of the processes for consumer-complaint resolution, financial examinations, and rate and form review found the NHID is effectively fulfilling its consumer protection functions, although some processes could benefit from more standardization or formal guidance.

Our audit presents 12 observations and recommendations. Seven observations refer to issues we found in the Consumer Services Division.

- Two recommend improvements in specific aspects of the complaint resolution process,
- Two recommend the need for formal procedures in the Enforcement Unit,
- One recommends consistency in processing complaints filed by consumers who have retained an attorney,
- One recommends quality control over Consumer Services Division data, and
- One recommends ensuring all consumer complaints are recorded in the Complaint Database.

Figure 2

Types Of Rate And Form Filings
State Fiscal Years 2003-2006



Source: LBA analysis of NHID filings data.

Four observations refer to issues we found in the Financial Examinations and Licensing Division.

- Three recommend clarification of statutes related to procuring and paying contract examiners and examination firms, and
- One recommends statutory compliance with conducting examinations of companies domiciled in other states.

Our last observation focuses on NHID-wide management issues and addresses the need to develop a business continuity plan to ensure continuance of operations in the event of an unanticipated disaster.

RECOMMENDATION SUMMARY

Observation Number	Page	Legislative Action May Be Required	Recommendations	Agency Response
1	29	No	Clarify policy regarding processing phone complaints and ensure all phone complaints are recorded in the Complaint Database.	Do Not Concur
2	31	No	Ensure all complainants receive acknowledgement of their complaint within two business days.	Concur
3	33	No	Develop and implement policies and procedures to ensure all complaints filed by consumers who have retained an attorney are handled consistently.	Concur In Part
4	35	No	Ensure disposition letters contain a thorough explanation regarding complaint resolution.	Concur
5	37	No	Establish a formal procedure for referring complaints to the Enforcement Unit.	Concur In Part
6	40	No	Formally develop and adopt procedures for Enforcement Unit investigations.	Concur
7	41	No	Re-establish quality control reviews and expand them to cover all aspects of the complaint resolution process. The reviews should include periodic assessment of the Complaint and Enforcement Databases and a review of all personnel who process consumer complaints.	Concur In Part
8	47	Yes	Use competitive bidding for procuring contracted examination services.	Do Not Concur
9	49	Yes	Seek clarification of RSA 400-A:37 for contracted examiner payments.	Concur
10	51	Yes	Seek clarification of RSA 400-A:37 related to Governor and Council approval for contracted examination services.	Concur

Observation Number	Page	Legislative Action May Be Required	Recommendations	Agency Response
11	53	Yes	Examine foreign companies licensed in New Hampshire that were not examined by an accredited state.	Concur In Part
12	57	No	Establish a written business continuity plan for NHID operations.	Concur

OVERVIEW

In July 2005, the Fiscal Committee adopted a recommendation by the joint Legislative Performance Audit and Oversight Committee (LPAOC) to conduct a performance audit of the New Hampshire Insurance Department's (NHID) consumer protection functions. The primary concern of the LPAOC was whether the NHID was adequately fulfilling its consumer protection functions. We held an entrance conference with the NHID in March 2006.

SCOPE, OBJECTIVES, AND METHODOLOGY

This performance audit was conducted in accordance with generally accepted government auditing standards applicable to performance audits and accordingly included such procedures as we considered necessary in the circumstances.

Scope And Objectives

We designed our audit to answer the following question – **Does the New Hampshire Insurance Department effectively fulfill its consumer protection functions?** Our audit period included State fiscal years (SFY) 2001 through 2006.

Specifically, we examined the following to guide our work in answering this question:

1. Effectiveness of the NHID's complaint-resolution process in helping consumers resolve insurance-related complaints.
2. Effectiveness and efficiency of the financial examinations process in adequately protecting consumers.
3. Effectiveness of the process for reviewing insurance rates and forms to protect consumers from excessive, inadequate, and unfairly discriminatory insurance rates.

Methodology

As part of the planning process, we obtained and reviewed: background information from the NHID; audits of other states' insurance departments; Government Accountability Office reports; and white papers, model laws, and other documents written by the National Association of Insurance Commissioners (NAIC) and the National Conference of Insurance Legislators. Where possible, we identified best practices for processes in the topics under review. We also reviewed State laws; NHID administrative rules, policies, and procedures; the 2003 NHID financial audit; and newspaper articles related to the topics under review.

We conducted interviews with NHID personnel and a member of the LPAOC, created flow charts to illustrate the processes used by the NHID in performing its functions, and developed a logic model illustrating the linkages between the NHID's activities and outcomes.

We sent mail surveys to 325 consumers who had filed complaints with the NHID's Consumer Services Division during SFYs 2005 and 2006 to obtain input regarding their experience with the

complaint resolution process. We received completed surveys from 183 consumers (56 percent return rate); the aggregated survey results are contained in Appendix B.

We also sent mail surveys to 20 other state insurance departments to obtain comparative information on the three areas under review. We received eight completed surveys from state insurance commissioners (40 percent return rate); the aggregated survey results are contained in Appendix C.

We sampled 350 consumer complaint and enforcement files and conducted file reviews to determine the accuracy of the Complaint and Enforcement Databases; as well as to identify issues with the complaint resolution process.

BACKGROUND

The NHID was formed in 1851 as the first insurance regulatory agency in the United States. Its current duties are codified in RSAs 400-A through 420-K. The Insurance Commissioner is charged with all duties pertaining to enforcing and executing State insurance laws. The Commissioner is responsible for collecting premium taxes and fees and regulating all segments of the insurance industry as it performs in the marketplace, particularly in the treatment of policyholders and claimants. The Commissioner is also responsible for ensuring insurance rates are not excessive, inadequate, or unfairly discriminatory.

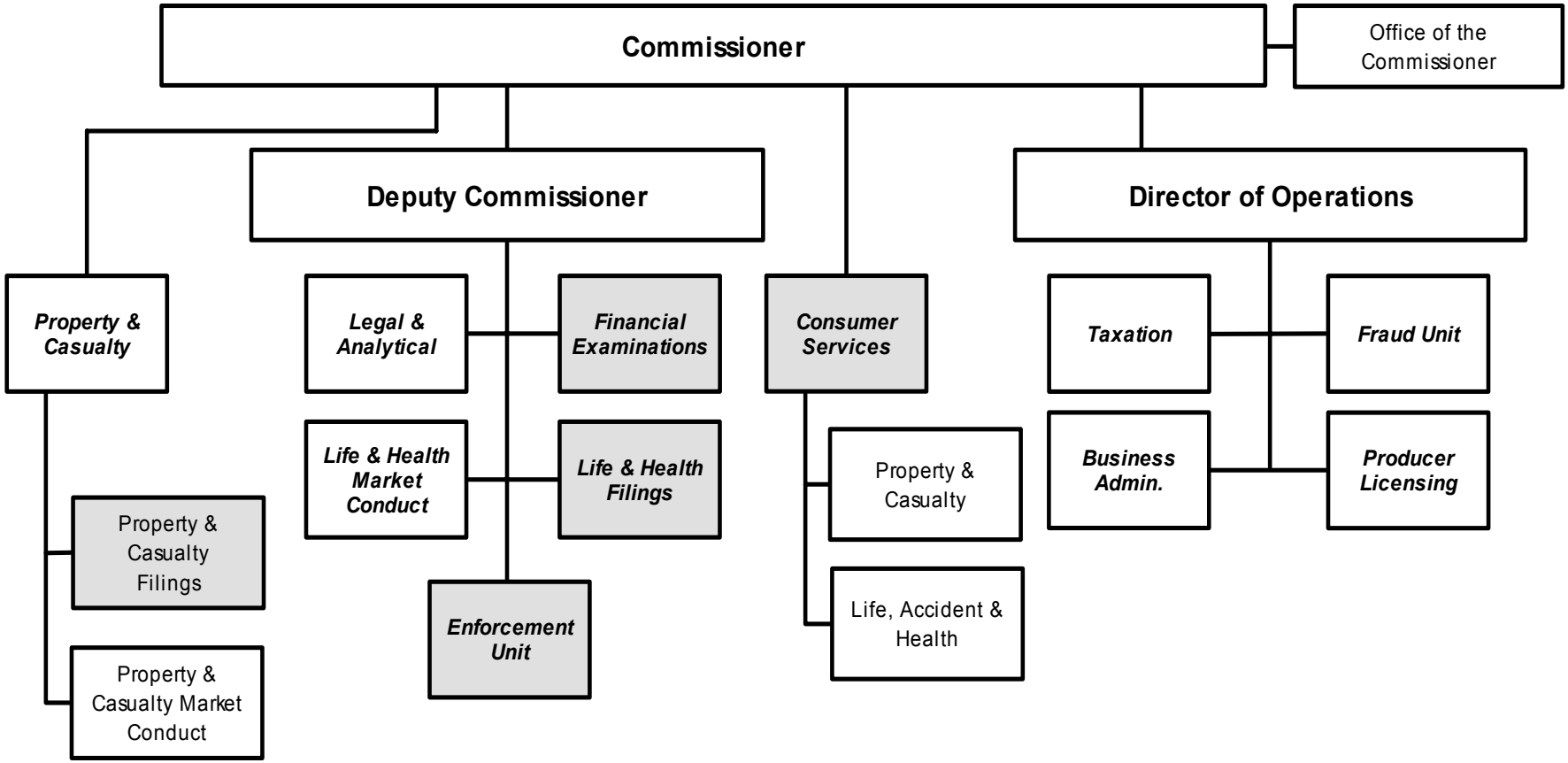
NHID Organization

As of August 2007, the NHID had 80 authorized full-time positions, with eight vacancies. The NHID, as currently organized, has eleven divisions. The organizational chart (Figure 3) shows the structure of the NHID. Although NHID management states the focus of all NHID activities is consumer protection oriented, our audit focused on operations in five operating units: Consumer Services, Financial Examinations, Property and Casualty Filings, Life and Health Filings, and the Enforcement Unit.

In 2005, the NHID began reorganizing. The reported goal of the reorganization (as shown in Figure 3) was to more effectively address problems in the insurance market through increased coordination and information sharing within the NHID. The NHID believes this will increase communication about market issues affecting each line of insurance, eventually resulting in better targeted market conduct and financial examinations. According to the Deputy Commissioner, the reorganization is expected to continue until 2008.

Figure 3

NHID Organizational Chart
As Of August 2007



Note:
1. The shaded boxes represent the operational units we examined.
2. The organizational chart does not reflect the organization in effect during our audit period.

Source: LBA analysis of NHID personnel information.

NHID Revenues And Expenditures

Since SFY 2002, the NHID's general administrative operations have been funded by assessments on all insurance companies writing business in New Hampshire. Prior to SFY 2002, the NHID had been funded by assessments on domestic companies only. Financial and market conduct examinations are funded through fees charged to the companies under examination. Prior to July 2007, the NHID also assessed a two percent premium tax on all insurers based on the gross amount of premiums written. In 2006, the Legislature amended RSA 400-A:32 to incrementally reduce the insurance premium tax to one percent for most lines of insurance over a four-year period starting July 2007 and ending January 2011. A two percent premium tax will remain in effect for health-related insurance lines.

The NHID collects both restricted and unrestricted revenue. Restricted revenue comes from four main sources: continuing education fees, an administrative assessment of all insurers doing business in New Hampshire, financial examination fees, and market conduct examination fees. Examination fees paid directly to contractors by companies under examination are not recorded as revenue. Unrestricted revenue comes from a number of sources including: the insurance premium tax; fees collected for producer licensing, an insurer's annual statement filing, and a company's application and initial certificate to conduct business in the State; and fees to sell surplus lines of insurance and annuities. RSA 400-A:35, Retaliatory Provisions, allows the NHID to collect different fees from different companies for the same service. Companies domiciled in a different state are charged either New Hampshire's fees or those charged by the domiciliary state, whichever is higher. RSA 400-A:15 gives the Commissioner the authority to levy and collect fines from insurers and producers found to be in violation of State insurance laws or administrative rules.

As shown in Table 1, from SFY 2001 through SFY 2006, the NHID expended approximately $32 million on operations and collected approximately $520 million in revenue from various revenue sources. All unrestricted revenue and excess funds from continuing education fees are recorded as unrestricted general fund revenue, while excess revenue from the administrative assessment is brought forward and used to reduce the subsequent year's assessment.

New Hampshire is in line with the majority of states in the way it funds its Insurance Department. According to information collected by the NAIC, thirty-five states (70 percent), including New Hampshire, do not receive any general funds for their operations. Twenty-three states, including New Hampshire, fully fund their operations through fees and assessments on insurance companies writing business within their state, while the 12 other states are funded through a combination of fees, assessments, fines, and penalties collected from companies writing business within the state, and other sources of revenue. No state receives 100 percent of its funding from its general fund; however, 15 states (30 percent) receive a portion of their budget from the general fund. Ten states receive at least 50 percent of their funding from their state general fund. General funding ranges from 94 percent in one state to two percent in another.

Table 1

NHID Revenues And Expenditures
State Fiscal Years 2001-2006

	2001	2002	2003	2004	2005	2006	TOTAL
Restricted Revenue	$3,719,788	$2,683,162	$5,701,177	$6,165,797	$5,582,503	$6,443,381	$30,295,808
Unrestricted Revenue	67,201,303	75,334,168	82,160,935	86,245,973	88,706,318	90,462,238	490,110,935
Total Revenue[a]	**$70,921,091**	**$78,017,330**	**$87,862,112**	**$92,411,770**	**$94,288,821**	**$96,905,619**	**$520,406,743**
Personnel	$3,190,525	$3,600,572	$4,724,794	$4,872,652	$4,757,805	$4,890,851	$26,037,199
Consultants[b]	142,084	49,953	86,014	102,657	86,460	80,088	547,256
Travel	59,387	88,113	246,387	315,792	194,663	240,243	1,144,585
Current Expenses	390,153	391,667	613,003	469,760	274,276	275,607	2,414,466
Other	129,596	136,925	120,535	121,959	496,890	846,961	1,852,866
Total Expenditures	**$3,911,745**	**$4,267,230**	**$5,790,733**	**$5,882,820**	**$5,810,094**	**$6,333,750**	**$31,996,372**

Notes:

a. Examination fees paid directly to contracted examiners are not included in revenue.

b. "Consultants" does not include contracted examiners used by the Financial Examinations Division.

Source: LBA analysis of Statement of Appropriations and revenue reports.

Consumer Services Division

The Consumer Services Division responds to consumer complaints and inquiries, and assists consumers in resolving their disputes with NHID-licensed companies and producers. The Division uses pamphlets and speaking engagements to educate the public about insurance products. It also provides referrals for issues outside its jurisdiction and administers the external review process for appealing health maintenance organization (HMO) decisions. The Division was fully staffed with nine personnel as of August 2007.

Consumer Complaints And Inquiries

The NAIC defines consumer complaints as written or oral communications expressing dissatisfaction with a specific insurance company or agent. The NHID uses this definition to distinguish between consumer complaints and inquiries. For the NAIC, the key component of a complaint is being a consumer grievance toward a *specific* insurance entity. The NAIC recommends insurance departments track both inquiries and complaints; however, only grievances toward a specific entity should be categorized and reported in a state's complaint statistics.

The NHID defines a consumer inquiry as any written or verbal consumer-initiated contact with the NHID. Inquiries include questions about specific insurance companies or products, requests for brochures or referrals, or contact related to new or existing complaints. Division personnel note any consumer-initiated contact and its resolution in the Consumer Assistance Tracking System (Event Log). Complaints and requests for the NHID to intervene are entered as new complaints and a record is automatically created in the Complaints Case Management System

(Complaint Database). All consumer calls regarding existing complaints are recorded in the Event Log and the Complaint Database.

The Event Log and Complaint Database were deployed in February and May 2003, respectively. The Division had no prior electronic system to track complaints and inquiries, and files existed only in hard copy. Between SFYs 2004 and 2006, the Division received 42,013 inquiries, including those related to new or existing complaints. Eight percent, or 3,397 inquiries became complaints. Table 2 shows the number of complaints the NHID received from SFYs 2004 through 2006.

Table 2

Consumer Complaints Opened And Closed
State Fiscal Years 2004-2006

	2004		2005		2006		TOTAL	
	Opened	**Closed[a]**	**Opened**	**Closed[a]**	**Opened**	**Closed[a]**	**Opened**	**Closed[a]**
Property & Casualty	735	727	746	757	725	720	2,206	2,204
Life, Accident & Health	318	309	334	346	393	378	1,045	1,033
Enforcement[b]	61	68	48	47	37	35	146	150
TOTAL	**1,114**	**1,104**	**1,128**	**1,150**	**1,155**	**1,133**	**3,397**	**3,387**

Notes:

a. Complaints closed in each fiscal year may have been opened in prior fiscal years.

b. "Enforcement" includes complaints referred directly to the Enforcement Unit as well as complaints initially processed by claims and hearings officers and later identified as potential violations. These same complaints were subtracted from the number of complaints processed by Property & Casualty and Life, Accident & Health to prevent double counting.

Source: LBA analysis of NHID consumer complaints and enforcement information.

As Table 3 illustrates, approximately two-thirds of complaints are related to property and casualty lines of insurance. Approximately one-third of all complaints filed are related to personal automobile policies, followed by complaints regarding health insurance (25 percent) and private residential homeowners' policies (18 percent).

The Consumer Services Division closed 3,387 consumer complaints between SFYs 2004 and 2006. Table 4 shows the resolution types for these complaints. Forty-one percent were found in favor of the complainant, compared to 46 percent in favor of the insurance licensee. Eleven percent of complaints were closed for other reasons, two percent were referred to entities outside of the NHID, and less than one percent were disposed as either an enforcement hearing or consent order. Fourteen consumer-initiated complaints resulted in consent orders against the insurance producer: six resulted in the licensee surrendering its license; four resulted in $11,500 in fines; three resulted in license suspension; and one resulted in a warning. In addition, three consumer-initiated complaints led to hearings. Consumers obtained almost $3.6 million in relief from insurance companies.

Table 3

Consumer Complaints Filed By Issue Area
State Fiscal Years 2004-2006

	2004	2005	2006	TOTAL
Property & Casualty				
Auto	406	435	408	1,249
Homeowners	219	199	180	598
Commercial	82	80	97	259
P&C Other[a]	28	32	40	100
Property & Casualty Subtotal	**735**	**746**	**725**	**2,206**
Life, Accident & Health				
Health	247	274	312	833
Life	57	46	67	170
LAH Other[b]	14	14	14	42
Life, Accident & Health Subtotal	**318**	**334**	**393**	**1,045**
Enforcement				
Referred By Claims And Hearing Officer	10	9	6	25
Referred Directly To Enforcement	51	39	31	121
Enforcement Subtotal	**61**	**48**	**37**	**146**
TOTAL	**1,114**	**1,128**	**1,155**	**3,397**

Notes:
a. "P&C Other" includes boat, credit insurance, flood, pet insurance, professional liability or malpractice, renters, service contract, title insurance, trip/travel insurance, warranty, workers' compensation, and NHID-designated unknown and other.
b. "LAH Other" includes annuities and two auto insurance complaints designated by the NHID as LAH.

Source: LBA analysis of NHID complaints data.

Consumer Complaint Processing

Consumers contact the Division by telephone, mail, e-mail, fax, or in person. Initial contacts are documented in the Event Log, and appended to the Complaint Database if Department intervention is sought. Claims and hearings officers contact licensees by mail, attaching the complaint and any accompanying documents, and request a response to the complaint within ten business days. Complainants are informed by mail of the Division's receipt of their complaint and notified they will be contacted when the Division has received the licensee's response. Complaint response due dates are monitored every seven to 14 business days. Licensees are contacted regarding late responses.

Licensee responses are reviewed to ensure all complaint issues are adequately addressed. If so, the claims and hearings officer mails the disposition to the consumer attaching the licensee's response and any accompanying documents. The disposition letter informs the consumer to notify the NHID with additional questions or if the consumer wishes to dispute the licensee's response. For responses not adequately addressing all concerns or issues, the claims and hearings officer requests more information and requests a response within ten days. The median number

of days to resolve a complaint between SFYs 2004 and 2006 was 26. Figure 4 illustrates the procedure for processing consumer inquiries and complaints.

Table 4

Complaints Closed By Resolution Type
State Fiscal Years 2004-2006

	2004	2005	2006	TOTAL
In Favor Of Complainant				
Non-Renewal/ Cancellation Rescinded[a]	45	56	38	139
Claim Refund To Customer	35	36	34	105
Claim Resolved/ Settled	199	241	245	685
Policy Issued/ Restored	18	16	4	38
Premium Dispute Resolved	17	36	33	86
Coverage Extended	25	43	14	82
In Favor Of Complainant Other[b]	74	73	93	240
In Favor Of Complainant Subtotal	**413**	**501**	**461**	**1,375**
In Favor Of Licensee				
Complies With State Laws/Regulations	234	334	294	862
Non-Renewal/ Cancellation Upheld[c]	54	20	20	94
Claim Denial Upheld	117	126	151	394
Underwriting Practice Upheld	37	16	21	74
In Favor Of Licensee Other[d]	36	28	61	125
In Favor Of Licensee Subtotal	**478**	**524**	**547**	**1,549**
Closed Other[e]	**169**	**103**	**111**	**383**
Referred To Outside Entities	**31**	**20**	**12**	**63**
Consent Order	**11**	**2**	**1**	**14**
Hearing	**2**	**0**	**1**	**3**
TOTAL	**1,104**	**1,150**	**1,133**	**3,387**

Notes:

a. "Non-Renewal/Cancellation Rescinded" includes cancellation notice and non-renewal notice rescinded.
b. "In Favor Of Complainant Other" includes advertising withdrawn/amended, claim reopened, company violated state law, deductible refunded or waived, delay resolved, endorsement processed, information furnished or expanded, no action requested/required, underwriting practice resolved, and other.
c. "Non-Renewal/Cancellation Upheld" includes cancellation notice and non-renewal notice upheld.
d. "In Favor Of Licensee Other" includes no jurisdiction/ no applicable law, premium due company, and NHID-designated other.
e. "Closed Other" includes information furnished or expanded, consumer withdrew complaint, no action requested/required, no jurisdiction or applicable law, no violation found, authorization form not received after 30 days, claim denial upheld, contract language dispute/legal issue, filed suit/retained attorney, question of fact for courts, company reimbursed consumer, company/agent settled and NHID-designated other and unknown dispositions.

Source: LBA analysis of NHID complaints data.

Enforcement Unit

The NHID has one enforcement investigator responsible for enforcement activities. The Enforcement Unit investigates possible violations of insurance laws and regulations and coordinates enforcement actions for all divisions within the NHID. Unit activities include: investigations of potential misconduct by insurance companies, insurance administrators, licensees, producers, and other insurance-related entities; establishing appropriate fines and penalties for violations found during market conduct examinations; and working with the Licensing Division to review applications for producer licenses. RSA 402-J:12 I (b) and (i) allow the NHID to refuse to issue, place on probation, suspend, revoke, or levy a penalty on producers violating insurance laws in another state or when licenses are suspended, revoked, not issued or non-renewed in another state. The Unit tracks other states' actions and issues fines or sanctions as appropriate.

Between SFYs 2004 and 2006 the Enforcement Unit processed 146 consumer complaints; 25 hearing requests under RSA 417 (the Unfair Insurance Trade Practices Act); 158 cases involving producer licenses, and 71 other enforcement actions including market conduct enforcement actions. Three of the Unit's 16 hearings and 14 of its 83 consent orders involved consumer complaints.

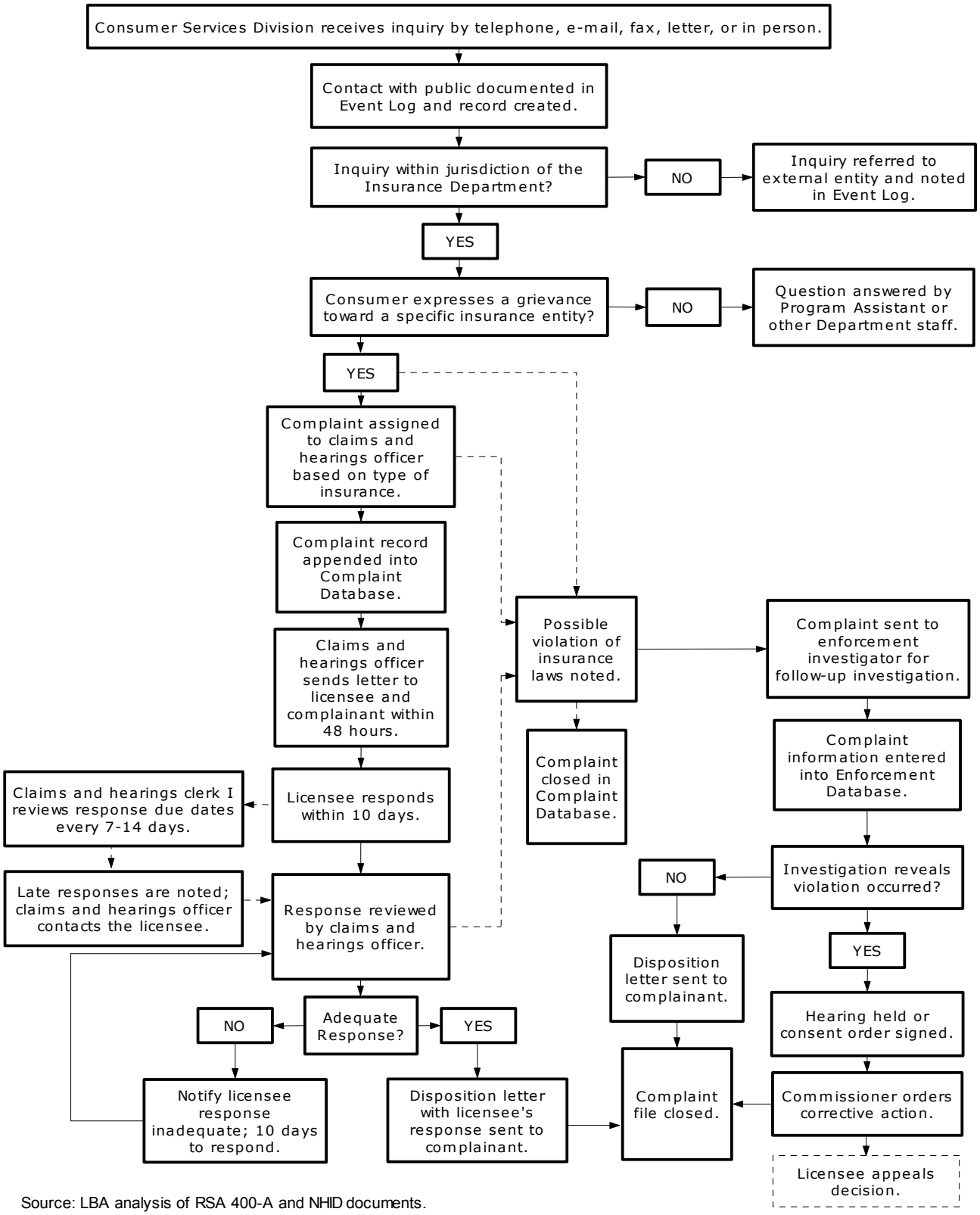
Investigations determining a violation of insurance laws or regulations may trigger a Commissioner-ordered hearing or attempt to settle the matter through a consent order. Licensees may appeal decisions to the NHID and, if denied, may appeal decisions to the State Supreme Court. The investigator explains the investigation's outcome to the consumer in a disposition letter.

External Review

The Consumer Services Division also processes external appeals of health insurance decisions and certifies external organizations as third party reviewers. RSA 420-J:5-a allows consumers to appeal HMO decisions to an independent external reviewer after exhausting all internal appeal procedures. Consumers may request either a standard or expedited review. Standard review requires consumers be notified within seven business days if they are entitled to an external review. Consumers may petition for an expedited external review if the time frames specified in RSA 420-J:5-b would seriously jeopardize the life or health, or ability to regain maximum function, of covered persons. For expedited reviews, under RSA 420-J:5-c, the NHID must immediately determine if consumers are entitled to external review and the external reviewer must make a decision within 72 hours. Between SFYs 2001 and 2006, the Division received 285 requests for external reviews; 140 requests (49 percent) met statutory requirements for external review. Sixty-one (44 percent) requests accepted for external review were reversed or partially reversed.

Figure 4

Consumer Complaint And Inquiry Processing Flow Chart



Source: LBA analysis of RSA 400-A and NHID documents.

Financial Examinations Division

The Financial Examinations Division reviews insurance company solvency by analyzing financial statements and on-site financial examinations. The Division also reviews license applications; grants, suspends, or revokes licenses based on a company's financial condition; monitors business changes that require regulatory action such as mergers, ownership changes, rehabilitations, and liquidations; and regulates surplus lines of insurance. The Division has 14 authorized positions. Eight personnel conduct financial examinations and five perform financial analysis. The Division also contracts with private examiners and firms for specialized skills or to supplement its own financial examinations staff as needed. As of August 2007, there was one vacancy in each section. As of June 2006, the NHID licensed over 950 insurance companies to do business in New Hampshire, including 41 domestic companies.

Financial Analysis

Through financial analysis the NHID monitors insurance company financial condition between formal financial exams. Analysts follow the NHID *Financial Analysis Procedural Manual* and the NAIC's *Financial Analysis Handbook*, which has been adopted into State law. Every domestic company's quarterly and annual statement is analyzed. Analysts also perform a less in-depth annual analysis of companies domiciled in other states, assuming other states' regulators are performing reasonable and reliable in-depth analyses of their domestic companies.

Companies file financial statements with both the NHID and the NAIC. Using the NAIC's *Personal Information Capture System*, financial analysts receive timely notification of domestic company financial statement filings, *Financial Analysis Solvency Tool* (FAST) scores, and *Insurance Regulatory Information System* (IRIS) ratios. The system also identifies companies the NAIC has designated as a priority for analysis. The NHID uses the NAIC priority ratings and the *Procedural Manual* to determine the priority order for reviewing domestic companies. As of the second quarter of 2006, one company was designated Priority A, five were designated Priority B, 11 were designated as Priority C, and 23 had no priority rating. One company was new to New Hampshire in 2006, and had not yet been assigned a rating.

- "Priority A" refers to companies where the NHID has already taken formal action (i.e. supervision, rehabilitation, or liquidation) due to financial impairment; or may have to within 18 months.
- "Priority B" refers to companies whose financial statements indicate a deteriorating financial condition that may require NHID action within 18 to 60 months.
- "Priority C" refers to companies where the NHID has noted an event or trends warranting further monitoring. All HMOs are assigned a priority rating of at least C.
- "No Priority" refers to companies where past analysis did not indicate current financial condition concerns.

After identifying priority ratings and creating an order to review companies, NHID financial analysts obtain company profile reports, IRIS ratio reports, and FAST score reports from the NAIC's *Internet-State Interface Technology Enhancement* (I-SITE). I-SITE allows states to obtain a company's financial profile compiled from the company's annual financial statements.

Analysts prepare summary reports for each quarterly and annual analysis, containing important information from the checklists and a conclusion. The Chief Financial Examiner reviews each analysis file.

Adverse material findings from an analysis are communicated to Division management, who determine appropriate regulatory action. Regulatory action may include supervision, wherein the NHID discusses financial concerns and obtains the company's correction plan. The NHID may monitor company progress in meeting the corrective action plan. The NHID may also require the insurer submit its business plan. Concerns regarding financial condition during a financial analysis may also trigger informal review of company practices, including rates and record keeping, to identify reasons for the financial condition. Informal review may trigger a targeted, or limited scope, examination of one aspect of company operations or a full-scope examination of all financial aspects.

Financial Examinations

RSA 400-A:37, I authorizes the NHID to examine any company as often as the Commissioner deems appropriate but at a minimum of once every five years for each State-licensed insurer. For companies domiciled in other states, RSA 400-A:37, I(c) allows the Commissioner to accept an examination report prepared by the insurance company's state of domicile, if the insurance department conducting the exam was accredited by the NAIC's Financial Regulation Standards and Accreditation Program at the time of the exam, or if the exam was conducted under supervision of an accredited insurance department. As of December 2006, 49 states and the District of Columbia were accredited by the Financial Regulation Standards and Accreditation Program. The New York State Insurance Department has not been accredited by the NAIC since June 2001. Washington State was also not accredited for a portion of the audit period.

The Financial Examinations Division schedules examinations of New Hampshire's 41 domestic insurance companies every three to five years, or more often if analysis of company financial statements reveals financial trouble. Financial examination assesses company solvency by ensuring there is an adequate level of loss claim or liability reserve and the quality of company investments. The Division follows NAIC standards established in *The Financial Condition Examiner's Handbook, The Accounting Procedures Manual,* and *The Administrative Policies Manual Of The Financial Regulation Standards Accreditation Program*. From SFYs 2001 to 2006, the Division completed 70 financial exams, ranging between six and 16 examinations each year. The average length of time to complete a financial examination was 12 months.

Financial Examination Process

The NHID prioritizes companies for examination based on concerns documented during annual and quarterly analyses of financial statements. Companies with concerns are examined in the beginning of the year, while companies whose review did not trigger a concern are examined towards the end of the year.

When beginning an examination, the NHID announces it in the NAIC's *Examination Tracking System* to allow other states opportunity to participate. Companies are notified approximately

one month in advance of examiners arriving, and receive a certificate of authority, outlining the scope of the examination and the examiners assigned. The examiner in charge (EIC) requests preliminary information and data from the company. The company's financial analysis file, work papers from prior examinations, a risk assessment of the company's five activity cycles (i.e., premium, losses and benefits, reinsurance, investments, and operating), and NHID established materiality thresholds are all part of the preliminary examination plan.

The Division uses an electronic work paper software package for documenting financial examinations. The EIC maintains the entire examination plan, while individual examiners have parts of the plan specific to their examination-related responsibilities on their computers. Examiners keep the EIC's examination plan updated by sharing their files and uploading to the EIC's computer. Examiners present findings to the company and any material adverse findings are noted in the examination report.

Contracted Examiners And Examination Firms

The NHID employs eight examiners to examine domestic insurers and uses contracted examiners as needed for expertise or to supplement its own staff. Between SFYs 2003 and 2006, the NHID used 12 different contracted examiners or examination firms in 16 exams, at a cost of approximately $6 million. See Observation Nos. 9, 10, and 11 for our concerns regarding contracted examiners and examination firms.

Examination Billing

Using an electronic tracking system, NHID staff examiners track billable hours and examination-related expenses including airfare, hotels, and meals. The NHID only bills companies for time spent on financial and market conduct examinations. Time spent on financial or market conduct analyses are not billed. The electronic tracking system allows the NHID to establish threshold limits for each expense category. Expenses exceeding the threshold limit or not allowed are automatically flagged and an electronic report is sent to the NHID Business Administration Unit for resolution. Examiners also complete State Form A-4 for expense reimbursement.

Data from time and expense reports are entered into the NHID data warehouse and converted into billable days based on a 37.5 hour work week. Monthly billing statements are sent to companies under examination for payment. The NHID bills companies monthly at an *estimated* per diem rate, which in November 2006 was $1,100 per billable day. This rate applies to billable hours for both financial and market conduct examinations. At the end of the fiscal year, the NHID determines the actual cost of operating the Financial Examinations and Market Conduct Divisions and calculates an *actual* per diem rate by dividing the cost of operating the two divisions by the number of billable hours for the fiscal year. The NHID applies this *actual* rate to each company's billable hours for that fiscal year, credits the company for monthly bills paid throughout the fiscal year, and sends a supplemental bill or refund as applicable. The NHID periodically adjusts the *estimated* per diem rate throughout the fiscal year if it determines the rate does not adequately cover its cost of conducting examinations.

Supervision, Rehabilitation, And Liquidation

The NHID may use various administrative actions, from supervision to rehabilitation and liquidation, for problems found following financial analysis or examination. Supervision is the least severe action, where companies must meet with the NHID regularly to consult about their daily operations. During this stage, the NHID advises on company operations, obtains plans to correct concerns, and monitors progress towards goals in the plans.

RSA 402-C:15 allows the Commissioner to file a verified rehabilitation petition in the Superior Court on several grounds including, but not limited to, liquidation or internal fraudulent activities. The NHID appoints a rehabilitator to take possession of an insurer's assets and daily operations in an attempt to return it to the market. Under RSA 402-C:17, the rehabilitator has authority to take necessary actions to reform and revitalize the insurer, including submitting a plan to the court for reorganization, consolidation, conversion, reinsurance, merger, or other transformation. Supervision and rehabilitation allow companies to continue operating and allow the NHID time to assess long-term solvency and prepare for liquidation if necessary.

Rehabilitators may petition the court for a liquidation order when, in association with the NHID, they determine further attempts to rehabilitate insurers would be hazardous or substantially increase the risk of loss to creditors, policyholders, or the public; insurers are about to become insolvent; or insurers are systematically reaching settlements or obtaining releases from claimants then delaying payment of the claim. The NHID may appoint a liquidator to take possession of company assets and file a proposal for dispersing them. The proposal must reserve amounts for paying administration costs and outstanding claims.

Rate And Form Compliance And Actuarial And Analytical Divisions

The Rate and Form Compliance and Actuarial and Analytical Divisions review proposed rates and forms. Each division performs a separate and distinct review of insurance forms and rates for consistency with State law and NHID administrative rules.

Until 2004, rates for all insurance lines needed prior approval from the Commissioner before use in the marketplace. Effective January 2004, RSA 412 allows additional rate approval methods. Known informally as the *Competitive Rating Law*, RSA 412:16 VII(b) allows using rates for certain lines of commercial property and casualty insurance prior to approval by the Commissioner. The *Competitive Rating Law* requires insurers writing certain commercial lines to file their rates and forms *within* 30 days of initial use rather than filing the rate 30 days before use. This is called the *use-and-file* method. The *use-and-file* method allows companies to respond to market change more quickly and allows them to market products more quickly. Theoretically, this fosters a more competitive market.

Rate changes in personal property and other casualty insurance lines still must be filed 30 days prior to their effective date. Filings not disapproved within 30 days may be used prior to NHID approval. This method is called *file-and-use*. Rates subsequently found problematic by the NHID must be corrected before any more policies are sold. Remediation goes forward and policies sold

prior to correction remain in effect until renewed. RSAs 408:52 and 415:1 require the Commissioner to approve all life, accident, and health insurance rates and forms prior to use.

The NHID uses an on-line filing system developed by the NAIC called the *System for Electronic Rate and Form Filing* (SERFF), which allows insurers to submit their rate and form filings electronically. Neither SERFF nor the NAIC review rate or form filing; the system routes the filings directly to the correct state insurance department. SERFF enables companies to send and states to receive, comment on, and approve or reject insurance industry rate and form filings. States submit their filing submission requirements checklists to SERFF and insurers log-on to check the up-to-date requirements and file the correct documents. According to the NAIC, using checklists increases the efficiency of filing preparation by increasing the accuracy and completeness of the filings. New Hampshire participates fully in SERFF, accepting property and casualty (P&C), and life, accident, and health (LAH) insurance filings. State SERFF filings increased from 12 percent in SFY 2003 to 46 percent in SFY 2006. All 50 states, the District of Columbia and Puerto Rico use SERFF, allowing the system to serve as a one-stop shop for companies with multi-state filings.

As Table 5 shows, the NHID received 25,325 rate and form filings between SFYs 2003 and 2006. Approximately 57 percent of filings were forms, 27 percent were rates, and seven percent were combined rates and forms. As shown in Table 6, between SFYs 2003 and 2006, the divisions reviewed 25,626 filings, 83 percent of which were approved. Six percent of filings were disapproved after review, while three percent were rejected prior to review because they did not comply with basic submission requirements.

Rate And Form Compliance Division

The Rate and Form Compliance Division has two functional areas: property and casualty; and life, accident, and health. Each functional area has five staff. The Division reviews policy and endorsement forms to ensure they conform to State laws and NHID administrative rules prior to use, with some exceptions.

For P&C insurance, RSA 412:5, I requires filing "policy forms, endorsements, and other commercial language" with the NHID "for a waiting period of 30 days before it becomes effective…" RSA 412:7 allows an exemption to the filing requirements for P&C forms and policy contracts for large commercial policy holders as defined by statute. According to RSA 412:5, a form filing is deemed to be approved unless denied by the Commissioner prior to expiration of the 30-day waiting period, unless the Commissioner orders an extension.

For credit life, accident, and health insurance, RSAs 408-A:7, 415:1 and 415:2 require filing all policies with the Commissioner for approval 30 days before use. The Commissioner must deny the filing within 30 days and insurers are prohibited from marketing the policy prior to the end of the 30-day period without written authorization from the Commissioner. RSA 408:52 requires all life insurance contracts to receive approval prior to being sold.

Table 5

Rate And Form Filings Filed By Type
State Fiscal Years 2003-2006

	2003		2004		2005		2006		TOTAL
	P&C	LAH	P&C	LAH	P&C	LAH	P&C	LAH	
Rate[a]	1,162	115	1,505	278	1,671	245	1,657	246	**6,879**
Form	1,378	1,630	1,480	2,428	1,736	2,121	1,692	2,053	**14,518**
Rate and Form	651	11	336	164	74	207	26	228	**1,697**
Other[b]	14	162	75	395	242	512	312	519	**2,231**
TOTAL	**3,205**	**1,918**	**3,396**	**3,265**	**3,723**	**3,085**	**3,687**	**3,046**	**25,325**

Notes:
a. "Rate" filings includes rule filings.
b. "Other" includes filings that did not have a designation, advertising, actuarial calculation, and loss cost.

Source: LBA analysis of NHID rate and form filing data.

Table 6

Rate And Form Filings Reviewed By Type
State Fiscal Years 2003-2006

	2003		2004		2005		2006		TOTAL
	P&C	LAH	P&C	LAH	P&C	LAH	P&C	LAH	
Approved	2,995	1,337	3,179	2,274	3,454	2,280	3,398	2,265	**21,182**
Disapproved	213	122	176	335	100	262	133	301	**1,642**
Filing Rejected	29	37	109	102	136	105	164	98	**780**
Withdrawn	90	21	57	71	77	85	49	96	**546**
Other[a]	1	264	0	463	0	389	0	359	**1,476**
TOTAL	**3,328**	**1,781**	**3,521**	**3,245**	**3,767**	**3,121**	**3,744**	**3,119**	**25,626**

Notes:
a. "Other" includes 'information only-form previously approved' and 'information only.'

Source: LBA analysis of NHID rate and form filing data.

The NAIC encourages insurance departments to develop review standards checklists outlining each state's filing and policy language requirements for each line of insurance. To promote uniformity in the filing process and help speed insurance products to the marketplace, the NAIC has developed a best practices guide and model checklist for each line of insurance to help states develop their review standards checklists. These are intended to provide clear expectations regarding product filing requirements, enhance the speed and uniformity of review, provide the basis for eliminating inconsistencies between state filing requirements, and eliminate unnecessary regulations. The NHID has developed review checklists for most lines of insurance written in New Hampshire. Checklists outline requirements for policy forms and statutory or administrative rule references for each requirement.

Actuarial And Analytical Division

The Actuarial and Analytical Division has two functional areas: property and casualty; and life, accident, and health. One actuary staffs each functional area. The Division reviews all actuarial aspects of forms, rules, and rates to ensure: premium rates and rating plans are not excessive, inadequate, or unfairly discriminatory; and premium rates conform to State law. Actuaries also assist in drafting legislation, setting regulatory policy, providing actuarial expertise to other NHID divisions, reviewing insurance company financial statements for compliance with statutory requirements, and assessing financial standing.

RSA 412:16, II requires every insurer, unless exempt by RSA 412:16, I, to file every proposed manual, minimum premium, class rate, rating schedule or rating plan and every other rating rule, as well as every modification. In a competitive market, RSA 412:16, VII requires insurers to file rates and supplementary rating information for personal risk policies at least 30 days before the effective date and within 30 days of the effective date for commercial risk policies unless the Commissioner determines an insurer's rates require closer supervision. In this case, the Commissioner may require the insurer to submit rates at least 30 days before the effective date for all policies, including commercial lines of insurance. Policies issued to large commercial policyholders are exempt from these filing requirements. In a non-competitive market, RSA 412:16, VIII requires filings to be on file for a 30-day waiting period before becoming effective. This period may be extended by the Commissioner for an additional period not to exceed 30 days to consider the filing. RSAs 408-A and 415 govern requirements for life, accident, and health rate filings, which must receive approval prior to being used.

RSA 412:15, I requires P&C insurance rates not be excessive, inadequate, or unfairly discriminatory. It further states a rate in a competitive market is not excessive. As such, the NHID relies on market forces to keep rates in check. However, in a non-competitive market, a rate is considered excessive if it is likely to produce an unreasonably high profit, or if expenses are unreasonably high in relation to the services provided. A rate is considered inadequate if it is unreasonably low for the insurance provided and continued use endangers the company's solvency, or if the rate is unreasonably low for the insurance provided and using it has or will substantially lessen competition or create a monopoly in the market. A rate is unfairly discriminatory if, after allowing for practical limitations, price differentials fail to equitably reflect differences in expected losses and expenses. RSA 415:2 authorizes the Commissioner to disapprove accident and health insurance forms if the accompanying rates are unreasonable compared to the premium charged; contain unfair, unjust, or inequitable provisions; or do not in other ways comply to the requirements of law.

Insurers must submit a rate filing each time they introduce a new product or when they change the rate for an existing product; however, the NHID requires Medicare Supplement providers to submit annual rate filings. There are typically six cost components used to calculate each rate: expense to cover anticipated losses, loss adjustment expenses (e.g. cost of insurance adjusters and legal representation), brokers' commissions, general administrative expenses, premium taxes, and company profit. Insurers submit proposed rates along with supporting documentation including past and projected operating expenses and losses. When reviewing rate filings, NHID actuaries analyze company-specific data and assumptions to ensure proposed rates or rate

changes are reasonable and justified. The NHID does not specify rates companies must charge, nor can it require a company to reduce costs for specific cost components. Instead it reviews the company's actual historic cost data and determines if rates are adequate to ensure future solvency and the rule filings are not unfairly discriminatory. The NHID has a requirement that rates may not be excessive for any life, accident and health lines of business, as well as workers compensation and medical malpractice coverage. In competitive property and casualty markets other than workers compensation, New Hampshire's rate review law does not allow rates to be disapproved as excessive. Instead the law relies on the market to regulate rates.

The Division does not monitor the marketplace to ensure rates rejected by the NHID are not used in the marketplace, nor does it monitor to ensure rates remain adequate after approval. Instead it relies on the other divisions within the NHID to ensure rates are adequate and to ensure insurers use the NHID-approved rates. The Financial Analysis Division examines financial statements submitted by companies to determine performance and solvency. During a market conduct exam, examiners test to ensure companies are using NHID-approved rates. Examiners will randomly select policies to ensure the rates used match those on file. Additionally, actuaries assist Consumer Services Division personnel with consumer complaints involving rate disputes.

Significant Achievements

It is important to recognize performance auditing by its nature is a critical process, designed to identify problems or weaknesses in past and existing practices and procedures. Noteworthy management achievements within the scope of the audit are included here. Such information provides a more fair representation of the situation by providing appropriate balance to the report. Significant achievements are considered practices, programs, or procedures that perform above and beyond normal expectations. Changes to enhance efficiency or effectiveness could be considered a significant achievement.

Credit Life/Disability Premium Return

The NHID worked with the New Hampshire banking community to ensure consumers who purchased pre-paid credit life and credit disability insurance as part of their loan transaction when they purchased automobiles received premium refunds if they paid the loan prior to the maturity date. The NHID worked with the Banking Department to identify banks failing to notify insurers of early auto loan payoffs. The NHID contacted the insurers, informed them of the early payoffs, required they issue premium refunds, monitored the payoffs with bank personnel, and required documentation to ensure all refunds due were made. Over 2,100 consumers have realized premium refunds totaling almost $650,000 as a result of NHID efforts.

"Health Cost" Website To Provide Comprehensive Healthcare Information System

The NHID worked with the New Hampshire Institute for Health Policy and Practice at the University of New Hampshire (UNH) to develop the "Health Cost" website. For the first time, price information became available to healthcare consumers on the cost of healthcare services. The Health Cost website is designed to provide New Hampshire consumers with information

necessary to make informed decisions about the purchase of healthcare - information the NHID considers critical to the success of high deductible, Health Savings Account compatible products.

Disseminating Customized Medicare Information

In February 2006, the NHID Consumer Services Division entered into a partnership with the UNH Cooperative Extension Service to customize Medicare Supplement insurance information available in New Hampshire. The UNH Cooperative Extension Service developed a database program based on the company and premium information supplied by the NHID that provides age-specific rate information for each New Hampshire carrier's Medicare supplement plans. When a consumer makes a request to the NHID, the UNH Cooperative Extension Service mails the consumer an age-specific report showing rates for each Medicare supplement plan available. The goal is to reduce the volume of information a consumer needs to compare costs.

Consumer Services Division Complaint Database

Prior to January 2003 the NHID Consumer Services Division manually processed all consumer complaints and inquiries, and exclusively maintained paper records. Not only was this process inefficient, it did not provide effective supervision or ensure accountability of Division employees. Additionally, it was difficult for management to ensure quality service was being provided to consumers. The manual system required manual review to obtain data and statistical information to respond to management's, Legislators', and others' needs. It also discouraged communication and information flow with other NHID divisions, which need complaint information on a regular basis to effectively perform their functions. Finally, in order to respond to information requests, Division personnel were often distracted from their consumer service duties to manually count and calculate complaint statistics.

Front-line Consumer Services employees needed procedures and a specialized tool to provide easy recording of complaint information, as well as to ensure consistency in collecting information and complaint processing. The necessary tool would provide consistency in the complaint-processing workflow, permit users to keep track of multiple open cases and their status, provide demographic and trend information to management, provide analytical data for market conduct and other department functions, reduce or eliminate errors, and ensure employee accountability and consumer satisfaction.

The Division Director worked directly with NHID Information Technology programming personnel to develop a computerized platform database that would meet this diverse set of needs. Since its implementation, the database has been invaluable to the NHID and has numerous specialized features that have been incorporated into the NAIC "State Based Systems" consumer complaint module. The module is being used by other states, including New Jersey, Rhode Island, Delaware, and Washington, D.C.

The database is an effective and efficient mechanism that has ensured immediate information flow and NHID-wide accessibility to complaint information. It has resulted in greater responsiveness to the public, employee accountability, and dramatically improved record-keeping and statistical data.

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LBA LOGIC MODEL
OF NHID CONSUMER PROTECTION FUNCTIONS

The New Hampshire Insurance Department's (NHID) mission is to promote and protect the public good by ensuring a safe and competitive insurance marketplace by developing and enforcing insurance laws and administrative rules. Our audit evaluated three functions or processes the NHID performs to achieve this mission: consumer assistance, financial examinations and analyses, and rate and form review.

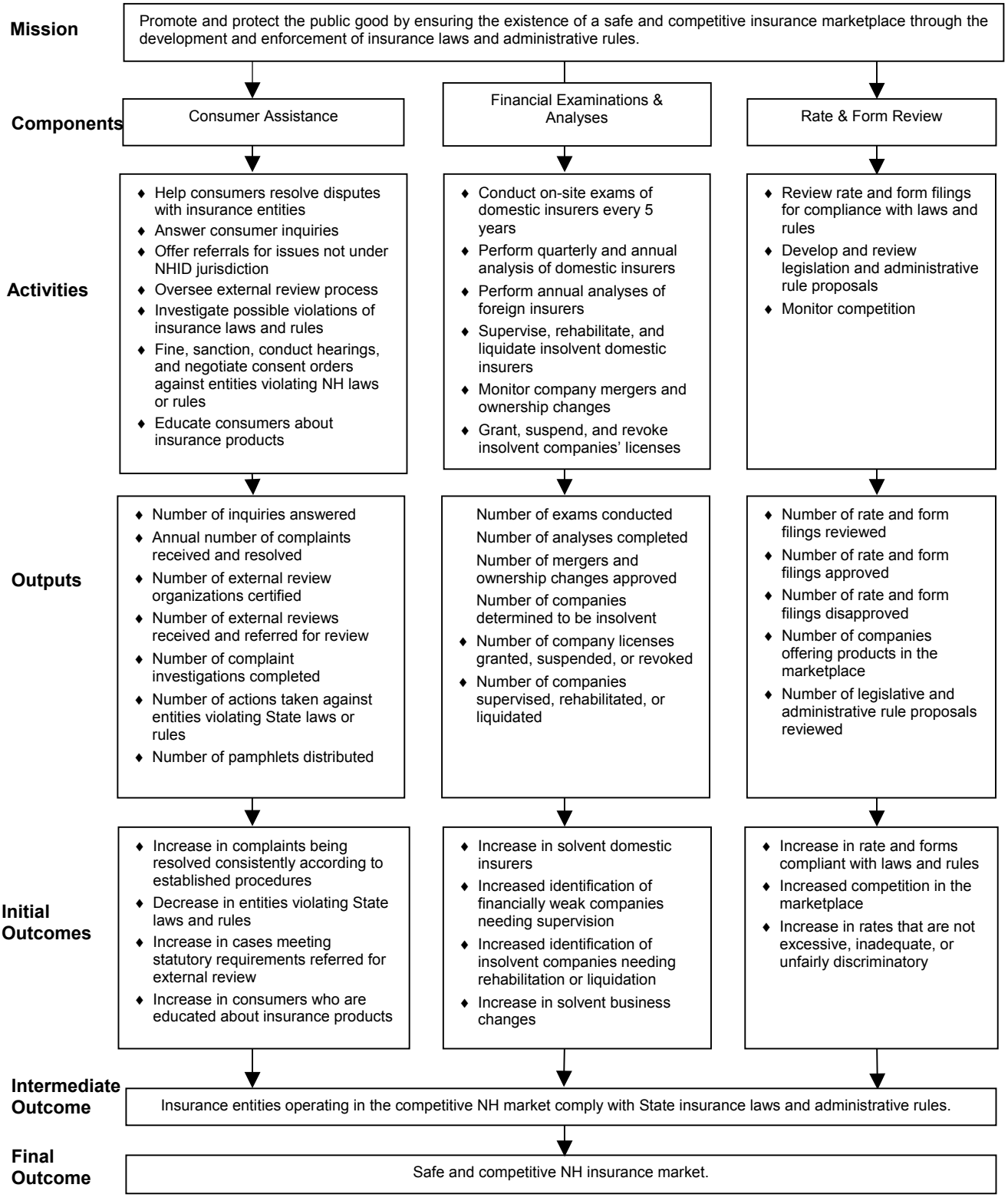
When measuring the performance of a program, one of the more difficult questions to answer is what contribution the program made to a department's outcomes. In most cases, there are many factors influencing outcomes in addition to the impact of a program's efforts. Determining the absolute extent to which a government program contributes to a particular outcome is not usually possible. Instead, the aim of performance measurement is to acquire insight and provide some evidence the program is actually having an impact. A key tool for determining attribution is a logic model, which illustrates intended relationships.

Logic models are presented as flow charts describing functions in a way that facilitates developing relevant measures by portraying intended causal relationships between activities, outputs, and outcomes. The flow chart thus illustrates how a program intends to solve identified problems. Individual program activities, outputs, and outcomes are arranged in rows. Relationships between the various activities, outputs, and outcomes are arranged vertically on the page according to the sequential flow of program logic. The arrows linking the program elements signify the intended flow of the program.

The NHID's mission and goals are included at the top of the page as reference points to show the rationale of the program. The activities describe what the program does to produce outputs. The outcomes are what the program hopes to change. Therefore, program outcomes, or the intended impact of the program, should be linked to the goal and mission. We present the following logic model, Figure 5, to aid in understanding of the NHID's activities when conducting consumer assistance, financial examinations and analysis, and rate and form review.

Figure 5

LBA Logic Model Of NHID Consumer Protection Functions



Source: LBA analysis of NHID processes.

CONSUMER SERVICES

The Consumer Services Division responds to consumer complaints and inquiries, and assists consumers in resolving their disputes with New Hampshire Insurance Department (NHID) licensees. The Division uses the National Association of Insurance Commissioners' (NAIC) definition of a complaint and has implemented its own procedural manuals for responding to consumer complaints. The Division does not formally prioritize complaints and staff strive to treat every complaint equally. The Division processed 3,397 complaints between State fiscal years (SFY) 2004 and 2006.

Our audit found 71 percent of consumers expressed satisfaction with how the Division processed their complaint and 72 percent reported the Division processed their complaint fairly. Our audit also found some inconsistencies in the way the NHID Consumer Services Division handles consumer complaints. Personnel who respond to consumer complaints do not always consistently apply the Division's procedural manuals or administrative rules. We found incomplete procedural manuals or not formally approved processes in the Enforcement Unit. In addition, records of complaints in the Complaints Case Management System (Complaint Database) and the Enforcement Case Management System (Enforcement Database) are not always complete or accurate. This is possibly due to insufficient oversight of data entry on the part of Division management. The Department should formally adopt procedures in use and reduce data entry errors in its databases by implementing additional quality control processes. These steps will help to reduce inconsistent processing of consumer complaints and ensure record keeping and oversight are improved.

Observation No. 1

Ensure All Phone Complaints Are Recorded In The Complaint Database

The NHID does not record all phone complaints in the Consumer Services Division's Complaint Database. The National Association of Insurance Commissioners defines a complaint as "any communication – written or oral – that expresses dissatisfaction with a specific insurance company or agent or other regulated entity." The Consumer Services Division applies this definition to its complaints. According to the Consumer Services Division Director, if the Division intervenes on a consumer's behalf, the Division considers it a complaint. However, Consumer Services Division personnel responsible for processing complaints reported complaints received over the phone are not officially complaints. These unofficial complaints are logged into the Consumer Assistance Tracking system (Event Log). Personnel stated some of these complaints can be resolved simply by telephoning the insurance company and are only entered into the Complaint Database if money is recovered or if the consumer ultimately decides to submit a complaint in writing.

We reviewed all 1,036 Event Log entries for June 2006. We found 13 instances (1.25 percent of entries in the Event Log) where Consumer Services Division personnel intervened on behalf of a consumer but did not record it in the Complaint Database. Of the 1,036 entries for June 2006, 124 were complaints, including the 13 phone complaints (ten percent) not logged into the Complaint Database. In these 13 complaints, notes in the Event Log included the identification

of the insurer, as well as names and contact numbers of personnel at the insurer. The notes also indicated the Consumer Services Division contacted personnel at the insurance company on behalf of the consumer.

The Division risks under-reporting consumer complaint information if personnel are not entering all complaints into the Complaint Database. Additionally, NHID management may not have complete information on trends regarding a particular insurance issue or company. Finally, members of the public calling to request complaint information regarding a particular insurance company may not receive complete information.

Recommendation:

The Division should clarify its policy regarding processing of phone complaints. Once it clarifies the policy, the Division should ensure staff are adequately trained on the policy and establish procedures to ensure all phone complaints are recorded in the Complaint Database.

Auditee Response:

We do not concur.

The Department disagrees with the auditor's methodology in analyzing the inquiries received by the Department in the month of June 2006. When a consumer contacts the Department, staff must determine whether the call is an "inquiry" and thus only entered into the Event Log, or whether the call rises to the level of a "complaint" and must be entered into the Complaint Database. If Consumer Services personnel do not believe that a consumer inquiry rises to the level of a complaint, but in fact the inquiry is a complaint, then the mistake made is not a failure to enter the inquiry into the Complaint Database but a failure to identify the inquiry as a complaint. This is not a situation where staff recognized the inquiry as a complaint and failed to enter it into the Complaint Database. Rather, staff failed to identify an inquiry was a complaint and needed to be entered into the Database.

The auditors cite 13 instances where staff erroneously determined that the call from the consumer was an inquiry rather than a complaint. One individual made 12 of the 13 data entry errors cited by the auditors in this one month period out of the nearly 3-1/2 years, or 42 months, that were within the scope of the audit. Of over 1,000 calls processed and entered as inquiries during this month in question (June 2006) in only 13 of those calls did staff make the incorrect determination as to whether the contact was an inquiry or a complaint.

The auditors characterize the failure to identify the 13 calls as complaints rather than inquiries as a failure to record all phone complaints in the Complaint Database, resulting in a 10% error rate (13 complaints out of a total of 124 complaints misidentified as inquiries and not logged into the Complaint Database). The Department feels that the 13 mistakes represents staff's failure to properly identify 13 out of 1,036 inquiries resulting in a 1.25% error ratio.

The Department will strive to reduce this error rate to less than 1.25%. The Department's policy has always been that oral complaints must be entered into the Complaint Database if the oral complaint is either verified by a written complaint form or if time is of essence and there is sufficient information provided orally to process the complaint without a written complaint form. Oral complaints that do not provide sufficient information for Consumer Services staff to act and for which the consumer fails to provide that information either orally or in writing are not entered into the Complaint Database and, in order to preserve the integrity of the Complaint Database, should *not be entered. This policy prevents over-reporting of complaints, erroneous complaints and the false representation of trends regarding any particular issue or company.*

The Department believes that consumer services staff are effectively processing oral complaints received by the Department. However, we agree that this is an important matter and will strive to further reduce the error rate. In that spirit, procedures have been reviewed again with staff at a recent staff meeting and staff received additional instruction and demonstration on the Division's Event Log and Complaint Databases. In addition, to further clarify the procedure of identifying complaints and entering them into the database, a flow chart and decision tree has been developed that will be used by staff as a "quick reference" guide.

Observation No. 2

Ensure Complaint Acknowledgement Letters Are Sent Within Two Business Days

Consumer Services Division personnel report the Division strives to send complainants an acknowledgement letter within two days of receipt of their complaint. The National Association of Insurance Commissioners' *Consumer Complaint White Paper* recommends states send an initial acknowledgment letter to the complainant within two business days of receipt of the complaint. Our file review of 300 complaints filed between January 2003 and June 2006 indicated 70 percent of complainants were not sent an initial acknowledgement letter within two days of the receipt of their complaint. When we adjusted to allow two extra days to account for weekends, our file review showed 52 percent of complainants were not sent acknowledgement letters within four days. We found the average number of days between the date the complaint was filed and the date claims and hearings officers generated the acknowledgement letter was seven days, ranging from acknowledgment letters issued on the same day the complaint arrived at the NHID to one instance in which a letter was issued 62 days after receipt of the complaint.

Additionally, our survey of consumers who filed complaints with the NHID in SFYs 2005 and 2006 indicated 26 percent (44 of 170 respondents) of complainants who answered the survey question reported they received an acknowledgement letter between one and two weeks after they filed their complaint, and 19 percent (32 respondents) reported they received their acknowledgment letter more than two weeks later. Two respondents who did not provide an answer to the survey question commented the NHID did not send an acknowledgement letter regarding their complaint. One of the two respondents reported calling the NHID three weeks after filing the complaint.

Recommendation:

The NHID should send acknowledgement letters to complainants within two business days of receipt of their complaint.

Auditee Response:

We concur.

The Division does have and did have a procedure in place to acknowledge receipt of complaints. When the Department receives a complaint, it is given to the Consumer Services Officer on that same business day. The Consumer Services Officer reviews the complaint to determine whether the Department has jurisdiction. If there is jurisdiction, the Consumer Services Officer sends an acknowledgement letter to the consumer and copy of the complaint to the licensee. Generally this process takes 2 days or less. Life, Accident and Health complaints have been consistently acknowledged within 1 business day.

However, due to the volume of Property and Casualty complaints received and insufficient staffing at the time, the Consumer Services Officer assigned to review Property and Casualty complaints was unable to review the complaint and provide an acknowledgement letter within 2 days. The Department would not dispute that due to the backlog, it took the Department longer than 2 days (instead, on average a week) to send an acknowledgement letter.

During most of the period reviewed by the auditors, the Division had only 2 Consumer Services Officers to process, review, analyze and negotiate all written complaints. Because of the expertise required for each line of insurance, one Consumer Services Officer specialized in property and casualty insurance complaints and the other handled life, accident and health insurance complaints. This is consistent with the way other insurance departments throughout the country operate.

However, the Department received on average twice the number of property and casualty insurance complaints as life, accident and health insurance complaints. Consequently, the Division experienced a backlog of property and casualty complaints and did not have sufficient staff to process acknowledgment letters within 2 business days. In most cases the fact that an acknowledgment letter was not sent within 2 business days did not mean that staff had not contacted the consumer or was not working on the consumer's complaint. Often staff were concentrating on resolving the problems that generated the complaint rather than issuing the acknowledgement letter. The Division hired an additional property and casualty Consumer Services Officer just two months prior to the end of the audit period, and as a result, the backlog and delay in sending acknowledgement letters has been eliminated.

In addition, the Department has, as of January 10, 2007, revised procedures to ensure the complainant is provided an acknowledgement of receipt of their complaint on the day it is received. An additional letter will be sent after the file is reviewed by the Consumer Services Officer that either informs the consumer that the Department has forwarded the complaint to the licensee for response, or refers the consumer to another agency or entity who can assist the consumer.

Observation No. 3

Consistently Handle Complaints Filed By Consumers Who Have Retained An Attorney

NHID Consumer Services Division personnel do not consistently comply with NHID administrative rules for handling complaints filed by consumers who have retained an attorney. INS 102.08(a) states, "The consumer services division attempts to mediate disputes between insureds and department licensees, but does not mediate or assist with disputes where the complainant is represented by counsel or the dispute is before the courts." Additionally, both the NHID web page containing complaint filing information and the informational handout sent to consumers requesting a complaint form state, "We cannot intervene in a dispute if you are represented by legal counsel or if the dispute is already before the courts."

During our file review of 300 complaints filed between January 2003 and June 30, 2006 we found the Division processed 11 cases for consumers who had retained an attorney. In five instances we found correspondence regarding the complaint was sent directly to the attorney. Conversely, during the same file review, we noted three instances in which the Division ceased processing the complaint when it became aware the consumer had retained an attorney. Also, during a review of miscellaneous correspondence between the Division and consumers in SFY 2006, we found three other complaints filed by attorneys on behalf of consumers, which the Division declined to process.

Three Consumer Services Division personnel acknowledged the Division should not process complaints filed by an attorney on behalf of a consumer. The Consumer Services Director also acknowledges the Division is not consistently following INS 102.08(a), but states the Division errs on the side of helping the public and has a moral obligation to help consumers regardless of whether they have hired an attorney. Division personnel state in instances where an attorney files a complaint on behalf of a consumer without the consumer's signature, the Division sends a form letter to the attorney, accompanied by a complaint form, stating the Division cannot intervene unless the consumer contacts it directly. However, the letter does not mention the prohibitions in INS 102.08.

The National Association of Insurance Commissioners (NAIC) does not specify a policy for handling complaints filed by consumers who have retained an attorney; however, it recommends each state establish a consistent policy based on the potential outcomes for consumers and the authority of the Division. As part of the policy, the NAIC recommends departments determine the type of attorney-represented complaints it should process.

Consumers filing complaints should have reasonable assurance their complaints are processed consistent with administrative rules. Departing from formally established administrative rules without explicitly stating why and when the NHID provides assistance to consumers who have retained an attorney may give the impression the NHID either treats consumers inconsistently or favors some consumers over others. Exceptions to established internal policies and procedures, including processing attorney-represented consumer complaints, should be made public so all consumers may take advantage of them.

Recommendation:

We recommend the NHID clearly define under which circumstances it should process attorney-represented complaints. Based on this analysis, we recommend the NHID either follow Administrative Rule Ins 102.08(a) or petition to have it changed.

Auditee Response:

We concur in part.

The Department does follow Administrative Rule Ins 102.08(a). Ins 102.08(a) does not prevent the Consumer Services Division from accepting consumer complaints from consumers represented by counsel and providing information to that consumer, to the consumer's attorney or for that matter to any licensee that is represented by legal counsel. Ins 102.08(a) only prohibits the Department from actively mediating disputes on behalf of a consumer where an attorney is already representing the consumer in the dispute in formal mediation or litigation (i.e. the dispute has been submitted to formal arbitration/mediation or a lawsuit has been filed).

The Department takes seriously its responsibility to assist consumers. Consumers have a right to retain counsel to represent their interests against licensees of the Department. Licensees of the Department are almost always represented by counsel. Licensees are permitted to request and receive assistance and information from the Department and are not prevented from doing so merely because they are represented by counsel. Similarly, the Department should provide assistance and information to consumers who retain an attorney. To withhold information or assistance to consumers (and not licensees) results in discrimination against consumers who exercise their right to obtain counsel, and this is not the Department's policy.

It is also important for the Department to receive and process complaints from consumers, even if they are represented by counsel, because these complaints bring to the Department's attention potential statutory and regulatory violations including violations of the Unfair Insurance Trade Practices Act, RSA 417:4. Neither the Department nor the auditors would find it acceptable for the Department to refuse to accept a complaint regarding an RSA 417:4 violation simply because the consumer affected is represented by counsel.

The Department has reviewed the files identified by the auditors as instances where the Department incorrectly applied Ins 102.08(a). The Department believes that in many of the instances cited, the Department did in fact correctly and consistently applying the rule.

However, the Department does agree that it can improve and clarify its policy regarding complaint processing when a consumer is represented by counsel. Therefore, the Department has reviewed again procedures in regard to Ins 102.08(a) with staff. In addition, the Department will look to amend Ins 102.08(a) to provide further clarification. The Department will also redraft the informational handout given to consumers who request a complaint form to eliminate any possible misunderstanding and will update information posted on the Department's website.

Observation No. 4

Disposition Letters To Consumers Should Provide More Explanation Regarding Complaint Resolution

The NHID Consumer Services Division personnel inconsistently provide complainants a thorough explanation of their complaint resolution, especially when the complaint was not resolved in the complainant's favor. Our survey of consumers who filed complaints with the NHID in SFYs 2005 and 2006 found 46 percent of respondents who answered the survey question (50 of 109 respondents) reported the NHID did not help them understand the reasons the complaint was not resolved in their favor.

When an insurance company provides a response to a consumer complaint, the claims and hearings officer determines if the response adequately addresses the issues in the consumer's complaint. When the claims and hearings officer is satisfied the licensee has adequately addressed the consumer's complaint, they send the complainant a disposition letter, attaching the insurance company's response.

In April 2003, the Consumer Services Division issued a training guide for using the Complaint Database. The training guide required disposition letters to contain a thorough explanation of the outcome to the consumer, especially for complaints found in favor of the insurance entity. The guide discourages simply writing that the licensee's response is enclosed, but rather states the disposition letter should explain why the licensee is correct and why the NHID cannot overturn its decision. The training guide allows a less thorough explanation if the complaint was resolved in favor of the consumer.

Our file review of 136 consumer complaints resolved in favor of the insurance company filed between January 2003 and June 2006, found 19 disposition letters (14 percent) did not provide the consumer a thorough explanation of the complaint resolution. Fifteen disposition letters (11 percent) did not explain to the consumer the information contained in the company's response. One letter stated the company's response was enclosed and the insurance company "appears to be addressing the issues involving the repair of your vehicle," while another simply stated the NHID did not find any violations of State law and the insurance company "adequately explained the actions taken" without offering the consumer an explanation of what those actions were. Four disposition letters simply stated the NHID reviewed the company's response and found no violation of New Hampshire State law; therefore, any further dispute was outside the NHID's scope. In two complaints, we found the consumer contacted the claims and hearings officer for a clarification after receiving the disposition letter.

Without more thorough disposition letters, the NHID risks dissatisfied consumers and repeat contacts from complainants who do not understand the explanation. Repeat contacts may lead to the claims and hearings officers needing to resolve the complaint a second time.

Recommendation:

The Consumer Services Division should review the effectiveness of its training guide and requirement ensuring disposition letters contain a thorough explanation of the resolution of the complaint, especially for complaints that are not resolved in favor of the consumer.

Auditee Response:

We concur.

Before a final disposition letter is sent, some consumers are contacted by phone and receive thorough verbal explanations of the company's response and the Department's determination. Complaint responses of this nature generally do not require further written reiteration of details that were previously explained directly in a telephone conversation. In addition, a telephone call affords the consumer with the opportunity to contemporaneously ask questions, get more detailed information, and have questions answered without the delays associated with written correspondence. A dialogue about the issues is often helpful to the consumer and provides the information in a timely manner. When complaints are time sensitive, this method is especially effective. Under circumstances such as these, any subsequent letter providing the same level of detail as the telephone conversation is redundant.

If in the auditor's opinion some disposition letters were not sufficiently thorough and detailed, this could be due in part to telephone calls to the consumer, thorough explanations from the insurance company - whose response is forwarded to the consumer - or the caseloads of the Consumer Services Division prior to the hiring of an additional consumer services officer. It should also be noted that the standard form of the closing of each response letter issued by the Department urges the consumer to contact the NHID if they have any remaining questions or concerns about their complaint, and provides the NHID toll free consumer hot line telephone number.

The auditors do not mention that the NHID routinely mails a postage prepaid satisfaction survey to random complainants much more contemporaneously with the closing of the complaint than the survey sent by the auditors. The NHID customer satisfaction survey form provides a space for the consumer to request additional assistance and/or information. Consumers who ask for additional explanation or assistance on the survey receive a call from the Department and additional information or assistance is provided. The auditors were provided with copies of the Department's consumer satisfaction survey. Consumer response to NHID surveys beginning in 2003 indicate an overall satisfaction rate of 87% with the Department's handling of consumer complaints. In addition, 89% of respondents indicated that all of their questions were answered and 91% indicated that the disposition letter was clear and understandable.

The Department strives to assist consumers in resolving insurance concerns. However, despite NHID best efforts, some consumers will remain dissatisfied with the resolution of their complaint because the Department may have been unable to provide the remedy which they believe, sometimes mistakenly, they are entitled to under their insurance contract or the law. Regardless of the detail provided in any letter to a consumer, a consumer who is dissatisfied with the outcome of their situation may feel the Department did not help them understand the reason his or her complaint was not resolved favorably.

However, the Department concurs that disposition letters should always contain a thorough explanation. Therefore, the Consumer Division Director earlier this year reviewed procedures regarding disposition letters and relevant sections of the Database training guide with division staff and has reinforced the need for more detailed explanation in disposition letters. Staff have also received additional instruction to offer and send brochures on related subject matter to the consumer to further educate the consumer on the type of insurance that is the subject of the complaint. Further, disposition letter content is being reviewed as part of the formal quality review evaluation actions outlined in our response under Observation No. 7.

In addition, in order to ensure the Department obtains immediate feedback from consumers who wish to provide it, the NHID has taken action to have an electronic survey feature added to the department's web site that will allow consumers to log on and provide their feedback immediately after receiving a response to their complaint. Consumers will be notified of the availability of the survey in the complaint response letter they receive from the Department. This feature will also allow the consumer to request a call back if there's a need for additional explanation or additional information. We anticipate this function will be available to consumers within the next year after the Department's new web site becomes operational.

Observation No. 5

Establish A Formal Procedure For Referring Complaints To The Enforcement Investigator

The NHID Consumer Services Division does not have a formal process for referring consumer complaints to the enforcement investigator. It also does not have a process for following up on complaints that have been referred to the enforcement investigator. The Division's informal policy requires personnel forward all complaints alleging violations of any insurance law or regulation to the enforcement investigator. Additionally, the Division has drafted a procedure requiring personnel forward all correspondence alleging a violation of RSA 417 (Unfair Insurance Trade Practices) directly to the enforcement investigator. The most recent version of the procedure was drafted in September 2004 but has not been formally adopted. During our audit period, the enforcement investigator worked within the Consumer Services Division. In June 2006, the enforcement investigator was moved from the Division and reported directly to the Chief Market Conduct Examiner. The NHID was in the process of reorganizing during our audit and as of December 2006, the NHID anticipated creating an Enforcement Unit consisting of an enforcement attorney and two enforcement investigators.

Consumer Services Division personnel identify two methods of referring complaints to the enforcement investigator. Personnel informally discuss potential violations of insurance laws and

regulations found while processing consumer complaints and physically transfer the file to the enforcement investigator. Consumer Services Division personnel close the complaint in the Complaint Database choosing "Referral to Department of Insurance Enforcement" as the disposition. The Complaint Database does not create a formal referral or notification to the enforcement investigator indicating the complaint has been referred. In November 2006, the Consumer Services Division began sending e-mail confirmation of complaints referred to the enforcement investigator. During our review of the Complaint Database from January 2003 through June 2006, we found 20 complaints whose disposition stated they had been referred to the enforcement investigator. Of these 20 cases, 13 were investigated and documented in the Enforcement Database; however, we found seven of the 20 did not have a corresponding entry in the database. The enforcement investigator retained hard copy files for two of the seven cases and informally determined two other cases did not warrant investigation; however, there was no record the other three cases were ever processed. Additionally, during our file review of 300 consumer complaints filed between January 2003 and June 2006, we found ten complaints alleging insurance agent or adjuster misconduct and four complaints specifically alleging violations of RSA 417, which were not referred to the enforcement investigator. We found an additional 13 complaints identifying potential violations of insurance regulations such as delays in claims payment and processing, which were also not referred to the enforcement investigator.

Personnel also stated complaints clearly alleging violations of insurance laws and regulations are sometimes referred directly from the Event Log to the enforcement investigator. During a review of the Event Log we found 113 complaints, which had been referred directly to the enforcement investigator. Of these 113 complaints, we could not find corresponding records in the Enforcement Database for 54 complaints; however, we found records in the Complaint Database for four of these 54 complaints.

Without a formal process for referring complaints to the Enforcement Unit, the NHID risks complaints involving potential violations of insurance laws and regulations are not properly referred. Additionally, the NHID runs the risk referrals do not receive appropriate follow-up attention. With the anticipated creation of an Enforcement Unit independent of the Consumer Services Division, formal procedures should ensure each Division is aware of its responsibilities regarding consumer complaint referrals.

Recommendation:

The NHID should establish a formal procedure for referring complaints to the Enforcement Unit. The procedure should include identification of complaints that should be referred to the Enforcement Unit, adequate documentation the complaint was referred, and follow-up procedures to ensure cases referred are received by the Enforcement Unit.

Auditee Response:

We concur in part.

The Division does have an established formal procedure for referrals and documentation of referrals to the Enforcement Unit. The Complaint Database is programmed so the Consumer

Services staff make referrals to the Enforcement Unit through the Complaint Database, and documentation of those referrals is retained in the Complaint Database.

However, as we learned during the audit, there was a programming error that resulted in the Database failing to save copies of the e-mailed referrals. Had the programming worked properly, when a complaint was referred to the Enforcement Unit, that e-mail referral that was sent to the Enforcement Unit would have been saved in the Complaint Database (with a link to the entries and all scanned documents relating to the complaint).

The Department believes staff did *properly make referrals to the Enforcement Unit but those referrals could not be verified as sent or received in the Database due to this programming error. However, the Department recognizes that the programming error resulted in the Department's inability to verify that referrals to the Enforcement Unit were made.*

Upon learning of the programming error and failure of the Database to retain copies of the e-mail referral, the Department instituted a new process in November of 2006, in addition to the embedded process, that provides clear documentation of the referral. Division staff now send a separate e-mail directly to the Enforcement Unit. Since November of 2006, the Enforcement Unit therefore now receives both the embedded e-mail and the direct e-mail from Consumer Services staff.

In addition, a form has been developed that will be scanned into the database (original retained in the paper file) that will document the date of the referral, the complainant's name, the carrier or agent named in the complaint, the reason for the referral, the name of the referring Division staff member and the date of the delivery of the referral form with a copy of the paper file to the enforcement investigator. The form will be initialed by the individual delivering the file and referral form.

This procedure implemented in November of 2006 to send a confirmation e-mail and scan a referral form into the Database is an additional process designed to ensure that electronic and paper record of the referral is captured and saved. While the e-mail referral embedded in the Database is not retained due to a programming error, it nevertheless still is and always was received by the Enforcement Unit since the inception of the Database in 2003.

In this way the Department no longer relies solely on the electronic transmission of enforcement referrals. The new procedure provides two electronic and one paper transmission of the referral and file documentation. In addition, the Department has developed a decision-tree for consumer services staff to use as a guide in determining which files should or should not be referred to enforcement. We believe these procedures will ensure more than adequate documentation that referrals are appropriately made and received by the Enforcement Unit.

Observation No. 6

Formally Adopt Procedures For Enforcement Unit Investigations

The NHID has not formally adopted procedures for conducting enforcement investigations. The NHID established the Enforcement Unit within the Consumer Services Division in 2003. In June 2006, the Enforcement Unit was transferred to the Market Conduct Division and personnel reported the NHID anticipates creating a separate Enforcement Unit as part of its reorganization. When the Unit was originally created, the enforcement investigator, the Unit's only employee, and the Consumer Services Director drafted written procedures for developing an enforcement investigation plan, processing proposed and approved consent orders, processing enforcement terms for violations of INS 1001.01(c), and investigating and retaining records of RSA 417 violations. The procedures were never formally adopted; however, Consumer Services Division personnel reported they have verbally implemented procedures for conducting investigations of RSA 417 violations and processing consent orders.

The Enforcement Unit records all enforcement investigations and actions including those involving consumer complaints, licensing actions, and other enforcement actions, in the Enforcement Database; however, the Unit does not have a manual for using the database. Between SFYs 2004 and 2006 the Enforcement Unit investigated 146 consumer-initiated complaints and 96 other enforcement issues. The Unit conducted 16 hearings and negotiated 83 consent orders, of which three and 14, respectively, were related to consumer-initiated complaints.

The enforcement investigator reported having insufficient time to maintain the Enforcement Database; therefore, the database may contain inconsistencies. As noted in Observation No. 5 on page 37, we found no formal process for referring cases to the enforcement investigator. Additionally, we found no evidence three complaints referred to the enforcement investigator were investigated, and found two complaints which the enforcement investigator determined did not warrant an investigation. We found no documentation supporting the decision not to investigate the cases.

The Enforcement Database contains notes outlining conversations with complainants and licensees in the note field; however, our review of 50 enforcement files filed between April 2003 and June 2006 showed inconsistent documentation. We found no hard copy file for five cases (ten percent) and found two of those five cases had little documentation in the Enforcement Database. One case record contained only one memo outlining the allegation in the consumer complaint and a brief description of the steps taken during the investigation; however, the file did not contain: the original complaint, the letter sent to the insurance company, the company's response, or memos of any subsequent calls made to the company. The other case referenced a letter that was not included in the file. We also noted inconsistent retention of documentation in hard copy files. Of the 50 files we reviewed, 15 (30 percent) did not contain the original complaint. Two files contained notes in the Enforcement Database referring to letters not included in the file. Additionally, one hardcopy case file contained a letter from the consumer's attorney identifying documents missing from the NHID's file after the attorney conducted a

review of the file. The file also contained a letter from the attorney requesting the source documentation cited in an investigation report later identified as not in the NHID's files.

The Consumer Services Division Director and the enforcement investigator acknowledge there are no formal procedures for the type of required information contained in an enforcement investigation or an investigation report. We note the Division has a draft procedure for developing an enforcement investigation plan, which requires a list of allegations or suspected violations against the licensee, citation to applicable laws and administrative rules, a list of past and current complaints against the licensee, a list of people to be interviewed including the purpose of each interview, sources of documentation to be reviewed, and other elements. The procedure also requires an investigative timeline and a target date for the completion of an investigation report and requires NHID management approve the plan prior to its implementation. The procedure was drafted in November 2002, but has not been formally adopted or implemented.

Without formal procedures for conducting enforcement investigations, the NHID risks inconsistent application of verbal procedures, inconsistent documentation of files, and continuity of operations if employees leave the NHID. Additionally, the NHID runs the risk new employees will not be consistently trained.

Recommendation:

The NHID should formally develop and adopt enforcement investigation procedures.

Auditee Response:

We concur.

As noted in the auditor's report, Enforcement Procedures have been drafted and implemented but not formally adopted. As part of the Department's reorganization there will now be an Enforcement Unit, to be headed by an Enforcement Counsel, who will be responsible for formally adopting enforcement procedures. The Department recently hired an attorney as the Enforcement Counsel who began work on August 1, 2007. In addition, the Department is in the process of reorganizing several internal functions. As a result, the Department hopes to reclassify an existing position to provide additional enforcement staffing. This reorganization will help ensure that procedures are effective and that staff does properly document, in both the Enforcement Database and in paper files, all records of enforcement actions and investigations.

Observation No. 7

Establish Procedures For Ensuring Quality Control

The Consumer Services Division does not perform quality review of complaints processed by Division personnel, nor does it systematically ensure data integrity in the Complaint and Enforcement Databases. In the past, the Director performed quality control reviews of closed consumer complaints handled by claims and hearings officers. The review included assessing

timeliness, adequacy of documentation, appropriate follow-up or referral, and quality of information offered to the consumer. The last quality control review was performed at the end of 2004 on complaints processed by two claims and hearing officers no longer employed by the NHID. According to the Consumer Services Director, the reviews were used only as a tool to document corrective instruction provided to employees with performance problems. The Division currently performs annual personnel evaluations and periodically sends out consumer satisfaction surveys to assess the quality of its consumer services.

The NAIC's *Consumer Complaint White Paper* recommends all states have quality control measures in place for monitoring performance of individuals processing complaints. The NAIC recommends formal supervisory review, phone monitoring, and consumer satisfaction surveys as methods used to assure quality service. At the time of our audit, the three current claims and hearing officers (two of whom have been in their position for at least three years and one who has been in the position for eight months), two claims and hearing clerks (who have been in their positions for three and one half and five years, respectively), and the enforcement investigator (who has been in the position for four years), reported they had not received quality control reviews; however the Division Director was consulted on all enforcement cases. Division personnel handling complaints stated they were not aware of a formal quality review process. They stated their work is only reviewed if they seek advice from each other or sources outside of their Division.

The Division also does not have a formal process for ensuring data integrity in either the Complaint or Enforcement Databases. One Division employee periodically checks entries made by another employee for missing information and duplicates. Additionally, another Division employee reviews a subset of closed complaint data to ensure information such as disposition and insurance type are coded properly for transmission to the NAIC's nationwide Complaint Database System. Errors or omissions found in the subset are corrected for the NAIC; however the corrections are not updated to the Division's Complaint Database. Other fields in the Division's Complaint Database are not reviewed for accuracy. Entries in the Enforcement Database are not reviewed for accuracy or completeness.

Our review of the Complaint Database identified the following problems:

- Seventeen complainants were erroneously entered into the Database more than once. Either the Director or the Division staff, with concurrence by the Director, affirmed the 17 cases were opened twice in error.
- In our sample of 300 complaints filed between January 2003 and June 2006:
  - Twenty-nine percent (80 of 273 files) of disposition dates were inaccurate. Of the inaccurate data, the average difference between the date on the disposition letter and the date the complaint was closed in the Database was 11 days.

Our review of the Enforcement Database identified the following problems:

- The note field for 146 consumer-initiated complaints opened by the Enforcement Unit between SFYs 2004 and 2006 found 11 percent (16 files) contained specific notes indicating enforcement activity occurred prior to the date the complaint was opened in

the Database (the "entered-opened" date). The average difference between the date indicated in the note field and the "entered-opened" date was 33 days.

- Twenty-five percent (36 files) were closed on the same day they were opened; 14 of these files occurring during a one-week span in June 2006. Of the 36 files, six were noted in the Enforcement Database as "no jurisdiction" or "no action requested/required." Another 17 files were noted as "no violations found;" however, two of the files indicate enforcement activity occurred on the complaint. Of the remaining 13 files, one resulted in a hearing, one resulted in a consent order in which the respondent's license was suspended, 11 were noted as "company reimbursed consumer" or "company/agent settled." Five of these files contained notes indicating enforcement activity prior to the "entered-opened" date.

Management uses the databases to track and report on the Division's workflow. Inaccurate data limits the NHID's ability to properly track complaint processing and produce reports that could assist management in analyzing the amount of time it takes the Division to process a complaint. Additionally, management is responsible for ensuring work performed by its personnel is accurate and reliable for decision-making purposes, as well as for ensuring work products conform to Division rules and procedures. As noted in Observation Nos. 1, 4, and 6, we found inconsistencies in the way consumer complaints are processed. Without periodic review, the NHID cannot ensure data used for decision-making purposes are accurate and reliable. Further, it cannot ensure consumer complaints are being handled according to Division procedures.

Recommendation:

The NHID should re-establish its quality control reviews and expand them to cover all aspects of the complaint resolution process. Part of this review should include periodic checks of information in the Complaint and Enforcement Databases for accuracy and duplicates; as well as a formal review of all personnel processing consumer complaints, including claims and hearings officers, claims and hearings clerks, and the enforcement investigator.

Auditee Response:

We concur in part. We do not concur that there are errors in the Complaint Database that demonstrate a lack of quality control by the Department. We concur that the accuracy of data in the Enforcement Database should be improved.

Complaint Database

We do not concur that there are errors in the Complaint Database that demonstrate a lack of quality control by the Department. In fact, the data in the Complaint Database is accurate, and quality control measures are in place.

The auditors allege that of 3,711 entries, 17 complaints were erroneously entered into the Database more than once. The Department believes that a .46 error ratio does not support a finding that data in the Complaint Database is inaccurate.

In addition, the auditors say that 29% of disposition dates are inaccurate as they are not the same date as the date on the disposition letter. The audit observation states that the average difference between the "date on the disposition letter and the date the complaint was closed in the database was 11 days." The NHID is perplexed by this finding because the NHID's own analysis concludes that the difference between the date the complaint was closed and the date of the disposition letter is .57 days. We are unable to determine how, when reviewing the data in the Complaint Database, the auditors determined an 11 day average gap. We believe that the auditors' calculation of the data is incorrect.

Because the Department disagrees with the auditors that the information in the Complaint Database is inaccurate, the Department also disagrees that NHID management cannot accurately track complaint processing and produce reports that assist management in determining the amount of time it takes to process a complaint. The Complaint Database provides accurate and timely reporting for management, market conduct and a number of other department divisions and functions, and it has proven itself to be an invaluable multipurpose tool for analysis, employee accountability, trends and a number of other management level purposes.

In regard to quality control reviews of data in the Complaint Database, while the Director has not performed a formal *quality control review of individual files since 2004, informal quality control reviews continue to the present. The Division utilizes periodic consumer satisfaction surveys, annual employee performance evaluations, and daily consultations and interactions with division staff on pending complaints, as well as routine review of database entries as quality control measures. Difficult files are discussed at periodic staff meetings and at a variety of policy meetings for both Property and Casualty (P&C) and Life, Accident and Health (LAH) products. In addition, the individual through whom all complaints are processed on a daily basis routinely checks entries made by other division employees, and points out entry errors either to the employee in question or the division director for correction. These quality control measures are considered acceptable methods of assuring quality service in accordance with the National Association of Insurance Commissioner's (NAIC) recommendations in its Consumer Complaint White Paper. It is therefore not true that the Department has no quality control review of data in the Complaint Database.*

The Department also believes that the auditors misunderstand established and existing quality control measures and certain Department processes. For example, the auditors state that the employee who reviews the closed complaints for proper coding for transmission to the NAIC does not correct errors in the Complaint Database that show up in the transmittal process. In fact, the employee that reviews closed files for transmittal to the NAIC is merely reviewing files to determine that all fields created for NAIC transmittal (and not for Department use) are in order so that the automatic transmittal process can proceed. Any issues uncovered and corrected by staff in this transmittal process only relate to the transmittal of information to the NAIC. The Department relies on the information in the file itself not in the transmittal data fields that were created solely for NAIC data transmittal needs.

While the Department believes that data the Division collects is accurate and statistically reliable, and that it has in place proven procedures for ensuring that staff provides quality services to consumers, the Department nonetheless is willing to put in place additional quality

control practices to further enhance the data collection process. The Department has reinstituted the more formal quality review process for each Consumer Services Officer. The review will take place prior to the completion of the Division of Personnel annual performance evaluation, and will include review of a fixed number of randomly selected complaint files processed by each Consumer Services Officer. In order to clarify any staff misunderstanding, the Division Director will review with staff the various quality review processes used by the Department to ensure all data in the Database is accurate and reliable.

Enforcement Database

As noted by the auditors, many Enforcement Procedures have been drafted, and while not formally adopted, have been followed by the Enforcement Examiner. The Department has created an Enforcement Unit, to be headed by a recently hired Enforcement Counsel, who will be responsible for formally adopting these enforcement procedures.

The Department also recognizes that the Enforcement Procedures were not always utilized to accurately document enforcement investigations undertaken. The Department would agree that there should be improvements made to the accuracy of data entered into the Enforcement Database. The Department will rely upon the newly hired enforcement attorney to make all necessary improvements and provide oversight and quality control review over the Enforcement Database. The Enforcement Attorney will oversee the work of the Enforcement Examiner and complete formal implementation of procedures to provide the necessary supervision and auditing of data entry in the Enforcement Database.

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FINANCIAL EXAMINATIONS

The Financial Examination Division performs financial analyses and conducts on-site examinations of insurance companies domiciled in New Hampshire to ensure their financial statements are fairly stated, identify and address concerns regarding an insurer's financial standing, and ensure their future solvency. The Division uses staff examiners and contracts with outside vendors for additional services as needed. We found the New Hampshire Insurance Department (NHID) was not conducting examinations of foreign insurers or paying contracted examiners and examination firms according to statute. Our audit also found that the Division neither seeks Governor and Council approval for personal service consulting contracts nor uses competitive bidding to procure contracted services.

Observation No. 8

Use Competitive Bidding For Procuring Contracted Examination Services

The NHID has no formal process for selecting contracted examination services. As described in Observation No. 9, the NHID used 12 contracted examiners to perform services in 16 exams during State fiscal years (SFY) 2003 through 2006, resulting in approximately $6 million paid to contract examiners. Financial Examinations Division personnel stated the NHID selects contracted examiners and examination firms based on prior experience with the NHID, the contract examiner's competence and reputation, the price of the services compared to the size of the company under examination, and whether the contract examiner has a conflict of interest. The NHID does not require competitive bidding when awarding contracts.

In conducting examinations, RSA 400-A:37, III requires the NHID to observe guidelines and procedures established in the National Association of Insurance Commissioners' (NAIC) *Financial Condition Examiners Handbook* (*Examiner's Handbook*). The *Examiner's Handbook* acknowledges that using independent contractors can lead to higher examination costs for insurers. The NAIC recommends using competitive bidding when selecting contracted examiners as one method of controlling costs associated with contract examiners. The *Examiner's Handbook* states, "Prior to selecting the independent contractor, the regulator should consider at least three competitive bids." Further, the *Examiner's Handbook* states, "The most responsive and responsible independent contractor whose bid reflects the lowest price should be considered." The NHID is accredited by the NAIC and is reviewed at least every five years to ensure it meets accreditation guidelines.

Our survey of other states' insurance departments revealed that of eight insurance departments, six states reported requiring competitive bidding for selecting contracted examiners. In addition to competitive bidding, two of the six states also reported allowing sole sourcing to obtain specialized skills not generally available. One state reported selecting contracted examiners from an approved pool of contractors. Only one state reported using only sole sourcing for selecting contracted examiners. Utilizing competitive bidding would be consistent with what appears to be best practice in other states.

Recommendation:

The NHID should follow the NAIC *Examiner's Handbook* guidance and use competitive bidding when selecting contract examiners and examination firms.

Auditee Response:

We do not concur.

The NHID does follow the NAIC's Examiner's Handbook and does employ competitive bidding when circumstances permit and doing so is likely to result in cost containment.

The auditors misread the requirements of RSA 400-A:37, III(a) and the recommendations of the NAIC Examiner's Handbook. The Handbook does not impose a blanket requirement mandating competitive bidding in every situation. In addition, both the legislature and the NAIC recognize that due to the challenges facing insurance departments when conducting examinations and the importance of the timely retention of qualified professionals, the commissioner must have broad discretion. Any procurement procedure must be flexible and appropriate to the circumstances of the particular examination in question.

RSA 400-A:37, III (a) states "In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the Examiner's Handbook adopted by the National Association of Insurance Commissioners. The commissioner may also employ such other guidelines or procedures as the commissioner may deem appropriate."

The Financial Condition Examiners Handbook at Part I Section IV-K(7) states:

> *If legislation permits and circumstances are warranted, it may benefit the regulator to consider the following procurement procedures in order to control costs when utilizing an independent contractor.*
>
> > *e. Prior to selecting the independent contractor, the regulator should consider at least three competitive bids.*

It is clear from the plain language of the Financial Condition Examiners Handbook that the recommendation that three bids be considered is "guidance" only[1]. Only if "circumstances are warranted" "may" it "benefit the regulator to consider" three competitive bids. If the Department were to require three competitive bids each time it contracts with an independent contractor it would not be in compliance with the guidance in the Handbook as it would disregard the Handbook's recommendation to utilize bids only if circumstances are warranted.

[1] The handbook states at page 3-51 "The above mentioned guidance, as it relates to procurement, contracts and travel expenses…"

The fact that the Commissioner, pursuant to RSA 400-A:37, III (a), "may also employ such other guidelines or procedures as the commissioner may deem appropriate" is further evidence of the discretion granted the Commissioner by the legislature. The Commissioner can rely upon procurement advice from the NAIC guidelines and any other guidelines or procedures as he "may deem appropriate."

The Department does follow the NAIC Examiner's Handbook guidance. In accordance with the Handbook, the Department solicits bids if circumstances permit and doing so is likely to result in cost containment. The Department has on many occasions solicited bids when retaining professionals and specialists (lawyers, investment bankers, actuaries) by authority of RSA 400-A:37, III (d). It should be noted that such professionals and specialists generally bill on an hourly basis. However, the total charge for any professional or specialist will depend not just upon the hourly rate but also upon the number of hours the professional or specialist will take to complete the work required. Therefore, the lowest hourly rate as listed in the bid does not necessarily correspond with the lowest final cost, since the hourly rate does not reflect the efficiency of the work performed. This makes active contract management much more important in limiting overall costs than competitive bidding based solely upon the hourly rate charged.

The Department does not always require competitive bidding, however, and this is also in accordance with the Handbook. For example, the Department has not required competitive bidding when there is a follow-up examination of a company and it is more efficient and cost effective to use the examiners that are already familiar with the company and the issues of the examination. In addition, the Department does not require bids when it is already aware, through previous examinations, of the hourly rate in the market of those individuals who are qualified and available to perform the service. Requesting bids in these circumstances would be mere pretense and would not result in cost containment.

Furthermore, as the auditors point out, the NAIC reviews the Department's retention of specialists and experts in examinations. The NAIC is especially qualified to review the Department's compliance with the NAIC Handbook in regard to procurement of independent contractors. The NAIC has determined that the Department meets or exceeds the NAIC's accreditation guidelines, including those associated with the retention of professionals for examinations under RSA 400-A:37.

Therefore the Department believes it is in full compliance with RSA 400-A:37, III(a), all other state requirements and the Handbook and the Department does not concur with this observation.

Observation No. 9

Seek Clarification Of Statutes Related To Payments To Contract Examiners

Our Financial And Compliance Audit Report For The Year Ended June 30, 2000 identified the NHID's practice of allowing its contracted insurance company examiners direct compensation by insurance companies under examination was not in compliance with RSA 400-A:37, VIII, which states, "the compensation allowance shall be paid directly to the state." The 2000 audit also identified the NHID did not record expenses paid directly by insurance companies to

contract examiners as examination revenue; therefore it was not being recorded in the State accounting system. Additionally, the audit identified the appearance of a potential conflict of interest and commented that the arrangement may create confusion regarding the contracted examiner's loyalty between the NHID and the company paying them directly. In their response to the audit finding, the NHID stated it would be "exploring other payment options, including elimination of the direct payment by companies to the examiner component."

We found the NHID made no changes in its practices during the audit period. Contract examiners regularly submit bills for their compensation to the NHID. The examiner in charge of the examination reviews contractors' bills for reasonableness and forwards them to the Chief Financial Examiner for approval prior to forwarding to the company under examination. The company under examination pays the contracted examiner directly and these payments are not recorded as examination revenue.

RSA 400-A:37, VII, states the "insurer or other person examined…shall bear the expense of the examination." Further, RSA 400-A:37, VII and VIII limit the types of payments to a reasonable per diem allowance for compensation and expenses as determined by the Commissioner and allows, at the Commissioner's direction, the travel expense allowance to be paid directly to the individual conducting the examination. However, it states the "*compensation* allowance shall be paid directly to the state [Emphasis added]." Between SFY 2003 and 2006, the NHID used 12 contracted examiners on 16 financial examinations, totaling approximately $6 million. One examination used three contracted examiners and resulted in $3.4 million in contracted examiner services.

According to the Deputy Commissioner, the NHID does not require insurers to submit examination payments directly to the NHID because statute requires the company under examination to bear the cost of the examination. The NHID maintains because the company is required to bear the cost of the examination, it is not the State's money to collect or record in the State's accounting system. Further, the NHID interprets RSA 400-A:37, VII and VIII as only applying to State employees, not contracted examiners.

Recommendation:

The NHID should seek clarification of RSA 400-A:37,VIII and other related statutes.

Auditee Response:

We concur.

The 2000 audit raised a related issue as to whether contract examiners who worked regularly and exclusively for the Department at that time should be converted to state employees. In response to this issue, the Department did convert these examiners to state employees. Under this new arrangement, most of the expense of examinations became payable to the state as "compensation allowance" and included in the NHID budget.

In addition, after the 2000 audit, the Department reviewed the provisions of RSA 400-A:37, III(d), RSA 400-A:37, VIII(d) and RSA 401-B and found them to be clear in requiring only that the per diem "compensation allowance" attributable to the work of state employee *examiners must be paid to the state. The payment to professionals and experts under the provisions of RSA 400-A:37, III(d); RSA 400-A:37, VIII(d) and RSA 401-B is not a "compensation allowance," nor is it required to be paid to the state. Instead, the statutes provide that the payment to professionals and experts acting as contract examiners (who are not state employees) must be made by the examined company directly to the contract examiner. The Department sought confirmation of this interpretation from the Attorney General's office and the Attorney General is in agreement with the Department's interpretation of these statutes.*

However, the Department was concerned that, despite the Attorney General's concurrence with the Department's position, the Audit Division of the LBA may persist in its interpretation of this statute in the current and future audits. For this reason, and because it is critical to the Department's ability to fulfill its statutory duty to protect the insurance-buying public that it can retain appropriate advice from outside experts, the Department requested legislation in the 2007 session, HB 782, to reduce the potential for misinterpretation. The Legislature has passed HB 782 and the bill was signed into law by the Governor on June 28, 2007 (2007 Chapter 255). This bill confirms the correctness of the Department's and Attorney General's interpretation of RSA 400-A:37, VIII that the NHID may retain contract examiners at company expense without making an appropriation under RSA 9 and without such payment qualifying as a department expenditure under RSA 4:15.

Observation No. 10

Seek Clarification Whether Statutes Require Governor And Council Approval For Examiner And Examination Firm Contracts

The NHID does not seek Governor and Council approval for contracts awarded to contracted examiners and examination firms who perform services during the course of a financial examination. On one financial examination, the NHID used three contract examination firms, who collected approximately $1.9 million, $1.1 million, and $198,000, respectively, for work performed over the course of 20 months from May 2002 through December 2003. On another examination, the contracted examination firm estimated the examination fees for the work performed to be $450,000. As described in Observation No. 9, the NHID used 12 contracted examiners to perform work on 16 examinations during SFYs 2003 through 2006 totaling approximately $6 million paid to contract examiners and examination firms.

RSA 4:15 requires State departments and agencies to obtain Governor and Council approval for the "expenditure of any moneys appropriated or *otherwise provided* to carry on the work of any department of the state government…for the purpose of securing the prudent and economical expenditures of the money appropriated [Emphasis added]." The Department of Administrative Services (DAS) *Administrative Handbook* requires Governor and Council approval for personal service contracts above $2,499 as well as contract amendments if the amended amount brings the total for the contract over the $2,499 threshold. The DAS *Handbook* considers a contract to be a personal service contract if the "predominate factor in acquiring a product is the individual's

skill." Personal service contracts include those contracted services provided by non-agency personnel involving personal skills including physicians, lawyers, and all consultants. The DAS Handbook further states all personal service contracts also need approval from the Division of Personnel.

RSA 400-A:37, I requires the NHID to conduct an examination of all insurers licensed to the State at least once every five years. The NHID uses a three-year cycle. The NHID follows guidelines established by the NAIC in developing a flexible yearly examination schedule and determining when companies are projected to be examined within the yearly schedule. The NHID submits the yearly schedule to the NAIC for accreditation purposes.

According to NHID personnel, the NHID does not seek approval from Governor and Council because financial examinations conducted under RSA 400-A:37 and RSA 401-B (insurance holding companies) are time sensitive; therefore, any delay in obtaining services for performing a thorough and comprehensive exam places an undue hardship and financial burden on the insurer.

Recommendation:

The NHID should seek clarification of RSA 400-A:37 and related statutes.

Auditee Response:

We concur.

The fees paid by examined companies to outside professionals and specialists who assist in examinations are not expenditures of the Department nor are they disbursements from the state treasury pursuant to RSA 4:14 and thus they are not subject to review by the Governor and Council pursuant to RSA 4:15. The Department's longstanding interpretation is that RSA 400-A:37, III (d) and RSA 401-B do not require that payment for outside professionals and specialists be collected by the State or become a liability of the State. The expenses for professionals and specialists are expenditures of the company not the State and by law must be paid directly to those individuals.

The Department asked the Attorney General's office to confirm the Department's interpretation and the Attorney General has agreed with the Department's interpretation. However, the Department was concerned that, despite the Attorney General's concurrence with the Department's position, the Audit Division of the LBA may persist in its interpretation of this statute in the current and future audits. For this reason, and because it is critical to the Department's ability to fulfill its statutory duty to protect the insurance-buying public that it can retain appropriate advice from outside experts, the Department requested legislation in the 2007 session, HB 782, to reduce the potential for misinterpretation. The Legislature has passed HB 782 and the bill was signed into law by the Governor on June 28, 2007 (2007 Chapter 255). This bill confirms the correctness of the Department's and Attorney General's interpretation of RSA 401-B and RSA 400-A:37, III (d).

Observation No. 11

Conduct Statutorily Required Examinations Of Foreign Companies Licensed In New Hampshire

The NHID does not conduct examinations of foreign companies licensed in New Hampshire according to statute. Foreign companies are companies domiciled in another state. RSA 400-A:37, I requires the NHID examine all companies licensed in New Hampshire at least once every five years. In lieu of an examination of a foreign insurer licensed in New Hampshire, RSA 400-A:37, I (c) allows the Commissioner to accept another state's examination report if its insurance department was accredited under the NAIC's Financial Regulation Standards and Accreditation Program at the time the examination was conducted; or if the examination was performed under the supervision of an accredited insurance department or with the participation of examiners employed by an accredited state insurance department.

As of December 2006, 49 states and the District of Columbia are accredited by the NAIC Financial Regulation Standards and Accreditation program. As of December 2006, the New York State Insurance Department is not accredited by the NAIC and has not been accredited since June 2001. Additionally, Washington State was not accredited by the NAIC for some portion of the audit period. As of February 2007, 105 companies domiciled in New York and seven domiciled in Washington State were licensed to sell insurance in New Hampshire. Due to the length of time the New York State Insurance Department was not accredited by the NAIC, it appears all 105 companies should have been examined. During the audit period, New Hampshire did not conduct financial examinations of insurance companies domiciled in these other states.

According to the NAIC, the New York State Insurance Department is not accredited because it has not passed all 18 laws and regulations necessary for accreditation. Personnel at the New York State Insurance Department reported the state has not enacted the NAIC model law concerning risk-based capital investments for property insurance companies. New York State Insurance personnel reported the department follows the NAIC *Financial Condition Examiners Handbook* and *Accounting Practices and Procedures Manuals* when conducting financial examinations.

NHID personnel reported although New York is currently not accredited by the NAIC, it takes an active role in insurance regulation and participates in the NAIC. Personnel reported examinations conducted jointly with the New York State Insurance Department are as stringent as examinations conducted in New Hampshire.

According to the *NAIC Administrative Policies Manual Of The Financial Regulation Standards And Accreditation Program,* the purpose of the law and regulation standards is to "assure that an accredited state has sufficient authority to regulate the solvency of its multi-state domestic insurance industry in an effective manner." The NAIC considers law and regulations to be "basic building blocks for sound insurance regulation."

Recommendation:

The NHID should conduct examinations of companies domesticated in other states according to statute. If NHID management believes RSA 400-A:37, I (c) is too restrictive in allowing acceptance of other states' examination reports, it should request the Legislature amend the statute.

Auditee Response:

We concur in part.

New Hampshire is not the only state that requires a foreign state be accredited in order to rely upon the foreign state's examination of its domestic insurance companies. The provisions found at RSA 400-A;37, I (c) are a NAIC model law (Model Law 390). Because of the emphasis on consistency between the states in regard to examinations and in the interest of avoiding duplicative examinations, a majority of states have adopted this model law. These states are thus similarly impacted when another state is not accredited by the NAIC. The NHID was an appointed member of the Accreditation Committee of the NAIC in 2006 and did bring this issue to the attention of the Accreditation Committee. Pursuant to the request by the NHID, the NAIC is actively working on a solution to this national issue.

Therefore NHID is not inclined to follow the recommendation of the auditors to amend RSA 400-A:37, I (c). The Department believes it must await the conclusion of the deliberations by the NAIC and review any resolution reached by the NAIC, before making change, if any, to RSA 400-A:37, I (c). To amend a model law in a premature, piecemeal manner would not be prudent or consistent with the directive in RSA 400-A:28, Interstate Cooperation, that requires the Commissioner to participate in the activities and affairs of the NAIC.

In the meantime, the NHID does not rely solely on the examination conducted by a non-accredited state. The NHID performs and performed its own annual desk examination of all Washington and New York domesticated companies to determine whether an examination or other regulatory action is warranted. If the Department has any concerns in regard to any company, it can and has participated in examinations, restricted the company's business in New Hampshire, required a deposit or taken other appropriate measures. The Department can, if it feels it is necessary, conduct a full examination. In addition, pursuant to the provisions of RSA 400-A:37, I(c), if the examination is conducted with the supervision of another accredited state or if examiners from an accredited state participate in the examination, then the NHID can rely (and has relied) on an examination conducted by New York or Washington.

New York has failed to become accredited because, for political reasons, the New York legislature has failed to enact a model law concerning risk-based capital, a law unrelated to New York's ability to properly conduct examinations. The New York Insurance Department is at the forefront of insurance regulation and chairs numerous NAIC committees. In all respects the New York Insurance Department is conducting examinations in full accord with NAIC standards and has earned the respect of other state insurance departments that rely on New York's leadership and analysis of insurance issues.

Therefore, the NHID is also not inclined to follow the recommendation of the auditors and conduct full duplicative examinations of New York domestics. The state of New York has a large domestic insurance industry, and it is not practical or cost effective for the NHID to conduct full examinations of all 105 companies domesticated in New York and licensed in New Hampshire when all 105 of these companies are already examined by the New York Department of Insurance. Nor would it have been practical or cost effective to re-examine Washington State's domesticated companies during that period when Washington was not accredited (1999-2001).

The Department concurs that during the period 1999-2001 Washington state was unaccredited and similarly, due to particular political circumstances, New York was and continues to be unaccredited, and thus RSA 400-A:37, I (c) would require the Department examine 7 Washington domesticated companies and 105 New York domesticated companies. The Department however, does not concur with the recommendations of the auditors as they are neither prudent nor practical. The Department feels the best course of action is to work with the NAIC on a national level to resolve this issue.

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MANAGEMENT CONTROLS

Management controls are an integral component of an organization's operations and management, providing reasonable assurance operations are effective and efficient, ensuring financial reporting is reliable, and helping organizations comply with applicable laws and regulations. Management is responsible for developing the detailed policies and procedures to operationalize controls. Controls encompass all aspects of an organization's operation, including information systems that are vital to an organization's operations. General controls for information systems applies to all information systems, including the mainframe, microcomputers, networks, and end-user environments. Specifically, general controls include backup and recovery procedures and contingency and disaster recovery planning. Management controls over contingency planning will help to mitigate the impact of a disruption of business operations.

The management control structure is weakened by the lack of documented policies and procedures. Nonexistent written business continuity policies and procedures hinder management and staff ability to recover operations in the event of a disaster.

Observation No. 12

Establish A Written Business Continuity Plan

The New Hampshire Insurance Department (NHID) has not prepared a business continuity plan to minimize disruption of NHID operations in the event physical disaster or other foreseen or unforeseen disturbances impact the NHID's information technology (IT) operations. The Director of Operations, in e-mail correspondence in November 2006, stated the NHID does not have a disaster recovery or business continuity plan, although it has discussed the need for one. As a result, no written disaster recovery or business continuity plan was provided to the auditors. The Director of Operations expressed the NHID is attempting to migrate data storage and server support to the National Association of Insurance Commissioners (NAIC); however, this process would not be complete until the latter part of 2007. The purpose of a business continuity plan is to document recovery strategies, plans, and policies and procedures necessary to implement a recovery process for essential IT resources.

The NHID's servers currently reside in a basement room with a water sprinkler system directly above the server cabinet. Best practice recommends a waterless gas-based fire suppression system. The Department of Administrative Services (DAS) maintains the building where NHID is located. The DAS has indicated to the NHID it has obtained specifications for a heptafluoropropane fire suppression system and will be putting it out to bid. The DAS anticipates the project to be completed during the summer of 2007. Information residing on the servers is backed up to tape nightly; however, back-up tapes are stored on-site at the NHID. Again, best practice recommends back-up tapes be stored in a secure location off-site. We note the server room also houses servers for two other State agencies.

The Consumer Services Division relies heavily on the NHID's servers to operate. The Consumer Services Division creates a record containing notes of all consumer-initiated contacts in the Consumer Assistance Tracking system (Event Log). The Division maintains a paper file of consumer complaints and enforcement investigations containing hard copy documents; however, it only records phone contact with consumers and insurers regarding consumer complaints in the activity screens within the Complaint Case Management and Enforcement Case Management systems. Consumer Services Division personnel also query the Event Log each time a consumer calls to determine if the consumer has contacted the NHID regarding a similar issue in the past. The systems are backed up hourly on two desktop computers within the Division; however, eight of the ten Consumer Services Division personnel who handle inquiries, consumer complaints, and enforcement investigations would not have access to the systems should the servers become unavailable.

The Financial Examinations Division currently uses the servers to submit time and expense reports electronically. Financial examiners log on to a secured NHID website and populate time and expense reports, scanning and attaching necessary receipts. Examiners in charge access the reports through the server. Once they are approved by the examiner in charge, the reports can be accessed by the Assistant Chief Examiner for further approval. When the reports are approved, the data is stored in the NHID's data warehouse on the NHID server. The Business Administration Unit extracts time and expense data from the NHID data warehouse to compile monthly billing statements, which are sent to insurance companies under examination for payment.

A business continuity plan is intended to minimize operational downtime by providing employees with documented and tested policies and procedures to follow in the event of system failures. A well-designed plan includes tested recovery strategies and plans as well as policies and procedures intended to implement an efficient and effective system recovery.

Recommendations:

The NHID should develop a written business continuity plan, in coordination with the Office of Information Technology, to minimize the effects on NHID operations in the event of an IT system failure. The plan should include written procedures for NHID handling consumer inquiries, complaints, and enforcement investigations until the server is restored. The written procedure should also address a process for storing back-up tapes off-site.

The NHID should also work with the DAS to monitor the procurement and delivery of the waterless fire suppression system for the server room.

Auditee Response:

We concur.

The Department has implemented business continuity measures and is situated to continue operations and minimize any disruption of information technology caused by fire, natural disaster or other disturbances. The Department had identified, prior to the audit, the same

concerns raised by the auditors, and the Department had developed a plan to address these concerns.

In regard to backups for Department servers, the Department's continuity plan is to expand its use of back-up storage through State Based Systems (SBS), a product offered through the NAIC. All data related to producer licensing is already both stored and backed up through SBS. The SBS server is located in Kansas City and has a concurrent off-site back-up system already in place and supplied by the NAIC. Unfortunately, due to product design issues, the Department's transitioning of consumer services to the SBS system will not be complete until later this year. In the meantime, the Department is storing tape back-ups for basement located servers within a fireproof safe on the first floor of the Walker Building. It will not be necessary to store back-up tapes off-site once the SBS system is in place at the end of this year. During the intervening 6 months the Department will look into off-site storage.

In addition, the Department also contacted OIT over a year ago to provide a solution pending transition to the SBS system. While OIT has agreed that they can perform concurrent back-ups and tape storage at their site either at Hazen Drive or at the Nash Building, OIT is not able to take on this project until early in FY 2008. Therefore all Consumer Service Division data will be protected by SBS before the OIT solution can be implemented.

The Department also does not agree that, should the server become unavailable, some Consumer Services personnel without desktop computer backup would lose access to the system. In addition to back up on two desktop computers, Consumer Services Division data is currently migrated to SBS (State Based System) in anticipation of the 2007 transfer to the NAIC supported SBS consumer services proprietary database. This migration could act as an additional back up should the need arise due to an IT failure. In addition, the NAIC has a concurrent back-up system running for every one of our Department's databases that are housed on the NAIC systems. This concurrent system is run at an off-site location 30 miles from the main site that is located in Kansas City, MO. The NAIC also maintains tape back-up and stores these tapes off-site and secured away from the main site and the concurrent back-up site. Furthermore, the Consumer Services Director's PC is used for backup of the consumer services database. Should the server become inoperable, both databases could be copied and distributed to Division staff within two hours using external hard drives. New entries would be manually logged and entered in the database once the server again becomes operational.

Finally in regard to the sprinkler system located above the server located in the basement of the Walker Building, the Department had designed in conjunction with the Walker Building renovations a space for the server to be located on the second floor in a room outfitted with a halon system. However, OIT stated that the servers for all agencies in the Walker Building must be located in the basement of the building. The Department has no authority over the fire protection systems used in the basement. DAS has authority and control in this regard and DAS did not outfit the basement with a halon system. The Department identified the sprinkler system as a concern at the time the Department moved into the Walker Building two years ago and requested that DAS take steps to protect the server.

The DAS had promised that it would take corrective action on this issue and that the RFP process for this project was to be completed by the end of March, 2007. Recent communications from the DAS, however indicate that the RFP process did not begin due to funding issues. We will continue to contact DAS on a monthly basis to monitor the procurement and delivery of the fire suppression system for the server room and remind DAS of the potential hazards caused by further delay in taking corrective action.

In conclusion, the Department has implemented business continuity measures to minimize adverse impacts upon NHID operations in the event of an IT system failure. However the Department recognizes that it would be beneficial to memorialize the Department's continuity plan and will begin the process of compiling in a single written document available both on and off-site, the various aspects of the Department's continuity plan.

Office Of Information Technology Response:

OIT concurs with the recommendation. Business Continuity plans touch all functions of the business, including such areas as personnel and facilities as well as information technology resources. They must encompass all aspects of an organization's operations that could be impacted by an accident, threat or natural disaster. OIT will work in partnership with the Department of Insurance to provide the IT components of business continuity planning (such as IT service continuity plans (i.e. disaster recovery), backup and recovery procedures, technical security procedures, network setup, and other technically specific activities), which will complement and meet the requirements, as outlined by the agency's overall business continuity plan.

In the event that the upgrade of the Walker Building data room is determined not to be feasible, OIT is ready to provide appropriate data center space at the Hazen Drive complex.

OTHER ISSUES AND CONCERNS

In this section we present issues and concerns we encountered during our audit that were not developed into formal observations, yet we consider noteworthy. The Legislature and the New Hampshire Insurance Department (NHID) may consider these issues and concerns deserving of further study or action.

Update Administrative Rules To Reflect Organizational Structure

Our Financial And Compliance Audit Report For The Year Ended June 30, 2000 identified the NHID Administrative Rule INS 102 did not reflect the NHID's organizational structure. Our review of the NHID's organizational structure against INS 102 revealed the NHID's structure still does not fully reflect INS 102 (*effective November 2003*) and the Table of Contents of INS 102 (Description of Department) does not reflect the body of INS 102.

Under the current organizational structure, the Consumer Services and Market Conduct Divisions are combined into one Division; however, INS 102 establishes each Division separately. We also observed the Divisions function independently of each other. Additionally, INS 102.10 establishes the Information Technology (IT) Division. The IT Division appeared in the NHID's organizational charts from State fiscal years (SFY) 2001 through 2004; however, the Division does not appear on the SFY 2005 and 2006 organizational charts. According to NHID personnel, IT personnel were transferred to the State's Office of Information Technology in August 2004.

According to the table of contents of INS 102, the NHID is organized into seven divisions:

- INS 102.02 Licensing Division,
- INS 102.03 Consumer Services Division,
- INS 102.04 Life, Accident, and Health Division,
- INS 102.05 Property and Casualty Division,
- INS 102.06 Examination Division,
- INS 102.07 Administrative Division, and
- INS 102.08 Fraud Division.

However, the body of INS 102 describes ten divisions:

- INS 102.02 Business Administration Division,
- INS 102.03 Actuarial and Analytical Division,
- INS 102.04 Legal Counsel,
- INS 102.05 Health Policy,
- INS 102.06 Financial Examinations and Licensing Division,
- INS 102.07 Rate and Form Compliance Division,
- INS 102.08 Consumer Services Division,
- INS 102.09 Market Conduct Division,
- INS 102.10 Information Technology (IT) Division, and
- INS 102.11 Fraud Division.

The NHID reported it is currently undergoing a re-organization to better facilitate communication and information sharing among its divisions. According to NHID personnel, the NHID anticipates amending and readopting INS 100 when the re-organization is complete, which is anticipated to be within the year.

We suggest the NHID update INS 102 to reflect the NHID's organizational structure once the re-organization is complete. We also suggest the NHID update the Table of Contents to reflect the body of INS 102 when amending and readopting INS 100.

Auditee Response:

The Department will look to revise Ins 100 as necessary when the reorganization is complete.

Better Communicate Information Regarding The Re-Organization Efforts To NHID Employees

Eight NHID personnel reported the NHID suffers from a lack of information flow, especially in regard to the re-organization efforts. Management has expressed it is attempting to re-organize the NHID to better facilitate information flow and to encourage information sharing between Divisions. According to the Deputy Commissioner, the re-organization started in mid-2005 and management expects it to be completed in approximately another year.

Seven NHID personnel expressed frustration about the lack of communication at the NHID. Personnel reported they are poorly informed about the NHID's re-organization efforts, including management's intended organizational structure, and that management has not tried to solicit input or buy-in from NHID employees. Five personnel reported the re-organization has started and stopped numerous times without a clear explanation from management of the reasons or a clear timetable for completion.

For instance, in April 2006, the Property and Casualty Rate and Form Compliance and Consumer Services Divisions were merged into one division. This structure was in effect for approximately one month and the Divisions were again split and re-formed into their original organizational structure. Some personnel reported not being told why the Divisions reverted back to their original organizational structures.

We suggest the NHID better communicate the goals and timetable for completion of the re-organization to its employees.

Auditee Response:

A re-organization by its very nature can raise concerns among staff and even with complete disclosure, rumors and misunderstandings can occur. Management has made every effort to avoid this result by meeting with staff on numerous occasions to discuss the re-organization. However, certain aspects of the re-organization must be kept confidential as they involve personnel matters that cannot be discussed with Department staff. The vast majority of staff is

aware of the re-organization efforts and have worked with management in the re-organizational efforts. Management will continue to communicate with staff on the re-organization, the goals of the re-organization and the timetable for completion.

Ensure Market Conduct Reports Are Issued In A Timely Manner

We were notified some market conduct examination reports are not issued timely. Market Conduct Division personnel reported as of November 2006 approximately 30 market conduct reports were still not completed, some dating back as long as four years. NHID personnel believe the National Association of Insurance Commissioners (NAIC) considers New Hampshire's delay in issuing market conduct examination reports a concern. We suggest the NHID identify the market conduct examination reports still pending, the reasons for the delay, and ensure future market conduct reports are issued in a timely manner.

Auditee Response:

The Department has identified the status of all market conduct reports and is working toward conclusion of all open exams. Delay in the completion of certain market conduct reports is a result of vacant examiner positions, and the Department has been filling vacant positions and creating new examiner positions to address this backlog.

Eliminate Re-Typing Filing Information From Transmittal Documents

Personnel in the Life, Accident, and Health (LAH) Compliance Division re-type certain filing information submitted by insurance companies in hardcopy format to save in electronic format. The Division uses the System For Electronic Rate And Form Filings (SERFF) to track both electronic and paper filings. For electronic filings, insurance companies include a "Form Filing Attachment" document, which lists and describes the individual forms contained within the filing. For paper filings, insurance companies may or may not submit a Form Filing Attachment. If the company submits a "Form Filing Attachment," the Division re-types the information submitted in the hardcopy to a template based on the electronic version. The template is then saved and attached it to the SERFF record. If a company does not submit a "Form Filing Attachment," Division personnel looks through the package and type the form number and description into the template. In November 2006, the NHID began requiring all LAH filings include a uniform transmittal document, which includes the "Form Filing Attachment." Without the "Form Filing Attachment," reviewers reported they would not be able to identify which policies companies are approved to sell. Division personnel reported re-typing the document is time consuming, taking up to a half hour if the filing includes multiple forms, endorsements, and riders. This can be compounded if the Division receives multiple paper filings in one day.

We suggest the NHID explore the possibility of scanning the "Form Filing Attachment" when it is submitted as a paper filing and eliminate the process of re-typing this information.

Auditee Response:

The Department cannot scan the "Form Filing Attachment" when companies submit paper filings. The information contained in the Form Filing Attachment must be manually entered into the template because it is critical to populate fields with the appropriate data in order to permit search functions to operate. Scanning the document will not populate search fields in the database. In any case, the Department is transitioning exclusively to electronic filing through the SERFF and will then no longer accept paper filings. When licensees file electronically through SERFF, licensees will populate all fields and data entry by Department staff will be unnecessary. The Department anticipates full transition to SERFF by the year's end.

Review Rate And Form Filing Archiving Requirements

The NHID's current rate and form filing archiving requirements are out-of-date with modern technology and not time efficient. NHID Administrative Rule INS 3100 requires insurance companies microfiche their approved rate and form filings for archiving purposes. The requirement was originally established in 1993 and has not been updated to consider modern electronic storage media. Currently, Division personnel must convert electronic filings to Portable Document File (PDF) and use a file transfer protocol to send them to a vendor who prints them out before transferring the filings onto microfiche cards. Companies submitting their filing through the System for Electronic Rate and Form Filings (SERFF) are charged for both the hardcopy printing and the microfiching. INS 401.12 (c), adopted in September 2006, requires companies submit life, accident, and health insurance filings through SERFF whenever possible. SERFF filings currently account for approximately half of the Division's filings.

Division personnel report spending two or more hours per week checking, organizing, and filing the completed microfiche, and helping researchers and members of the public find the correct fiche in the filing cabinets. The filing system is complicated and may become backlogged when personnel must file new microfiche while helping the public. Personnel reported it would be more efficient for the public to access approved filings through a computer terminal instead of through microfiche. NHID management reported during the past two years, the NHID has been exploring the use of electronic media for archiving purposes.

We suggest the NHID continue this exploration since the NHID is actively attempting to increase the number of electronic filings. Once the NHID chooses another method of archiving, we suggest the NHID change the administrative rule to match the new method.

Auditee Response:

The Department disagrees that it has not assessed the costs and benefits of an alternative archival system for rate and form filings. For over two years the Department has explored the use of alternative electronic media for archival filing and has been in the process of determining whether an alternative method to microfiche is both cost effective and practical. After looking at possible contracts with all current state approved vendors, we have determined that none of the current state approved vendors will be able to meet our growing needs as we expand our SERFF

filings. We have also looked at many of the options available in the current local market to determine whether any local system could meet our needs economically and within our current personnel restrictions. One option includes asking our clerical personnel to scan all the paper filings and use SERFF as our electronic storage medium. The Department is also actively considering the possibility of an RFP to explore options in the national open marketplace and will update Administrative Rule Ins 3100 as necessary to match the updated technology requirements.

Establish Consistent Policy For Handling Complaints Copied To The Department

We noted inconsistencies in handling complaints where consumers send copies to the NHID. During our file review of 300 complaint files, we found three instances where the consumer copied the NHID on correspondence sent to an insurer. In two instances the Division processed the copied letter as a normal complaint; however, in the third instance the consumer was asked to fill out a complaint form, providing duplicate information, before the complaint was processed. According to the Consumer Services Director, copied complaints should be processed the same as all other complaints and according to the division's Complaint Processing Procedure Manual. Our review of entries in the Event Log for SFY 2006, found 46 complaints whose note fields indicated they had been copied to the NHID. Of these 46, we found the Division did not appear to follow-up on six (13 percent).

We suggest the NHID assess the most appropriate process for handling copied complaints and establish clear and consistent procedures for both the LAH and P&C sections. We also suggest the NHID ensure Division personnel consistently follow the established procedure.

Auditee Response:

The Division does have a consistent procedure for all complaints regardless of the type of insurance involved. This procedure has been in place since 2003.

When the Division receives copies of correspondence not addressed to the Department, it must determine whether the consumer wishes to file a complaint with the NHID. It is often the case that consumers or their attorneys copy the Department in correspondence to insurance companies but do not wish the Department to take any action. If the intent of the consumer is not clear from the correspondence, staff sends the individual a form letter and complaint form requesting the form be returned if the consumer wishes to file a complaint with the Department.

The auditors provided information in regard to copied correspondence in the Event Log. The auditors cite 6 out of 46 letters in FY 2006 received by way of copied correspondence that were entered into the Event Log but required further action from the Department. The Department agrees that in three of the six instances cited, the Department should have opened a complaint but did not. However in the remaining three instances it was clear from the files that there was either no allegation of wrongdoing or no action required on the part of the Department. Therefore, in only three instances out of 46 did the Department fail to properly process copied correspondence. This is an error ratio of .065 and is not statistically significant.

While the Department believes that in the vast majority of cases it is correctly and consistently applying its policy regarding copied correspondence, the Director has again reviewed with staff all established procedures for handling complaints and correspondence copied to the Department. Staff will soon receive an updated procedure manual and refresher training. Thereafter, they will receive annual refresher training on Division procedures.

CONCLUSION

The New Hampshire Insurance Department (NHID) is responsible for regulating all segments of the insurance industry, particularly treatment of policyholders and claimants. Our audit of the processes for consumer-complaint resolution, rate and form review, and financial examinations found the NHID is effectively fulfilling its consumer protection functions. NHID staff are cognizant about their role in protecting the consumer and understand the impact their respective functions contribute to the overall safety and stability of New Hampshire's insurance marketplace. We also found some processes could benefit from more standardization or formal guidance.

The Consumer Services Division processes complaints in an effective manner; however, it should implement more formal quality control reviews and formally adopt policies and procedures in use. Consumers we surveyed were generally satisfied with the services provided by the Consumer Services Division. Seventy-one percent of consumers responding to specific survey questions expressed some level of satisfaction with the way the NHID processed their complaint, 72 percent reported the NHID handled their complaint fairly, and 80 percent reported they would contact the NHID again with another insurance problem. However, we found quality review processes, if improved, would positively impact some consumers' ability to obtain consistent services from the Division. Some complaints alleging violations of insurance laws or regulations were not referred to the Enforcement Unit. We also found the Division may be under-reporting a small number of complaints it processes because of errors in recording some telephone complaints in the correct database. Under-reporting complaints impacts the quality of information consumers receive regarding a particular insurance company as well as limits management's ability to effectively analyze trends in the marketplace. Formal adoption of procedures and more training would help Consumer Services Division personnel reduce such errors.

We found the Financial Examinations Division conducts financial examinations and analyses effectively; however, we found issues in the way the Division procures and pays contracted examiners. The Division is reviewed every five years to ensure it meets national accreditation standards and has been accredited for the entire audit period. However, the Division's current practice for procuring contractors and compensating contract examiners does not allow for transparency regarding contract awards and does not provide adequate oversight and assurance the best value was obtained for the services rendered. On-site financial examinations are costly and these costs are eventually passed on to policyholders through the rates insurers charge. We believe cost savings may be realized by competitively bidding examination contracts. Additionally, the NHID's practice of allowing insurers to directly compensate contracted examiners is not in compliance with statute and does not provide adequate assurance contracted examiners' loyalties lie with the NHID. The full cost of operating the Financial Examinations Division is not recorded in the State's accounting system.

The NHID's process for reviewing rates and forms is effective. All policy forms, with some exceptions, are subject to prior approval from the NHID, ensuring forms comply with State laws and regulations before they are used in the marketplace. Under RSA 412, the Legislature has allowed some commercial property and casualty rates to be filed and used without prior NHID

approval; however under other statutes, the NHID still approves rates for all personal lines of insurance prior to being used in the marketplace. This process gives consumers some assurance rates and forms are in compliance with laws and regulations and will allow for future solvency of the company, further ensuring companies are able to pay their claims.

While we found the NHID is effective in fulfilling its consumer protection functions and staff strive to ensure quality service to the consumers of New Hampshire, we believe implementation of the recommendations in this report could further improve the effectiveness of its consumer protection role.

APPENDIX A

DEPARTMENT RESPONSE TO AUDIT

THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

21 South Fruit Street Suite 14
Concord, New Hampshire 03301

Roger A. Sevigny
Commissioner

August 14, 2007

The Honorable Marjorie K. Smith, Chair
Fiscal Committee of the General Court
Legislative Budget Assistant's Office
State House, Room 102
Concord, New Hampshire 03301

Re: The New Hampshire Insurance Department Consumer Protection Functions Performance Audit Report dated August 2007

Dear Representative Smith and Members of the Fiscal Committee:

I would like to start by thanking the Audit Division of the Office of the Legislative Budget Assistant (LBA) for the time and effort they put into this audit and to the report. LBA management and audit staff have been very accessible throughout the process and have treated Insurance Department staff with courtesy and respect.

The purpose of the audit, as outlined by the Legislative Performance Audit and Oversight Committee, was to assess whether the New Hampshire Insurance Department (NHID) effectively fulfills its consumer protection functions. This audit scope was further refined by the LBA to include three specific areas: the process for consumer complaint resolution, rate and form review, and financial examinations. We are gratified that the LBA has determined that the NHID is effective in all three areas—i.e. that the Consumer Services Division processes complaints in an effective manner, that the NHID's process for reviewing rates and forms is effective, and that the Financial Examinations and Licensing Division conducts financial examinations and analyses effectively.

We are aware that performance auditing, by its nature, is a critical process designed to identify problems or weaknesses and that, for this reason, a performance audit report will never contain the words "outstanding job" or "truly excellent performance." At the same time, we understand that there are a number of areas in which we need to improve, and this audit has been a good opportunity to confirm our beliefs about where we should focus our attention. We intend to work diligently to further improve our consumer services and consumer protection functions.

I look forward to answering any questions you may have about the audit report or the NHID's plans for improving its performance in protecting the insurance buying public. Thank you.

Sincerely,

Roger A. Sevigny

Telephone 603-271-2261 • FAX 603-271-1406 • TDD Access Relay NH 1-800-735-2964
Website: www.nh.gov/insurance

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APPENDIX B

LBA CONSUMER SERVICES SURVEY AGGREGATED RESULTS

Notes:

- ***Responses are in bold.***
- ***Totals may not add up to 100 percent due to rounding.***
- ***325 surveys were mailed and 183 (56 percent) were returned.***
- ***We used the number of respondents as our denominator.***

Purpose: The New Hampshire Office of the Legislative Budget Assistant – Audit Division is currently conducting a performance audit of the New Hampshire Insurance Department's consumer protection functions. The primary purpose of the enclosed survey is to assist us in evaluating the New Hampshire Insurance Department's consumer complaints resolution process between July 1, 2004 and June 30, 2006. You were randomly selected to receive this survey because you filed a complaint with the Insurance Department during this time. Your responses will enable us to efficiently collect information about your experience with the Insurance Department's process; therefore your responses are essential to our audit.

Confidentiality: All responses are confidential, consistent with RSA 14:31-a, II. Individual surveys will not be shared with the NHID. According to State law (RSA 14:31-a, II), audit work papers, such as interviews and surveys, are not public records. However, work papers used to support our final report may be made available by a majority vote of the fiscal committee after a public hearing showing proper cause. It is our policy not to name you specifically in our final report. Your responses will be combined with others and will be reported as aggregate data in our final report. We ask for your name in order to track the receipt of surveys and to follow up on responses if needed.

Question Format: The questions primarily consist of multiple-choice questions with some Yes/No responses and open-ended questions. You may add additional information and comments at the end of this survey.

Answering Questions: Please answer the survey as honestly and accurately as possible based upon your direct experience with the complaint resolution process. If you have filed more than one complaint with the New Hampshire Insurance Department, please answer the questions in regards to your complaint filed between July 1, 2004 and June 30, 2006. Select the best answer and completely darken the corresponding circle using blue or black ink, or a pencil. Some questions may allow you to provide multiple answers by asking you to mark all that apply. You may assume you only need to mark one item if this statement does not appear. Please fill in circles completely as shown below.

1. How did you become aware of the New Hampshire Insurance Department's regulatory role in resolving consumer complaints against insurance companies? **(Mark all that apply.)**

One hundred eighty two respondents provided 201 answers to question 1.

Insurance company or agent	**54**	**(30%)**
Insurance Department Website	**33**	**(18%)**
Other Government agency	**16**	**(9%)**
Elected Official	**9**	**(5%)**
Attorney	**18**	**(10%)**
Phone Directory	**19**	**(10%)**
Other (Please Specify):	**52**	**(29%)**

Fifty two respondents provided 52 responses to question 1G:

• Family member or friend	**17**	**(33%)**
• Personal knowledge of the Department	**12**	**(23%)**
• A provider	**5**	**(10%)**
• Police Department	**2**	**(4%)**
• Word of mouth	**2**	**(4%)**
• Telephoned the NHID to inquire	**2**	**(4%)**
• Work for the State of NH	**2**	**(4%)**
• NH Help Line	**2**	**(4%)**
• Professional society	**2**	**(4%)**
• Newspaper	**1**	**(2%)**
• Adjuster	**1**	**(2%)**
• Bank	**1**	**(2%)**
• Business information	**1**	**(2%)**
• Library	**1**	**(2%)**
• Don't recall	**1**	**(2%)**

2. How did you contact the New Hampshire Insurance Department concerning your complaint? **(Mark all that apply)**

One hundred eighty one respondents provided 227 responses to Question 2.

Mailed written complaint	**84**	**(46%)**
Telephoned the Department	**101**	**(56%)**
E-mailed complaint	**13**	**(7%)**
Completed NAIC complaint form	**19**	**(10%)**
Other (Please Specify):	**10**	**(6%)**

Ten respondents provided ten comments to Question 2E:

• Walked into Department	**8**	**(80%)**
• Fax	**1**	**(10%)**
• Haven't contacted the Department	**1**	**(10%)**

Two respondents provided 2 additional comments:

• Do not recall	**1**
• Only way was in writing!	**1**

3. Did you retain an attorney ***before*** you filed a complaint with the New Hampshire Insurance Department?

One hundred eighty two respondents provided 182 responses to question 3.

✔ Yes	**8**	**(4%)**
No	**174**	**(96%)**

4. From the time you submitted your complaint, how long was it before the Insurance Department contacted you about it?

One hundred seventy respondents provided 170 responses to question 4.

Within 48 hours (2 days)	**40**	**(24%)**
Between 2 days and 1 week	**54**	**(32%)**
Between 1 and 2 weeks	**44**	**(26%)**
More than 2 weeks	**32**	**(19%)**

Eleven respondents provided 11 comments: The last two comments were from consumers who did not provide a response to Question 4.

- Don't know/ don't remember **8**
- Immediately **1**
- No response **1**
- They didn't; I had to call them 3 weeks later **1**

5. Did the Insurance Department adequately explain the complaint resolution process to you?

One hundred seventy six respondents provided 176 responses to question 5.

Yes	**151**	**(86%)**
No	**25**	**(14%)**

Two respondents commented the Department did not provide a good explanation.

6. Did the Insurance Department keep you updated on the status of your complaint?

One hundred seventy six respondents provided 176 responses to question 6.

Yes	**129**	**(73%)**
No	**47**	**(27%)**

- One respondent commented they could not remember.

7. How did the Department make you aware of the resolution of your complaint?

One hundred seventy five respondents provided 191 responses to question 7.

Written Communication	**136**	**(78%)**
Telephone Call	**43**	**(25%)**
Was Not Made Aware	**12**	**(7%)**

Ten respondents provided ten comments:

- Can't remember **3**
- Called the Department **2**
- E-mail **1**
- Useless **1**
- Both (Written and phone call) **1**
- Forwarded me the answer from insurance company, which complied with my request. **1**
- None **1**

8. Did the Insurance Department provide you with the insurance company's response to your complaint?

One hundred sixty eight respondents provided 168 responses to question 8.

Yes	**133**	**(79%)**
No	**35**	**(21%)**

- Two respondents commented they could not remember.

9. How satisfied were you with the Insurance Department's processing of your complaint?

One hundred eighty one respondents provided 181 responses to question 9.

Very Satisfied	**71**	**(39%)**
Satisfied	**40**	**(22%)**
Somewhat Satisfied	**18**	**(10%)**
Somewhat Unsatisfied	**12**	**(7%)**
Unsatisfied	**13**	**(7%)**
Very Unsatisfied	**27**	**(15%)**

10. Did the Insurance Department address all of your concerns?

One hundred seventy eight respondents provided 178 responses to question 10.

Yes	**118**	**(66%)**
No	**60**	**(34%)**

- One respondent commented "Do not remember."

11. If the complaint was not resolved in your favor, did the Insurance Department help you understand why?

One hundred nine respondents provided 109 responses to question 11.

Yes	**59**	**(54%)**
No	**50**	**(46%)**

Two respondents provided 2 comments:

- Do not remember **1**
- Somewhat **1**

12. Do you feel your complaint was handled fairly by the Insurance Department?

One hundred seventy four respondents provided 174 responses to question 12.

Yes	**125**	**(72%)**
No	**49**	**(28%)**

- One respondent commented, "I have mixed feelings about it."

13. Would you contact the Insurance Department again with another insurance problem?

One hundred seventy eight respondents provided 178 responses to question 13.

Yes	**142**	**(80%)**
No	**36**	**(20%)**

14. Could the Insurance Department have done more to help you resolve your complaint?

One hundred seventy four respondents provided 174 responses to question 14.

No	**105**	**(60%)**
Yes	**69**	**(40%)**

Seventy two respondents provided 72 comments:

• The Department should be more impartial.	**7**
• The Department needs stronger authority in general, including stronger legislative authority.	**6**
• The Department should have more authority to encourage or compel the company to settle insurance claims.	**6**
• The Department could give more direction or information regarding the next step to take in resolving their complaint.	**5**
• The Department should generally have more communication with the consumer.	**5**
• The Department should take more time to investigate/pursue complaints further.	**4**
• The Department is doing a good job.	**4**
• The Department should have more enforcement power to prosecute licensees.	**3**
• The Department should request and examine all pertinent information.	**3**
• The Department should keep consumers updated on in a more timely manner.	**3**
• The Department should meet with the consumer to clarify the consumer's issues.	**2**
• The Department should better ensure the company's response addresses all of the consumer's concerns.	**2**
• The Department should gain a better understanding of the consumer's issue.	**1**
• Create an arbitration board or panel.	**1**
• Other comments specific to their case.	**20**

Additional Comments
Eighty respondents provided 99 additional comments:

• Satisfied with the Department's efforts/Department was helpful/courteous.	**17**
• The Department did not completely address the consumer's questions/concerns.	**8**
• The consumer received a settlement from the insurance company shortly after the NHID stepped in.	**7**
• The Department has little power or does not use its full power.	**6**
• Thank you to the NHID.	**6**
• NHID provided prompt service.	**5**
• Would contact the NHID again or recommend services to others.	**4**
• NHID provided a thorough response to the consumer's issue.	**3**
• The NHID sides with insurance companies.	**2**
• NHID does not provide adequate consumer protections.	**2**
• Futile to file a complaint with NHID.	**2**
• NHID did not mediate dispute, just sent letters back and forth.	**2**
• NHID did not provide adequate follow-up.	**2**
• Keep funding the NHID/ NHID needs more staff.	**2**
• Dissatisfied with NHID efforts.	**2**
• Other comments specific to individual policies/ comments on specific insurance entities.	**29**

APPENDIX C

LBA SURVEY OF OTHER STATES' INSURANCE DEPARTMENTS

Notes:

- ***Responses are in bold.***
- ***Totals may not add up to 100 percent due to rounding.***
- ***20 surveys were mailed and eight (40 percent) were returned.***
- ***We used the number of respondents as our denominator.***

Purpose: The New Hampshire Office of the Legislative Budget Assistant – Audit Division is currently conducting a performance audit of the New Hampshire Insurance Department's consumer protection functions. The primary purpose of the enclosed survey is to assist us in evaluating the New Hampshire Insurance Department's consumer complaints resolution process, the process for conducting financial examinations, and the rate and forms review process. You were selected to receive this survey based on your Department's funding source and size or your state's proximity to New Hampshire. Your responses will enable us to efficiently collect information about your state Insurance Department's processes; therefore your responses are essential to our audit.

Confidentiality: All responses are confidential, consistent with RSA 14:31-a, II. Individual surveys will not be shared with the New Hampshire Insurance Department or any other entity. According to State law (RSA 14:31-a, II), audit work papers, such as interviews and surveys, are not public records. However, work papers used to support our final report may be made available by a majority vote of the Fiscal Committee after a public hearing showing proper cause. It is our policy not to name you specifically in our final report. Your responses will be combined with others and will be reported as aggregate data in our final report. We ask for your name in order to track the receipt of surveys and to follow up on responses if needed. **Some of the survey questions may be better answered by personnel other than yourself; therefore, your signature is requested to confirm your review of, and agreement with survey responses.**

Question Format: The survey consists of multiple-choice questions, Yes/No responses, and open-ended questions. You may add additional information and comments at the end of this survey.

Answering Questions: Please answer the survey as honestly and accurately as possible **based on your state's fiscal year.** The survey is divided into four sections: general department information, consumer services, financial examinations, and rate and form review. **Each section of the survey may be better answered by personnel responsible for the respective functions.** Consumer services refers to the division within your Department responsible for handling and resolving consumer complaints and inquiries. If the property and casualty and life, accident, and health consumer services divisions are separate in your Department, please combine your answers to include both divisions together in your responses. Financial examinations refers to the division within your Department responsible for conducting on-site financial examinations and financial analysis. If these sections are separate in your Department, please combine your answers to include these functions together. Rate and form review refers to the division within your Department responsible for reviewing and approving rates and forms for compliance with state laws or regulations, including conducting actuarial analysis of rates. If these sections are separate within your Department, please combine your answers to include these functions together.

Insurance entity refers to insurance companies as well as insurance producers such as agents, brokers, and consultants.

General Department Information

1. How many authorized full-time equivalent positions does your Department have?

   Eight states provided eight responses.

   Average: 85.3 FTE positions

   Minimum: 27 FTE positions
   Maximum: 131.2 FTE positions

2. How many full-time equivalent vacancies does your Department have?

   Eight states provided eight responses.

   Average: 2.3 FTE vacancies

   Minimum: 0 FTE vacancies (three states reported zero vacancies)
   Maximum: 6 FTE vacancies

3. How many enforcement positions does your Department have?

   Eight states provided eight responses.

   Average: 4.6 FTE positions

   Minimum: 1 FTE position
   Maximum: 10.5 FTE positions

   3a. In which division(s) are enforcement positions located?

   Eight states provided 10 responses.

Legal Division	**4**	**(50%)**
Investigations Unit	**2**	**(25%)**
Market Conduct	**1**	**(13%)**
Fraud Prevention	**1**	**(13%)**
Enforcement Unit	**1**	**(13%)**
Each section does own enforcement	**1**	**(13%)**

4. What was your Department's authorized budgeted for the following years:
   Seven states provided a response for 2004 and 2005.
   Eight states provided a response for 2006.

	2004	**2005**	**2006**
Average:	**$ 6.8 Million**	**$ 7.3 Million**	**$ 8.2 Million**
Minimum:	**$ 3.2 Million**	**$3.5 Million**	**$ 3.5 Million**
Maximum:	**$9.8 Million**	**$ 11.5 Million**	**$ 11.8 Million**

Consumer Complaints And Inquiries

5. How many authorized full-time equivalent positions does your division have?

   Eight states provided eight responses.

   Average: 12 FTE positions

   Minimum: 3 FTE positions
   Maximum: 29.5 FTE positions

6. How many full-time equivalent vacancies does your division have?

   Eight states provided eight responses.

   Average: .7 FTE vacancies

   Minimum: 0 FTE vacancies (six states reported zero vacancies)
   Maximum: 3.5 FTE vacancies

7. What is your division's authorized budget for the following years?

   Two states provided two responses.
   Six states reported not tracking budgets separate from the department budget.

	2004	2005	2006
Average:	**$ 467,720**	**$ 473,294**	**$ 490,857**
Minimum:	**$ 467,720**	**$ 450,274**	**$ 450,000**
Maximum:	**$ 467,720**	**$ 496,314**	**$ 531,713**

8. Does your division handle consumer complaints of self-insured health plans?

   Eight states provided eight responses.

   Yes **3 (38%)**
   No **5 (63%)**

9. Does your division use the National Association of Insurance Commissioners' definition of consumer complaints?

   Eight states provided eight responses.

   Yes *(Please skip to question 10.)* **5 (63%)**
   No *(Please answer question 9a.)* **3 (38%)**

   9a. If no, what does your division use as the definition of consumer complaints?

   - **Any written complaint, in which the bureau needs to conduct further investigation or to communicate in writing with a regulated entity for a response or resolution** **1**
   - **Do not define a complaint in statute** **1**
   - **No distinction between complaint and inquiry** **1**

10. For each fiscal year, how many consumer ***complaints*** did your division:

Eight states provided eight responses; however, one state was excluded from the analysis because it did not distinguish between complaints and inquiries.

	2004	2005	2006
Average Receive:	**2,195**	**1,936**	**1,875**
Minimum Receive:	**576**	**543**	**417**
Maximum Receive:	**5,160**	**4,589**	**4,370**
Average Dispose:	**2,351**	**2,006**	**1,763**
Minimum Dispose:	**534**	**576**	**390**
Maximum Dispose:	**6,066**	**5,205**	**4,154**

11. How many consumer ***inquiries*** did your division receive in each of the following years?

Eight states provided eight responses; however, one state was excluded from the analysis because it did not distinguish between complaints and inquiries and one state was excluded because it did not track phone calls.

	2004	2005	2006
Average:	**18,752**	**17,982**	**15,869**
Minimum:	**917**	**686**	**292**
Maximum:	**42,598**	**40,494**	**37,746**

12. In each year, how many complaints were:

	2004	2005	2006
Resolved in favor of the consumer *(Please answer question 12a.)*	**56%**	**59%**	**51%**
Resolved in favor of the insurance entity	**38%**	**37%**	**46%**
Referred for administrative action	**2%**	**2%**	**12%**
Resolved in other ways *(Please answer question 12b.)*	**35%**	**42%**	**28%**

12a. For those resolved in favor of the consumer, how many resulted in:

	2004	2005	2006
Money recovered for the consumer[a]	**238**	**236**	**142**
A consumer's policy being reinstated	**23**	**20**	**15**
Administrative action taken against the insurance entity	**3**	**3**	**0**

Note:

a. Three states reported recovering an average of $6 million, $5.9 million, and $5.2 million each year.

12b. Please specify other ways complaints were resolved.

13. How can consumers file complaints with your division? (*Mark all that apply.*)

Eight states provided 27 responses.

Only on an official complaint form	**4**	**(50%)**
By sending a letter including fax and e-mail	**7**	**(88%)**
Over the phone	**3**	**(38%)**
By walking into the Department	**7**	**(88%)**
Through the NAIC website	**2**	**(25%)**
Other (Please Specify):	**4**	**(50%)**

Four states provided one response to Question 13F:

- Department website **4**

14. How does your division prioritize consumer complaints? (*Mark all that apply.*)

Eight states provided 23 responses.

Do not prioritize	**2**	**(25%)**
Based on date of filing	**6**	**(75%)**
Based on harm to the consumer	**4**	**(50%)**
Based on critical or emergency situations	**5**	**(63%)**
Based on time sensitive issues	**4**	**(50%)**
Based on general urgency of the complaint	**2**	**(25%)**
Other (Please Specify):	**0**	**(0%)**

15. Does your division accept complaints filed by a third-party, including someone providing services for an insured?

Eight states provided eight responses.

Yes (*Please answer follow-up question 15a.*)	**4**	**(50%)**

No (*Please answer follow-up question 15b.*)	**4**	**(50%)**

15a. If yes, how are these complaints processed?

Four states provided four responses.

Handle as a normal complaint	**2**	**(50%)**
Follow-up with consumer to obtain release to pursue complaint	**1**	**(25%)**
Other (Please Specify):	**1**	**(25%)**

One state provided one response to Question 15a.C:

- Requiring proof of power of attorney

15b. If no, why not?

Four states provided four responses.

• **Confidentiality/privacy issues**	**2**	**(50%)**
• **Would detract from assisting consumers**	**2**	**(50%)**

16. Does your division handle any complaints ***exclusively*** through phone correspondence?

Eight states provided eight responses.

Yes (*Please answer questions 16a - c.*)	**0**	**(0%)**
No (*Please skip to question 17.*)	**8**	**(100%)**

16a. If yes, what types of complaints are handled exclusively through phone correspondence?

_____

_____

16b. Are complaints handled exclusively through phone correspondence handled by the same personnel who handle written complaints?

Yes (*Please skip to question 16c.*)

No (*Please answer follow-up questions 16b-1 & 16b-2.*)

16b-1. If no, do personnel who handle complaints exclusively through phone correspondence have the same level of training as personnel handling written complaints?

Yes

No

16b-2. If no, what type of training do they receive?

_____

_____

16c. If yes, does your division have criteria for determining which complaints are handled exclusively through phone correspondence?

- Yes (*Please answer follow-up question 16c-1.*)
- No (*Please skip to question 17.*)

16c-1. What are the criteria for determining which complaints are handled exclusively through phone correspondence?

_____

_____

17. How does your division inform consumers about the disposition of their complaint?

Eight states provided eleven responses.

Phone call	**3**	**(38%)**
Disposition letter	**8**	**(100%)**
Other (Please Specify):	**0**	**(0%)**

18. On average, how long does it take the division to resolve consumer complaints?

Eight states provided eight responses.

Less than one (1) month	**2**	**(25%)**
One (1) to two (2) months	**5**	**(63%)**
Two (2) to six (6) months	**1**	**(13%)**
More than six (6) months	**0**	**(0%)**

19. Do personnel working to resolve consumer complaints have the authority to <u>*levy fines*</u> against insurance entities found to have violated state law?

Eight states provided eight responses.

Yes (*Please answer question 20.*)	**2**	**(25%)**
No (*Please skip to question 19a.*)	**6**	**(75%)**

19a. If no, which division or personnel has the authority to *levy fines*?

Six states provided eight responses.

Enforcement personnel within the consumer services division	**2**	**(33%)**
Enforcement personnel external of the consumer services division	**4**	**(67%)**
Other (Please Specify):	**2**	**(33%)**

Two states provided two responses to Question 19a.C:

- **Attorney General's Office 1**
- **Legal Department 1**

20. Do personnel working to resolve consumer complaints have the authority to *take administrative action* (e.g. revoke licenses or require probation) against insurance entities found to have violated state law?

Eight states provided eight responses.

Yes	**1**	**(12%)**
No (*Please answer question 20a.*)	**7**	**(88%)**

20a. If no, which division or personnel has the authority to take *administrative action*?

Seven states provided nine responses.

Enforcement personnel within the consumer services division	**2**	**(29%)**
Enforcement personnel external of the consumer services division	**4**	**(57%)**
Other (Please Specify):	**3**	**(43%)**

Three states provided three "other" responses:

- **Attorney General's Office 1**
- **Legal Department 1**
- **Commissioner 1**

Financial Examinations

21. How many authorized full-time equivalent positions does your division have?

Eight states provided eight responses.

Average: 18.4 FTE positions

Minimum: 5 FTE positions
Maximum: 35 FTE positions

22. How many full-time equivalent vacancies does your division have?

Eight states provided eight responses.

Average: 1.1 FTE vacancies

Minimum: 0 FTE vacancies (three states reported zero vacancies)
Maximum: 2 FTE vacancies

23. What is your division's authorized budget for the following years?

One state provided a response. Six states reported not tracking division budgets separate from the department budget. One state did not provide a response.

2004	2005	2006
$ **2,997,715**	$ **3,506,168**	$ **4,109,672**

24. How many financial ***examinations*** did your division complete in each of the following years?

Seven states provided seven responses for 2004 and 2005. Six states provided responses for 2006.

	2004	2005	2006
Average:	**19**	**14**	**15**
Exams Completed:		**Number of states:**	
< 10	**3**	**3**	**3**
10 – 20	**1**	**0**	**1**
21 – 30	**2**	**4**	**0**
31 – 40	**0**	**0**	**2**
41 – 50	**0**	**0**	**0**
> 50	**1**	**0**	**0**

25. How many financial ***analyses*** did your division complete in each of the following years?

Eight states provided eight responses.

	2004	**2005**	**2006**
Average:	**117**	**115**	**109**
Analyses Completed:		**Number of states:**	
1 – 50	**1**	**1**	**1**
51 – 100	**2**	**2**	**2**
101 – 150	**3**	**3**	**3**
151 – 200	**2**	**2**	**2**
> 200	**0**	**0**	**0**

26. In addition to conducting financial examinations and analysis, which of the following functions does your division perform?

Eight states provided 24 responses.

License insurance companies	**7**	**(88%)**
Monitor company rehabilitation and liquidation	**7**	**(88%)**
Review changes in ownership status	**7**	**(88%)**
Other (Please Specify):	**3**	**(38%)**

Three states provided six responses to Question 26C:

- **Collecting annual statements** **1**
- **Holding company filings** **1**
- **Statutory compliance** **1**
- **Public information requests** **1**
- **Securities deposit** **1**
- **Market regulations** **1**

27. Did the financial examinations division use contractors to conduct any part of its exams from 2001 - 2006?

Eight states provided eight responses.

Yes (*Please answer questions 27a – 27d*)	**8**	**(100%)**
No (*Please skip to question 28.*)	**0**	**(0%)**

27a. How much did the division expend on contract examiners for the following years?

Five states provided five responses.

	2004	2005	2006
Average	**$ 852,272**	**$ 1,964,377**	**$ 837,421**
Minimum	**$ 106,200**	**$ 0**	**$ 0**
Maximum	**$ 2,300,000**	**$ 7,600,000**	**$ 2,000,000**

27b. What types of services does the division contract out for? (*Mark all that apply.*)

Eight states provided 17 responses.

Daily examination/analysis work	**7**	**(88%)**
Specialized skills	**7**	**(88%)**
Other (Please Specify):	**3**	**(38%)**

Three states provided four responses to Question 27b(c):

- **Actuarial review** **2**
- **Investment review** **1**
- **Rehabilitation** **1**

27c. How does your Department pay contracted examiners?

Eight states provided ten responses.

Department pays contract examiner from Department budget	**3**	**(38%)**
Department collects revenue from company and pays contract examiner	**3**	**(38%)**
Company under examination pays contract examiner directly	**3**	**(38%)**
Other (Please Specify):	**1**	**(13%)**

One state provided one response to Question 27c(d):

- **Department simultaneously bills company under examination for reimbursement.**

27d. How does the Department procure contracted services? (*Mark all that apply.*)

Eight states provided 11 responses.

Competitive bidding	**6**	**(75%)**
Sole Source[b]	**3**	**(38%)**
Other (Please Specify):	**2**	**(25%)**

Two states provided two other responses:

• **Approved pool of contractors**	**1**	**(50%)**
• **Financial examination contracts are specifically exempt from competitive bidding; however, they must contain payment terms and conditions, and specified terms/duration, and must be reported in the state's information system.**	**1**	**(50%)**

Note:

b. Two states that reported they allow sole sourcing also reported they use competitive bidding. Only one state uses sole sourcing exclusively.

27d-1. If your Department does not require competitive bidding for procuring contracted services, please explain why.

Use sole sourcing for specialized skills not generally available.	**1**	**(50%)**
Department has used the same contractors for more than ten years.	**1**	**(50%)**

Rate And Form Review

28. How many authorized full-time equivalent positions does your division have?

Eight states provided eight responses.

Average: 9.8 FTE positions

Minimum: 5 FTE positions
Maximum: 18 FTE positions

29. How many full-time equivalent vacancies does your division have?

Eight states provided eight responses.

Average: .9 FTE vacancies

Minimum: 0 FTE vacancies (three states reported zero vacancies)
Maximum: 2 FTE vacancies (two states reported two vacancies)

30. What is your division's authorized budget for the following years?

Two states provided two responses. Six states reported not tracking budget information separate from the department budget.

	2004	2005	2006
Average:	**$ 435,645**	**$ 419,029**	**$ 441,302**
Minimum:	**$ 178,734**	**$ 173,005**	**$195,329**
Maximum:	**$ 692,555**	**$ 665,053**	**$ 687,275**

31. For each of the following years, how many ***rate*** filings did your division:

Eight states provided eight responses.
Two states did not differentiate between rate and form filings; therefore, we combined the responses for questions 31 and 32 and reported the total number of rate and form filings.

	2004	2005	2006
Average Receive:	**13,161**	**13,707**	**11,589**
Minimum Receive:	**4,442**	**4,348**	**4,094**
Maximum Receive:	**14,110**	**15,930**	**33,890**
Average Dispose:	**12,742**	**12,077**	**9,839**
Minimum Dispose:	**1,527**	**1,728**	**2,266**
Maximum Dispose:	**43,066**	**42,116**	**33,890**

32. For each of the following years, how many ***form*** filings did your division:

Combined with Question 31; see above.

	2004	2005	2006
Receive:	_____	_____	_____
Dispose:	_____	_____	_____

33. On average, how long does your division take to approve ***rate*** filings?

Seven states provided seven responses. (Note: one state reported it does not approve rates.)

Within 30 days	**4**	**(57%)**
Between one and two months	**3**	**(43%)**
Between two and three months	**0**	**(0%)**
Between three and four months	**0**	**(0%)**
Between four and six months	**0**	**(0%)**
More than six months	**0**	**(0%)**

34. On average, how long does your division take to approve ***form*** filings?

Eight states provided eight responses. One state reported it does not approve forms.

Within 30 days	**5**	**(63%)**
Between one and two months	**1**	**(13%)**
Between two and three months	**1**	**(13%)**
Between three and four months	**1**	**(13%)**
Between four and six months	**0**	**(0%)**
More than six months	**0**	**(0%)**

35. In your state, what percentage of an average ***property and casualty*** insurance rate is attributed to the following components?

- **Two states provided responses to parts B-F.**
- **Four states reported they do not track this information.**
- **Two states did not respond.**

Anticipated loss (i.e. claims)	**No responses**	Average Premium taxes	**3.0%**
		Minimum Premium taxes	**2.5%**
		Maximum Premium taxes	**3.5%**
Average Overhead costs (e.g. personnel, supplies, fees)	**9.3%**	Average Producer commissions	**15%**
Minimum Overhead costs	**8.5%**	Minimum Producer commissions	**15%**
Maximum Overhead costs	**10%**	Maximum Producer commissions	**15%**
Average Profit	**7.6%**	Other	**0%**
Minimum Profit	**5%**	Please Specify: _____	
Maximum Profit	**10.2%**	_____	

36. In your state, what percentage of an average ***life, accident, and health*** insurance rate is attributed to the following components?

Five states reported they did not track this information.
Three states did not provide a response.

- Anticipated loss (i.e. claims) ___ %
- Overhead costs (e.g. personnel, supplies, fees) _____%
- Profit _____%
- Premium taxes ____%
- Producer commissions ___%
- Other _____%

Please Specify: _____

_____

37. Does your division use the National Association of Insurance Commissioner's System for Electronic Rate and Form Filing (SERFF)?

Eight states provided eight responses.

Yes (*Please answer follow-up questions 37a – 37d.*)	**8**	**(100%)**
No (*Please skip to question 38.*)	**0**	**(0%)**

37a. What percentage of your division's filings are received via:

SERFF	**Paper Filing**
35%	**65%**

37b. Do you use SERFF to track paper filings?

Yes	**1**	**(13%)**
No	**7**	**(88%)**

37b-1. If you do not use SERFF to track paper filings, what do you use?

Seven states provided eight responses.

SIRCON	**3**	**(43%)**
MS Access	**1**	**(14%)**
Oracle	**1**	**(14%)**
Internal System	**2**	**(29%)**
Manual System	**1**	**(14%)**

37c. What ***advantages*** has SERFF created for your state?

Eight states provided 25 responses.

Faster turn-around time	**4**	**(50%)**
Less storage space	**3**	**(38%)**
Improved/ease of access to filing	**3**	**(38%)**
Easier for record retention	**3**	**(38%)**
Less paper	**3**	**(38%)**
Allows public access to filings	**2**	**(25%)**
Facilitates electronic funds transfer (EFT)	**2**	**(25%)**
Other	**5**	**(63%)**

37d. What ***disadvantages*** has SERFF created for your state?

Seven states provided ten responses.

Large filings must be printed out	**1**	**(14%)**
SERFF is slow	**3**	**(43%)**
Reconciling checks with electronic filings is time consuming	**2**	**(29%)**
Difficult to manage public access	**1**	**(14%)**
Bugs in SERFF	**1**	**(14%)**
Training costs are high	**1**	**(14%)**
Upgrading to the new version of SERFF was slow	**1**	**(14%)**

38. How does your Department archive rate and form filings?

Eight states provided ten responses.

Portable Document File (PDF)	**1**	**(13%)**
On a CD	**0**	**(0%)**
Using microfiche	**1**	**(13%)**
Keep a hard copy of the filing	**5**	**(63%)**
Other (Please Specify):	**3**	**(38%)**

Four states provided four responses to Question 38E:

- **Archive through SERFF** **3** **(75%)**
- **Image file** **1** **(25%)**

Please provide any additional comments here:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

End Of Survey. Thank You

APPENDIX D

CURRENT STATUS OF PRIOR AUDIT FINDINGS

The following is a summary of the status of the observations related to the New Hampshire Insurance Department contained in prior audit reports. Related observations are contained in our:

• *New Hampshire Insurance Department Financial And Compliance Audit Report For The Fiscal Year Ended June 30, 2000*.

Copies of prior audits can be obtained from the Office of Legislative Budget Assistant, Audit Division, 107 North Main Street, State House, Room 102, Concord, NH 03301-4906.

Our New Hampshire Insurance Department Financial And Compliance Audit Report For The Fiscal Year Ended June 30, 2000 contains six observations related to our current audit.

NO.	Title	Status
2	Examiner Hours Worked And Travel Expenses Should Be Subject To A Documented Review Procedure	# # #
15	Compensation Payments To Contract Examiners Should Be Made In Accordance With State Statute (See current observation No. 9)	# # #
17	Organizational Rules Should Be Revised To Reflect Current Operating Structure (See Other Issues And Concerns)	#))
19	Independent Contractors Should Be Classified As Employees For Tax Purposes	# # #
20	Written Contracts Should Be Required For Independent Contractors	# # #
23	Automated Timekeeping/Billing System Needed For Examination Billings	# # #

Status Key

Fully Resolved	# # #
Substantially Resolved	# #)
Partially Resolved	#))
Unresolved	)))