

Department of Commerce and Insurance

March 2003

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John G. Morgan
Comptroller

March 31, 2003

The Honorable John S. Wilder
Speaker of the Senate
The Honorable Jimmy Naifeh
Speaker of the House of Representatives
The Honorable Thelma M. Harper, Chair
Senate Committee on Government Operations
The Honorable Mike Kernell, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the performance audit of the Department of Commerce and Insurance. This audit was conducted pursuant to the requirements of Section 4-29-111, *Tennessee Code Annotated*, the Tennessee Governmental Entity Review Law.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the department should be continued, restructured, or terminated.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/dlj
01-081/01-084

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit

Department of Commerce and Insurance

March 2003

AUDIT OBJECTIVES

The objectives of the audit were to determine the department's legislative mandate and the extent to which it has carried out that mandate efficiently and effectively and to make recommendations that might result in more efficient and effective operation of the department.

FINDINGS

Financial Analysis Process Policies and Procedures Are Applied Inconsistently

The Division of Insurance conducts quarterly and annual financial analyses of insurers domiciled in the state. Based on our review of analysis files, however, the formal and informal policies and procedures in place regarding this process are not applied consistently in all cases. The inconsistent application of policies and procedures, both formal and informal, may hinder the division's ability to detect financially troubled insurers and/or insurers engaging in unlawful and improper activities, thereby endangering the policyholders of Tennessee (page 31).

The Division Does Not Adequately Follow Up to Ensure That Companies Correct Identified Deficiencies

The division's examination of an insurance company may result in a list of deficiencies and directives with which the company must comply. The examination process is weakened, however, by the division's lack of timely, on-site follow-up to ensure that appropriate corrective actions have been taken and that the company has remedied identified problems. Concerns about the division's examination follow-up

system were also raised in the June 1992 performance audit of the Division of Insurance (page 36).

The Division Did Not Always Ensure That Insurance Companies Met All Requirements Related to Deposits Held for the Protection of Policyholders

Our review of deposit-related documentation for a sample of 20 insurance companies indicated that the Division of Insurance did not always ensure companies met all requirements. In addition, although the division staff did apparently perform some reviews to determine whether securities were acceptable, the division did not have a formal process to ensure that companies met (and continued to meet) state and departmental requirements, as well as the requirements of their individual depository agreements. Without such a process, policyholders and creditors may be at greater risk if insurance companies experience financial difficulties (page 38).

The Division Should Ensure That Staff Uniformly Follow Policies and Procedures When Conducting Examinations of Insurance Companies or Document Their Reasons for Not Following Those Procedures

Our review of examination working papers indicated that methods used in examination, documentation of items and procedure steps, and the depth of examinations appear to vary depending on the examiner in charge of a particular examination. Inconsistent application of policies and procedures governing the examination process could hinder the Division of Insurance's ability to detect, as early as possible, and take appropriate and timely regulatory action against, those insurers in financial trouble and/or engaging in unlawful and improper activities (page 40).

The Division Has Not Been Consistent in Applying and Documenting Its Insurance Admission Process

As part of the process for permitting an insurance company to conduct business within the state, division staff gather and discuss pertinent information about the company's soundness and ability to serve Tennessee policyholders. However, our review of insurance admissions files for 12 companies indicated that the division was not always consistent in the information it gathered. Furthermore, the files provided no explanation as to why some seemingly relevant information was not obtained for some companies. The division also did not consistently document specific details concerning its admissions decisions, such as the reasons for denials of admission (page 42).

Training and Certification of Bomb and Arson Special Agents Need Improvement

We identified two basic weaknesses in special agents' preparedness to handle their duties investigating arson and bombings: 1) the lack of regular annual training relating to Peace Officer Standards and Training (POST), and 2) the lack of supervisory-related training (page 45).

Bomb and Arson Policies and Procedures Are Incomplete

The Director of Bomb and Arson stated that he was in the process of updating these policies and procedures, using those of the Tennessee Bureau of Investigation (TBI) as a model. A comparison of the section's policies and procedures with those of the TBI indicated that the section lacks policies addressing several investigative and non-investigative areas (page 47).

Arson-related Training for Local Fire and Police Departments Needs Improvement

Investigations involving suspected arsons are, in most locations in the state, handed off to state investigators because of lack of local expertise. The large number of volunteer fire departments compounds the problem of lack of investigative expertise. Effective detection by local investigators is important, however, because the section does not have the resources to investigate every suspicious fire in the state (page 50).

Case Files and Conversations Are Not Properly Secured

Information concerning Bomb and Arson Section cases in paper files and in related conversations is not secured at the central and field offices. Information in paper files is not only unprotected from intentional and unintentional damage or destruction, but also is not easily retrievable. In addition, sensitive conversations regarding ongoing cases are not always conducted in enclosed rooms (page 51).

The Majority of Fire Departments Do Not Report Fire Incident Data to the Tennessee Fire Incident Reporting System, and the Division Has No Authority to Enforce Such Reporting

As of September 2001, only a third of Tennessee's 663 fire departments reported fire incident data to the Tennessee Fire Incident Reporting System (TFIRS). *Tennessee Code Annotated* does not specifically require fire departments to report data to TFIRS, and the Division of Fire Prevention has no authority to force fire departments to report. Reporting of fire incident data is important, however, because

it can help the division identify departments or areas needing additional training, technical assistance, and fire prevention education. In addition, some federal fire prevention grants to Tennessee could be negatively impacted if fires are underreported (page 53).

The Department Needs to Implement a Formal, Comprehensive Fire-Prevention Education Program

Staff indicated that education efforts are informal in nature and included activities such as occasionally providing fire-prevention education in schools, referring requests for such education to local fire departments, and, if requested, providing brochures on fire prevention. An August 2002 edition of the *U.S. Fire Death Patterns by State* indicated that Tennessee's 1995-99 average fire death rate per million was 26.5, the third highest nationally (page 58).

The Electrical Inspection Section Does Not Periodically Review the Competency of the 20 Cities/Counties Granted Exemption from State Electrical Inspections

By law, the State Fire Marshal may authorize municipalities to perform their own electrical inspections and, thereby, be exempt from the state inspections. Twenty entities are exempt and have held these exemptions since at least 1984. The Electrical Inspection Section, however, does not periodically review the exempt entities' operations to ensure that their standards and their inspection programs are adequate (page 60).

The Codes Enforcement Section Is Not Performing the Required Audits of the Local Governments Granted Exemptions from State Building and Fire Codes

By law, local governments can request, and receive, an exemption from statewide building construction safety standards if they certify in writing that they have adopted certain building codes and are adequately enforcing those codes. The Codes Enforcement Section is not, however, auditing the records and transactions of these local governments to ensure that they are adequately performing their enforcement functions, as required by statute (page 61).

Some Codes Enforcement and Deputy Electrical Inspectors' Personnel Files Lack Necessary Documentation

Some of the personnel files reviewed lacked information such as (1) documentation showing that those persons meet the minimum qualifications required for their job classification; (2) a state application—applicable for Codes Enforcement personnel only; and/or (3) an annual evaluation. The lack of such documentation could indicate the existence of employees (state or contract) who do not have adequate qualifications to perform their jobs, as well as a failure by management to adequately oversee the hiring, performance, and training of employees (page 63).

The Majority of Manufactured Houses Are Being Set Up Without the Required Anchoring Permits and Inspections

Manufactured homes that have not been properly anchored may pose a threat to the homes' occupants and/or persons living nearby. In 1976, the General Assembly passed legislation requiring that manufactured homes be anchored by an installer approved by the State Fire Marshal and be inspected for compliance with standards set by the department. Legislation passed in 1981 added a requirement that the installer apply for a permit prior to installing a stabilizing system. Despite these requirements, which have been in place for 20 or more years, our review indicated that few installation permits are being issued and few inspections are being conducted. As a result, the department has no assurance that manufactured houses have been installed properly, by licensed individuals, and in compliance with standards (page 64).

The Division of TennCare Oversight Needs to Establish Formal Policies for Conducting Operations

The division's policy manual, which includes guidance for performing general office duties (e.g., locating documents) as well as for addressing technical matters (e.g., taking complaints from providers or corresponding with MCOs), is a compilation of memos and e-mails issued by division management. These memos and e-mails often refer to staff members

by name (instead of job title) and are casual in tone. While the policies address situations as they arise, it is difficult to determine if a policy rescinds or updates a previous policy.

Furthermore, most of the memos and e-mails do not include the date on which the policy goes into effect (page 66).

OBSERVATIONS AND COMMENTS

The audit also discusses the following issues: (1) Division of Insurance staffing issues; (2) department actions in response to Gramm-Leach-Bliley; (3) the lack of periodic routine examinations of investment advisers; (4) the lack of building codes for one- and two-family dwellings; (5) the status of a polygraph examiner for the Bomb and Arson Section; (6) the need for Bomb and Arson staff to become Certified Fire Investigators; (7) the department's lack of authority to oversee fire departments; (8) AIMS 2000; (9) the Emergency Communication Board and access to 911 services; (10) the need for coordination among several agencies in overseeing and monitoring the TennCare Program; (11) the TennCare Oversight Division's actions to identify and address the MCOs' and BHOs' financial problems; and (12) the TennCare Oversight Division's efforts to enforce compliance with claims processing requirements (pages 5-31).

ISSUES FOR LEGISLATIVE CONSIDERATION

The General Assembly may wish to consider a formal definition of "fire department," which would include training and background-screening requirements for firefighters and would delineate between full-time and volunteer fire departments. The General Assembly may also wish to consider giving the Department of Commerce and Insurance authority to intervene when problems arise that threaten fire service in a particular locality (page 70).

The General Assembly may wish to clarify language in Section 68-102-111, *Tennessee Code Annotated*, to require fire departments to report fire incident data to TFIRS at least annually (page 70).

"Audit Highlights" is a summary of the audit report. To obtain the complete audit report, which contains all findings, recommendations, and management comments please contact

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Performance Audit Department of Commerce and Insurance

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Performance Audit Department of Commerce and Insurance

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of the Department of Commerce and Insurance was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Section 4-29-223, the department was scheduled to terminate June 30, 2002. As provided for in Section 4-29-115, however, the department will continue through June 30, 2003, for review by the designated legislative committee. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review of the department and to report to the Joint Government Operations Committee of the General Assembly. The performance audit is intended to aid the committee in determining whether the department should be continued, restructured, or terminated.

OBJECTIVES OF THE AUDIT

The objectives of the audit were

1. to determine the authority and responsibility mandated to the department by the General Assembly,
2. to determine the extent to which the department has met its legislative mandate,
3. to evaluate the efficiency and effectiveness of the department's activities and programs, and
4. to recommend possible alternatives for legislative or administrative action that may result in more efficient and effective operation of the department.

SCOPE AND METHODOLOGY OF THE AUDIT

Certain activities and procedures of the Department of Commerce and Insurance were reviewed, with a focus on fiscal years 2001 and 2002. The audit was conducted in accordance with government auditing standards generally accepted in the United States of America and included

1. review of applicable legislation, executive orders, and department rules, policies, and procedures;
2. examination of the department's records, reports, information summaries, and Internet homepage;
3. a review of performance and financial and compliance audit reports on the department, as well as such reports from other states and the federal government;
4. interviews with division personnel; and
5. analysis of information obtained from other states, the federal government, and state and national organizations.

This audit does not include a review of the Division of Regulatory Boards. A performance audit of 14 of the professional regulatory boards was released in February 1999.

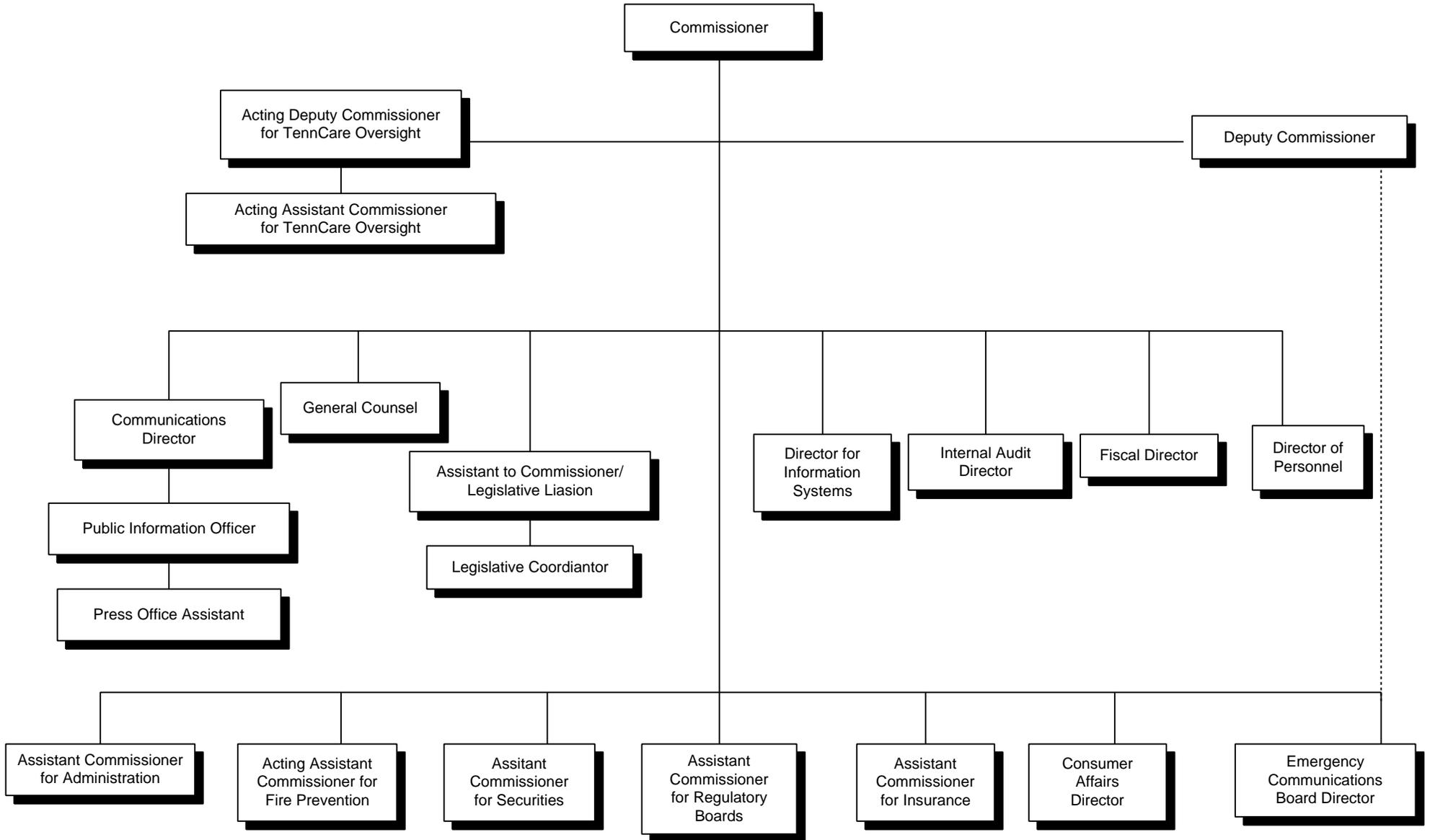
ORGANIZATION AND RESPONSIBILITIES

The State of Tennessee has regulated the insurance industry since at least 1873. The Department of Insurance and Banking was created in 1913. In 1971, the department split into the Department of Banking and the Department of Insurance, and in 1983 the Department of Insurance became the Department of Commerce and Insurance. The department's primary responsibilities are to enforce the insurance laws of the state; to supervise life, fire, casualty, and other insurance companies authorized to transact business in Tennessee; to initiate statewide fire prevention programs; to investigate the origin and circumstances of fires; to enforce the Consumer Protection Act; to receive, investigate, and resolve consumer complaints; to enforce state laws pertaining to securities dealers and salesmen; and to supervise occupational regulatory boards, commissions, and advisory committees.

As of June 30, 2002, the department had 612 full-time staff positions (543 filled), 131 part-time staff positions (127 filled), and one seasonal staff position (vacant). The department's expenditures for the year ended June 30, 2002 totaled \$55,714,200—\$33,316,600 from state appropriations, \$271,000 from the federal government, and \$22,126,600 from other revenue sources.

The department is organized into eight major functional areas: administrative services, insurance regulation, regulation of securities, consumer affairs, TennCare oversight, regulation of trades and professions, emergency communications, and fire prevention and investigation. (See page 3 for an organization chart of the department.)

**Department of Commerce and Insurance
Organizational Chart
December 2002**



The Administration Division's services include the office of the commissioner, fiscal services, management information services, personnel, legal services, and audit consulting and oversight. The division is responsible for coordinating the activities of all divisions, boards, and commissions that are part of the department. The division also supervises personnel, fiscal, and data processing functions for the department.

The Division of Insurance is responsible for enforcing the state's insurance laws and supervising more than 1,600 insurance companies authorized to do business in Tennessee.

The Division of Securities is responsible for enforcing all state laws pertaining to securities dealers and sellers and protecting Tennessee's investors by maintaining the integrity of the securities market.

The Division of Consumer Affairs is responsible for enforcing the Tennessee Consumer Protection Act, which protects consumers and legitimate business enterprises from those who engage in unfair or deceptive trade practices. The division also promotes fair consumer practices and consumer education and regulates health clubs.

The TennCare Oversight Division provides financial and operational oversight of the ten managed care organizations (MCOs) and two behavioral health organizations (BHOs) participating in the TennCare Program. By overseeing, examining, and monitoring the MCOs and BHOs under contract with the state, the division determines compliance with statutory and contractual requirements relating to MCO/BHO financial responsibility, stability, and integrity. The division also determines MCO/BHO compliance with requirements for accurate and timely processing of claims.

The Division of Regulatory Boards provides licensing, regulation, and disciplinary action of professions and businesses. The following professions and businesses are overseen by the division: cosmetologists; funeral directors and embalmers; land surveyors; engineers; private investigators; polygraph examiners; real estate agents and brokers; accountants; auctioneers; alarm system contractors; interior designers; pharmacists and pharmacies; barbers; contractors; automotive manufacturers, dealers, and salesmen; collection services; burial services; home improvement; real estate appraisers; boxing and auto racing; private protective services; geologists; architects and landscape architects; and employee leasing.

The Emergency Communications Board promotes statewide wireless enhanced 911 service. The board is empowered to provide advisory technical assistance to emergency communications districts; establish technical operating standards for emergency communications districts; review and revise wireless 911 standards; and review and approve reimbursements for expenditures related to implementation, operations, maintenance, or improvements to statewide wireless enhanced 911 service.

The Division of Fire Prevention provides services to promote fire safety education and fire prevention. These efforts include inspection of institutional facilities and electrical installations; arson investigation; construction plans review; the Tennessee Fire Incident

Reporting System; registration of electricians; fireworks and explosives user permitting; licensing and regulating sprinkler contractors, liquid petroleum gas distributors, and fire extinguisher dealers; and regulation of the mobile home industry. The division is also responsible for enforcing building and safety codes for most new construction, schools, and other existing structures.

OBSERVATIONS AND COMMENTS

The issues discussed below did not warrant findings but are included in this report because of their effect or potential effect on the operations of the department and on the citizens of Tennessee.

DIVISION OF INSURANCE STAFFING ISSUES

The Division of Insurance needs a sufficient number of qualified examiners and financial analysts to effectively review and examine all domestic insurers in compliance with statutory requirements and National Association of Insurance Commissioners (NAIC) standards. As of December 2001, the division employed 14 full-time examiners and six financial analysts, and also used the services of three contract examiners. At this staffing level, the division has been able to meet the statutory requirement to examine every five years each insurance company licensed in the state. In addition, with one brief exception (see below), the division has been judged by the NAIC to have sufficiently met the NAIC standards necessary for accreditation. According to Financial Analysis Section management, however, in order to meet the NAIC standards financial analysts have had to work significant amounts of overtime following the receipt of the companies' annual statements. Management anticipates that the need for such overtime will decrease, and eventually may be eliminated, once the additional staff added (see page 6) have been fully trained.

The division bases its regulatory processes and reviews of insurance companies on the standards set by the National Association of Insurance Commissioners (NAIC). The NAIC standards for regulatory processes have resulted in format standardization of both the financial analysis and examination processes nationwide. The NAIC is responsible for accrediting insurance departments as to their adherence to NAIC standards, as well as periodically reviewing the accreditation of each state. On-site accreditation reviews are performed every five years unless major problems are identified in the interim.

The NAIC suspended the accreditation of the Division of Insurance in March 2000, in the aftermath of the incident involving the Franklin American Life Insurance Company. In July 2000, the Division of State Audit issued a special report on this incident entitled *Review of Inaction on the Part of Insurance Division Employees Involved in the Regulation of Franklin American Life Insurance Company*. The NAIC review team concluded that there may have been

a serious failing in the regulatory duties and responsibilities of the Insurance Division with regard to one of the companies reviewed by the NAIC team. Problems were identified in several key areas including communication of relevant information to/from financial analysis staff, appropriate supervisory review, appropriate depth of review, documentation of analysis procedures, and timely action in response to material adverse findings.

In the review by the NAIC accreditation team in September 2000, the Tennessee regulatory program was found to be in compliance with standards established by the NAIC. Based on this review, the team recommended that the Insurance Division of the Tennessee Department of Commerce and Insurance regain its accreditation. The review team did make additional comments, however, recommending that, after a financial analysis of an insurance company is complete, the analyst prepare a narrative summary addressing the insurer's overall financial condition and operating environment, including a discussion of the insurer's strengths and weaknesses. It was also noted that the supervisory review program had been "stretched to the point" where it was difficult to ensure that the review of all analyses were timely, thorough, in-depth, and challenging.

The NAIC requires the Division of Insurance to have the resources to effectively review the financial condition of all domestic insurers on a periodic basis, in a manner commensurate with the financial strength and position of each insurer. The NAIC also looks to see if resources are available to complete targeted examinations when needed. During the most recent accreditation review, the NAIC recommended that examinations be conducted more frequently than the five-year statutory mandate, if resources are available. According to Examination Section management, however, at the current level of resources, examiners are able to perform only the statutorily mandated examinations.

According to division management, the NAIC's general guidance is that there should be no more than 15 to 20 companies assigned to each financial analyst. In our review of the Financial Analysis Section, we determined that two of the six financial analysts employed by the Division of Insurance as of December 2001 were assigned more companies in the annual audit process than suggested by NAIC guidelines. For the quarterly audit process, it appeared that the number of companies assigned per analyst fell within the range suggested by NAIC guidelines. However, two of the analysts were responsible for performing supervisory reviews of other analysts' audits in addition to conducting the audits of their own assigned companies. As a result of these added responsibilities, the workload of one of those analysts rose above the upper limit recommended by the NAIC guidelines, and the workload of the other analyst increased toward the upper end of the range specified. (This stretching of the supervisory review program was an issue noted in the most recent NAIC accreditation review.)

Following the Franklin American insurance scandal and the subsequent loss of NAIC accreditation, the Division of Insurance received additional examiner and analyst positions. As of December 2002, the Financial Analysis Section has 14 analyst positions, with no vacancies, and the Examinations Section has 18 full-time field examiners, 4 vacant positions, and 3 contract examiners.

Qualifications of staff are also an accreditation issue. Insurance companies that are licensed in more than one state are subject to zone examinations. The NAIC requires the examiner in charge of a zone examination to be a Certified Financial Examiner (CFE). If a zone examination is not conducted by a CFE, insurance regulators in other states are unable to accept the examination report. Of the 18 full-time examiners (excluding the Chief Examiner) employed by the Division of Insurance in December 2002, only six had their CFE certifications. Based on our survey of Division of Insurance staff, they believe that the incentives the division offers for obtaining the CFE certification, as well as other certifications, are inadequate.

Division of Insurance management should continue to monitor the workloads and qualifications of examination and financial analysis staff to ensure that sufficient staff are available and are allocated in such a manner as to ensure timely identification of troubled insurance companies.

DEPARTMENT ACTIONS IN RESPONSE TO GRAMM-LEACH-BLILEY

The federal Gramm-Leach-Bliley Act of 1999 was passed to “enhance competition in the financial services industry by providing a prudential framework for the affiliation of banks, securities firms, insurance companies, and other financial service providers.” In response to the provisions of the act, the National Association of Insurance Commissioners (NAIC) and its member states (including Tennessee) have taken a variety of actions related to promoting uniformity and cooperation among regulators and safeguarding customer information.

Promoting Uniformity and Cooperation

Under pressure from the insurance industry and the Gramm-Leach-Bliley Act and in order to improve the standards regarding the financial analysis and examination processes, the NAIC has undertaken an agenda of initiatives intended to streamline and promote uniformity at the state level. Tennessee has implemented several of these initiatives. In order to comply with the NAIC initiative promoting the national treatment of companies, Tennessee is now using the Uniform Certificate of Authority Application for insurance companies applying for admission to transact business within the state. Also, the Division of Insurance has entered into information-sharing agreements with the U.S. Department of the Treasury’s Office of Thrift Supervision, the U.S. Office of the Comptroller of the Treasury, the Federal Deposit Insurance Corporation, and the Federal Reserve in order to facilitate communication and coordination between regulators. Tennessee, in an effort to achieve compliance with the NAIC initiative regarding producer licensing reciprocity and uniformity, submitted its regulations regarding producer licensing for NAIC review. The NAIC review detailed the deficiencies with the current regulations in reference to NAIC standards. Based on these recommendations, the Department of Commerce and Insurance submitted a proposal to the General Assembly to bring Tennessee regulations into compliance. Legislation based on the NAIC model regarding producer licensing and reciprocity was passed (with amendment) during the 2002 legislative session, which should make Tennessee regulations Gramm-Leach-Bliley compliant with regard to reciprocity.

Safeguarding Customer Information

Title V of the Gramm-Leach-Bliley Act states that “each agency or authority . . . shall establish appropriate safeguards for the financial institutions subject to their jurisdiction . . . (1) to insure the security and confidentiality of customer records and information; (2) to protect against any anticipated threats or hazards; and (3) to protect against unauthorized access to or use of such records or information which could result in substantial harm or inconvenience to any customer.” Further, Section 502(b) of the law requires that “a financial institution may not disclose nonpublic personal information to a nonaffiliated third party unless the consumer agrees and is given an explanation of how to exercise their choice not to allow such a disclosure.”

In 2001, the General Assembly passed legislation to direct the Department of Commerce and Insurance in its regulation of insurance companies under the Gramm-Leach-Bliley Act. Chapter 107 of the Public Acts of 2001 declared that disclosure by an insurer of nonpublic personal information in violation of the Gramm-Leach-Bliley Act was to be viewed as “an unfair or deceptive act or practice.” Furthermore, the legislation grants the Commissioner of the Department of Commerce and Insurance the authority to implement rules and regulations concerning the disclosure and the use of consumers’ nonpublic personal information. An emergency rule, based upon the model rule put forth by the NAIC, was immediately put into place. The emergency rule was replaced with another rule (also based on a NAIC model rule), effective November 13, 2001.

The Division of Insurance is also participating in the NAIC survey to determine what steps companies are taking to meet the privacy restrictions required by Gramm-Leach-Bliley. The division sent a letter to all Tennessee domestic insurance companies providing a notice of the rulemaking and directing all companies to participate in the survey. Once the NAIC receives all the surveys and analyzes the results, it is going to report to all the state insurance regulatory divisions on how insurance companies in their respective states are doing. At the time of our fieldwork, it had not yet been determined whether the NAIC would continue to use the survey to determine insurance companies’ compliance with the Gramm-Leach-Bliley privacy restrictions. Division staff stated that, in addition to using the survey, the division is working on the development of procedures (e.g., as part of the examination process) to ensure that insurance companies are complying with the privacy restrictions.

THE DIVISION DOES NOT CONDUCT PERIODIC ROUTINE EXAMINATIONS OF INVESTMENT ADVISERS

Section 48-2-111, *Tennessee Code Annotated*, states that all records of registered broker-dealers and investment advisers are subject “at any time and from time to time to such reasonable periodic, special, or other examinations . . . by representatives of the commissioner, as the commissioner deems necessary or appropriate in the public interest or for the protection of investors.” Currently, the Division of Securities conducts examinations when an alleged problem has been reported, but does not conduct routine examinations. According to staff, the division stopped conducting such examinations in the late 1980s because of limited resources. Routine examinations of broker-dealers and larger-scale investment advisers are conducted by

other entities, but no one appears to be conducting examinations of smaller-scale investment advisers.

The National Association of Securities Dealers (NASD) performs both routine and for-cause examinations of broker-dealers, and the federal Securities and Exchange Commission (SEC) is responsible for conducting for-cause as well as routine examinations of investment advisers. The federal National Securities Markets Improvement Act (NSMIA) of 1996 specifies that the SEC is responsible for regulating investment advisers who manage \$25 million or more, while states are responsible for regulating investment advisers who manage less than \$25 million. The act does not, however, specifically require states to examine the transactional behavior of those investment advisers. Currently, investment advisers in Tennessee who manage less than \$25 million are not being examined periodically, unless possible problems have been reported.

Division of Securities staff stated that they would like to once again initiate routine examinations of investment advisers as well as broker-dealers. The division has five staff members in the broker-dealer section and five full-time investigators who handle enforcement duties. According to staff, one additional examiner, to be placed in the broker-dealer section in 2004, could be allocated to allow routine examinations. Historically, routine examinations were conducted by the broker-dealer section.

It appears that surrounding states with similar or even smaller staffs conduct routine examinations. For example, officials from the Alabama Securities Commission report that despite the small size of their staff, they conduct routine examinations of investment advisers in their state. They reported that their six staff members split their time between conducting examinations and performing other responsibilities. Similarly, officials from the North Carolina Secretary of State's Office reported that they conduct routine examinations of investment advisers. They stated that although they only have two examiners, they annually conduct 120 routine examinations. Moreover, each of the states contacted as well as a representative of the SEC indicated that routine examinations are important to ensure the public's protection and reduce the potential for abuse in the securities sector.

LACK OF BUILDING CODES FOR ONE- AND TWO-FAMILY DWELLINGS

Tennessee was among 20 states that did not have statewide building codes for one- and two-family dwellings as of October 2002. (Two other states had adopted statewide residential codes, but limited them to state-funded residential housing or rental homes/duplexes.) Local jurisdictions may have imposed such building codes, but according to the Director of Codes Enforcement, only about half of Tennessee's counties have done so. In the last few years, the Federal Emergency Management Agency (FEMA) and the insurance industry have begun to promote the positive impact of building codes. They are not only promoting the strengthening of building codes, but they are also encouraging the establishment of building codes for one- and two-family dwellings as a means of minimizing or preventing the destruction caused by natural disasters. The insurance industry has begun promoting better and stronger building standards

and enforcement because they affect insurance ratings and can reduce the claims made on insurance companies after a natural disaster.

Strong building codes are the foundation of Project Impact: Building Disaster Resistant Communities, FEMA's nationwide initiative to make prevention the focus of emergency management in the United States. FEMA's studies of tornado damage in 1999 found that there would have been considerably less damage to residential structures if newer building codes and engineering standards had been adopted, followed, and enforced. Building or upgrading homes to the most recent versions of the codes and standards would have reduced significant damage to homes in the direct path of less violent tornadoes. Many building failures could have been avoided with better construction techniques, better building materials, and the effective use of structural connections. During a 1999 speech, the U.S. Federal Insurance Administrator stated that there is abundant evidence from 30 years of National Flood Insurance Program loss experience that structures built to the program's higher construction standards are 77% less likely to be damaged, with fewer and less severe losses. The higher standards are estimated to save U.S. taxpayers \$800 million per year in damages avoided.

The state should evaluate the costs and benefits of developing and implementing statewide building standards for one- and two-family dwellings—weighing the cost of additional regulation and inspection against the potential decrease in structural damage, injury, and loss of life that could result from strengthening standards for residential housing throughout the state.

STATUS OF A POLYGRAPH EXAMINER FOR THE BOMB AND ARSON SECTION

Section staff stated that bomb and arson investigations have been impeded because of lack of a readily available polygraph examiner. Currently, the section has to borrow the services of an examiner from either the Tennessee Bureau of Investigation (TBI) or the Bureau of Alcohol, Tobacco, and Firearms (ATF). The department is not charged for these services. The Director of Bomb and Arson indicated that getting access to a TBI examiner generally takes approximately a week (24 hours in an emergency situation, e.g., in murder cases). The demand for polygraphs is too high within the TBI and ATF for these agencies to promptly provide polygraph services to the section in all circumstances. One special agent indicated that murder cases sometimes require up to ten polygraphs involving suspects and witnesses.

The major repercussion of not having a polygraph examiner available during initial questioning of suspects and witnesses is that these individuals' cooperation with special agents tends to decline with the passage of time. Section staff stated that delays many times result in suspects changing their minds about agreeing to be polygraphed because friends, relatives, or attorneys convince them not to cooperate. According to the TBI Deputy Director, "As timing is often essential in acquiring a confession and frequently there are no second chances, a polygraph examiner can be a tremendously valuable asset to any investigative agency." Another repercussion of delayed polygraphs is cases turning "cold" (i.e., as information gets old it becomes less valuable).

The Director of Bomb and Arson stated in January 2002 that he had gotten approval from the Department of Finance and Administration's Office of Criminal Justice Programs to use federal Edward Byrne Memorial Grant funds to train a special agent as a polygraph examiner and acquire related equipment. According to updated information obtained in November 2002, a special agent is in polygraph school and is scheduled to complete his training in mid-December 2002. The training and related polygraph equipment were provided under the Department of Commerce and Insurance's Homeland Security Initiative.

NEED FOR BOMB AND ARSON STAFF TO BECOME CERTIFIED FIRE INVESTIGATORS

The Director of Bomb and Arson stated that a bomb and arson investigator becoming a Certified Fire Investigator (CFI) is equivalent to getting a graduate degree since it is "a very demanding program" to complete. At the ATF, a CFI is considered above a street-level agent. In court, CFIs qualify as expert witnesses. Officials from the ATF and fire marshal offices from other states agreed on the value of CFI certification. According to the local ATF Special Agent In-Charge, the CFI "is a specialization that lays a foundation for successful fire determination and subsequent prosecution. The standards have to be high so the agent can take the expertise from the fire scene to the courtroom scene."

The Bomb and Arson Section's goal is that all special agents with five or more years of experience will become CFIs. One certifying organization is the International Association of Arson Investigators (IAAI). Nine of 20 field agents (and 7 out of 14 field agents with five years of experience or more) had CFIs or CFI-related certifications, as of October 2001. Section staff indicated that there was no incentive for certification, such as payment of examination fees or increases in salary.

As of November 2002, the director of Bomb and Arson indicated that the section was still unable to provide any financial incentives for certification. However, the section has hired an agent who is a CFI instructor, and the director's plan is to develop an in-house program to grant a Certified Fire and Explosives Investigator (CFEI) certification. Although such certification would not result in increased salaries, agents could obtain the certification without having to pay for exams, etc.

THE DEPARTMENT DOES NOT HAVE THE AUTHORITY TO OVERSEE FIRE DEPARTMENTS

Section 68-102-101 et seq., *Tennessee Code Annotated*, which outlines the powers of the Division of Fire Prevention, does not give the department authority to oversee volunteer or full-time fire departments. There is no formal definition of what a "fire department" is, including who qualifies as a member of such a department. The fire department chiefs, as the commissioner's "assistants," are only required to report suspicious fires within ten days.

The Assistant Commissioner for Fire Prevention indicated several negative repercussions regarding the lack of regulation of fire departments. The department cannot respond to citizen

complaints regarding issues such as departments' slow responses to fire or solicitation of funds. In cases of solicitations, citizens sometimes have suspicions as to whether departments are properly using raised funds. According to the assistant commissioner, an individual can put a sign "on a barn," call himself a fire department, and collect money through subscriptions.

Another issue is the identification of fire departments for the purposes of grants. The federal government (e.g., the U.S. Fire Administration) and the state need to be assured that grant funds do not go to fraudulent fire departments. A third issue is which individuals have the right to attend the Tennessee Fire Service and Codes Enforcement Academy for firefighting training. A fourth issue is which local agencies the department should communicate with as "fire departments." The assistant commissioner stated that there has to be a minimum standard for fire department operations for citizens to know exactly what a fire department is and should be doing, and to prevent a false sense of security. He added that city fire departments are not the problem; the volunteer ones are.

According to the Director of Bomb and Arson, another problem is the presence of "firebugs," or arsonists, among members of volunteer fire departments. As of October 2001, 11 such individuals had been identified by special agents as suspects and/or defendants during the past three years. The director stated,

Nearly \$1,700,000 in fire losses resulted because of the action of these defendants. Targets included a fire department, a car dealership, residential dwellings, barns, a mobile home, and a house of worship. There were no deaths or injuries associated with these incidents . . . We emphasize that the bulk of men and women in the volunteer fire service provide a valuable contribution to their respective communities. However, inasmuch as screenings and background checks are rarely conducted, a relatively small number of individuals with less than pure motives are sometimes members of these units.

In addition to the cases worked by Bomb and Arson, the section assisted the Hamilton County Sheriff Department's arson unit in 1998 with an arson case involving seven volunteer firefighters, one of whom burned to death. State arson investigators in other states also indicated a "firebug" problem. According to the U.S. Fire Administration's *Arson in the United States*, inadequate screening of volunteer firefighters is a major cause of the problem. "One of the most egregious situations is when a firefighter betrays the public's trust and turns to arson. . . . While it is not possible to predict a person's behavior absolutely, warning signs of the propensity of a prospective fire service member to set fires might be discovered through proper screening and background checks." Motives of these arsonists include excitement, wanting to appear a hero, and frustration because of a lack of fire incidents.

Some other states have the authority to regulate fire departments. In Maryland, for example, all fire departments have to be chartered by the state. Members of fire departments are required to undergo background checks. Although Ohio does not formally define "fire department," firefighters must be recognized by the State Fire Marshal or be trained through approved training programs.

The General Assembly may wish to consider a formal definition of “fire department,” which would include training and background screening requirements for firefighters and would delineate between full-time and volunteer fire departments. The General Assembly may also wish to consider giving the Department of Commerce and Insurance authority to intervene when problems arise that threaten fire service in a particular locality.

AIMS 2000

The purpose of Arson Intervention and Mitigation Strategy (AIMS) 2000 is to replace the section’s old paper case management system, which did not give staff the ability to electronically retrieve information. A pilot project funded by the U.S. Fire Administration, AIMS 2000 is designed to collect case data from field staff, the arson programs of six major cities in Tennessee (Chattanooga, Jackson, Johnson City, Knoxville, Memphis, and Nashville), and also from federal databases. Special agents enter data straight into their laptop computers, which then transmit the data to the AIMS 2000 server located at the Department of Finance and Administration’s Office for Information Resources (OIR).

In addition to allowing electronic data retrieval, AIMS 2000 makes data entry easier and helps ensure that case reports are complete. The system has “drop options” (i.e., multiple choices for answers) that save time during data entry. A special agent also has to fill out all fields on a particular input screen before he or she can go on to the next screen. These features help ensure that all necessary data are entered into the system and that case information is standardized. A good set of data is important because district attorneys are more likely to prosecute if the case information provided is reliable and complete. In addition, when a case is opened AIMS 2000 creates an incident report that goes straight to the commissioner, allowing the commissioner to know about all reported arsons.

Although Bomb and Arson staff indicated problems in implementing AIMS 2000, including delays in training field staff in how to use the system and some difficulties in the transfer of data from laptops to the system’s server, AIMS was fully implemented at the end of 2001. The section should continue to evaluate training needs or other problems of AIMS 2000 and implement timely solutions.

THE EMERGENCY COMMUNICATIONS BOARD AND ACCESS TO 911 SERVICES

The Emergency Communications Board was created by Chapter 1108, Public Acts of 1998, for the purpose of ensuring that all Tennesseans have access to both landline and wireless 911 services. The board oversees the operations of local emergency communications districts, which are responsible for improving access to 911 services at the local level. Pursuant to Sections 7-86-302 and 304, *Tennessee Code Annotated*, such oversight includes ensuring the financial stability of such districts and “assisting emergency communications district boards of directors in the area of management, operations, and accountability, and establishing emergency communications for all citizens of the state.”

The board is funded through a charge on all commercial mobile radio service subscribers and users whose principal wireless service or billing address is in Tennessee. The specific amount of the charge is determined by the board but must be approved by the General Assembly through a joint resolution. Section 7-86-303, *Tennessee Code Annotated*, requires the board to distribute 25 percent of the revenue generated by the charge to emergency communications districts for the provision of 911 service based on their proportion of the state's population, as indicated by the most recent census.

Section 7-86-307, *Tennessee Code Annotated*, requires the board to develop and implement a statewide plan for landline and wireless enhanced services to all citizens of Tennessee. Federal Communications Commission Order 94-102 of 1996 requires that wireless enhanced 911 service be implemented in two phases.

1. Phase One requires the ability to relay to the 911 centers the telephone number and the location of the cell site or tower receiving the wireless 911 call.
2. Phase Two requires the capacity to identify the latitude and the longitude of a wireless 911 call, within a radius of 125 meters (401 feet), in 67 percent of all cases.

Exhibit 1 indicates the extent of implementation of landline and Phase One services county-by-county, as of April 2002. The board's executive director indicated that landline and Phase One implementation happens simultaneously. The vast majority of counties have both services. Exhibit 2 indicates the extent of the implementation of Phase Two. Only 13 central Tennessee counties have the capacity to receive Phase Two data from carriers.

The board's former executive director (who resigned in April 2002) indicated several barriers to implementing all the board's legislative mandates. These barriers include a small staff having difficulty with technically complex regulatory duties, the lack of a technical consultant to help the board with its regulation of emergency communication districts, and the high cost of implementing Phase Two. Full implementation could cost up to \$34 million a year, more than the board takes in as wireless revenues. The board should consider solutions to these barriers and make appropriate recommendations to the commissioner.

EFFECTIVE OVERSIGHT AND MONITORING OF THE TENNCARE PROGRAM REQUIRE COORDINATION AMONG SEVERAL STATE AGENCIES

The Department of Commerce and Insurance is one of several state agencies responsible for monitoring the TennCare program. Other state agencies having some oversight responsibility include the Department of Finance and Administration (including the TennCare Bureau), the Department of Health, the Department of Mental Health and Developmental Disabilities, the Office of the Comptroller of the Treasury, and the Tennessee Bureau of Investigation. In addition, the Select Oversight Committee on TennCare is the legislative committee charged with monitoring TennCare. Given the complexity of the program and the number of state entities involved, the coordination and sharing of information are of crucial importance for the consistent administration and monitoring of TennCare.

Table 1 lists the state entities mentioned above, their authority, and their primary oversight responsibilities. A brief description of each entity’s oversight responsibilities follows. Since none of these entities, except the Department of Commerce and Insurance, fell within the scope of this audit, we did not assess the extent to which each fulfills its mission in relation to TennCare. However, we did evaluate the extent to which the Department of Commerce and Insurance works with other agencies.

**Table 1
State Entities Monitoring TennCare**

Entities	Authority	Primary Responsibilities
Department of Commerce and Insurance	<ul style="list-style-type: none"> • Sections 56-32-215 and 56-51-132, <i>Tennessee Code Annotated</i> • Executive Order 1, effective January 26, 1995 	<ul style="list-style-type: none"> • Ensure HMO/BHO compliance with state law, contracts, etc. • Provide financial oversight of TennCare MCOs
Department of Finance and Administration	<ul style="list-style-type: none"> • Executive Order 23, effective October 19, 1999 	<ul style="list-style-type: none"> • Administer TennCare
Department of Health	<ul style="list-style-type: none"> • Section 56-32-215, <i>Tennessee Code Annotated</i> 	<ul style="list-style-type: none"> • Ensure an HMO can provide adequate health care services
Department of Mental Health and Developmental Disabilities	<ul style="list-style-type: none"> • Memorandum of Understanding (between the department and the Bureau of TennCare) 	<ul style="list-style-type: none"> • Administer the TennCare Partners Program
Office of the Comptroller of the Treasury	<ul style="list-style-type: none"> • Memorandum of Understanding (between Commerce and Insurance and the Comptroller’s Office) • Sections 4-3-304, 8-4-109, and 4-29-111, <i>Tennessee Code Annotated</i>. 	<ul style="list-style-type: none"> • Conduct audits of TennCare MCOs and BHOs, state agencies and departments
Tennessee Bureau of Investigation	<ul style="list-style-type: none"> • Executive Order 47 (February 11, 1983) 	<ul style="list-style-type: none"> • Investigate provider fraud
Select Oversight Committee on TennCare	<ul style="list-style-type: none"> • Sections 3-15-501 through 510, <i>Tennessee Code Annotated</i> 	<ul style="list-style-type: none"> • Regularly review programs, functions, and activities related to TennCare

Department of Commerce and Insurance

Executive Order 1, dated January 26, 1995, created the TennCare Oversight Division of the Department of Commerce and Insurance to provide financial oversight of TennCare managed care organizations (MCOs). Through oversight, examination, and other monitoring activities, the division determines if the MCOs and behavioral health organizations (BHOs) participating in TennCare are in compliance with statutory and contractual requirements relating to their financial responsibility, stability, and integrity. As of April 22, 2002, ten managed care organizations provided services for the 1.4 million Tennesseans enrolled in TennCare. Table 2 presents enrollment numbers by MCO. Enrollees are assigned to one of the two BHOs (Premier or TBH) for mental health and substance abuse services.

Table 2
Enrollment by MCO
As of April 22, 2002

	Medicaid/ TennCare	Uninsured/ Uninsurable	Total
Better Health Plans	25,732	18,151	43,883
BlueCare/Volunteer State	152,050	134,878	286,928
John Deere	39,466	36,953	76,419
OmniCare	80,666	42,189	122,855
Preferred Health Partnership	56,143	57,178	113,321
TLC/Memphis Managed Care	127,272	80,647	207,919
Universal	74,360	69,787	144,147
VHP	20,642	13,292	33,934
Xantus	86,289	77,685	163,974
TennCare Select	148,950	93,043	241,993
Statewide	811,570	623,803	1,435,373

The department is required by law to examine, at least every four years, the affairs of any TennCare health maintenance organization (which includes all TennCare managed care organizations) and any providers with whom the organization has contracts, agreements, or other arrangements. The TennCare Division conducts these examinations, which focus on claims processing operations, as well as financial and contractual compliance. See pages 26 and 22 for discussions of claims processing and financial compliance respectively. Contractual compliance issues include grievances/appeals, provider contracts, marketing, MCO/BHO coordination, subcontractors, and Title VI.

Table 3 lists the dates of the most recent examination reports released as of July 31, 2002. The department has not issued recent examination reports for Xantus and TCCN since Xantus has been in receivership since March 31, 1999 (the department essentially runs the program) and TCCN had been under supervision since June 14, 1999, (with TennCare Oversight Division examiners monitoring activities daily). Because of unresolved problems, the state terminated its

contract with TCCN effective October 31, 2001. (See Appendix 4 for additional information about Xantus and Appendix 5 for more information about TCCN.) Because Better Health Plans and Universal Care joined the program July 1, 2001, examinations of these two plans had not been released as of July 31, 2002. According to the assistant commissioner over the division, the department wanted the plans to accrue six months of data before the first examination. Both MCOs were, however, scheduled for examination fieldwork during 2002.

Table 3
Most Recent Examination Reports Released
As of July 31, 2002

	Exam Period	Date Issued	Type of Exam
John Deere Health Plan	October 1, 1999 – December 31, 1999	October 15, 2001	Claims Processing Market Conduct Exam
Memphis Managed Care d/b/a TLC Family Care Healthplan	January 1, 1998 – March 31, 1999	July 7, 1999	Claims Processing Market Conduct Exam
OmniCare Health Plan	April 1, 2000 – June 30, 2000	November 9, 2001	Claims Processing Market Conduct Exam and Limited Scope Financial Exam
Preferred Health Partnership	January 1, 1996 – December 31, 1997	July 6, 1999	Claims Processing and Financial Exam
Premier Behavioral Systems	July 1, 1998 – June 30, 2000	October 26, 2001	Claims Processing and Limited Scope Financial Exam
Tennessee Behavioral Health	July 1, 1998 – June 30, 2000	October 26, 2001	Claims Processing and Limited Scope Financial Exam
VHP	October 1, 1995 – June 30, 1997	February 23, 1998	Claims Processing and Financial Exam
Volunteer State Health Plan/BlueCare	January 1, 2000 – March 31, 2000	August 31, 2001	Claims Processing Market Conduct Exam and Limited Scope Financial and Compliance Exam

Findings from the above examinations are found in Appendix 3. Examinations are coordinated with auditors from the Comptroller of the Treasury’s TennCare Section. (See page 21.) Examinations are scheduled assuming three weeks of fieldwork and include financial, contract compliance, and claims processing test work unless noted otherwise. Examiners do not typically test compliance for services provided by subcontractors when those services are provided off-site.

Department of Finance and Administration

Executive Order 23, issued on October 19, 1999, transferred the functions related to TennCare from the Department of Health to the Department of Finance and Administration, making the department the primary agency responsible for TennCare. The department (i.e., TennCare Bureau) has the authority to receive, administer, and supervise all funds related to TennCare, as well as promulgate rules and policies necessary for the program’s administration.

In addition to its administrative duties, the TennCare Bureau monitors quality of care, network adequacy, and contract compliance for the managed care organizations.

The Department of Commerce and Insurance's TennCare Oversight Division and the TennCare Bureau must work together to ensure that statutory and contractual requirements are enforced. According to the assistant commissioner, the TennCare Bureau asks the division to review and comment on drafts of contracts to ensure appropriate regulatory language is included. In addition, division staff refer enrollee complaints to appropriate Bureau personnel. The division also depends on the TennCare Bureau to enforce findings of noncompliance. The division does have limited authority to assess penalties for noncompliance, and it has used this authority when a plan fails to remedy its claims processing deficiencies. When problems continue, however, the department notifies the TennCare Bureau and advises the bureau to assess liquidated damages. To ensure the bureau is informed of potential problems, division staff send the bureau's Director of Contract Compliance a copy of relevant correspondence with the MCOs. While addressing problems with Xantus and TCCN, the division updated the bureau, as well as other Finance and Administration officials, the Comptroller, and the Commissioner of Health, on its regulatory actions.

Department of Health

The Department of Health is responsible for determining whether a health maintenance organization applying for a Certificate of Authority is capable of providing basic health care services efficiently, effectively, and economically. The department is to review the organization's medical management, quality improvement, utilization management, and other programs, as well as the network of hospitals, physicians, pharmacies, and other providers in the proposed service area. Thereafter, the department is required to inspect each organization at least every three years. Findings must be reported to the Commissioner of Commerce and Insurance, who may suspend or revoke a certificate of authority issued to an HMO.

Department of Mental Health and Developmental Disabilities

The Tennessee Department of Mental Health and Developmental Disabilities [formerly Tennessee Department of Mental Health and Mental Retardation] is the state agency responsible for administering the TennCare Partners Program. By Memorandum of Understanding with the TennCare Bureau, the department reviews BHO provider networks and develops quality indicators for the Partners Program. The department is working with the TennCare Bureau on establishing a monitoring unit that reports to both agencies.

Office of the Comptroller of the Treasury

Several sections within the Comptroller's Division of State Audit – Medicaid/TennCare, Financial and Compliance, and Performance Audit - periodically monitor TennCare MCOs and BHOs or the agencies responsible for the TennCare program and its oversight. Under a memorandum of understanding between the Office of the Comptroller of the Treasury and the Department of Commerce and Insurance, the Comptroller's Medicaid/TennCare section and the

department's TennCare Oversight Division conduct joint examinations of each TennCare managed care and behavioral health organization that contracts with the state. The memorandum was formulated to help ensure that examination activities were coordinated and that there was no duplication of effort. (The Medicaid/TennCare section is solely responsible for examinations of Xantus, since Commerce and Insurance is currently running that program.) The Comptroller's Medicaid/TennCare section also conducts special reviews or other audit work for various aspects of the TennCare program, as requested.

The financial and compliance section conducts financial and compliance audits of all state departments, agencies, and institutions. The most recent such audit of the Department of Finance and Administration (including TennCare) was released in December 2001 and covered the year ended June 30, 2001. The performance audit section conducts audits (pursuant to the Governmental Entity Review Law) which focus on the extent to which state agencies and departments fulfill their legislative mandates. The March 1999 Department of Health performance audit focused largely on the administration of the TennCare program, and this performance audit of the Department of Commerce and Insurance includes an evaluation of the TennCare Oversight Division's regulatory actions regarding TennCare MCOs and BHOs.

Tennessee Bureau of Investigation (TBI)

The TBI Medicaid Fraud Control Unit (MFCU) investigates provider fraud. Management of the MFCU frequently meet with each MCO, while MFCU investigators have been assigned to meet with each MCO on a regular basis to educate the organizations on identifying and reporting fraud. The MFCU helps host quarterly "Round Table" meetings where representatives of all the MCOs and BHOs discuss problems relating to fraud. MFCU personnel also reportedly meet with officials from the TennCare Bureau, Attorney General's Office, the Department of Commerce and Insurance, and the Health Related Boards to exchange ideas on overlapping issues.

Select Oversight Committee on TennCare

The intent of the Select Oversight Committee on TennCare is to help ensure that the TennCare program will achieve its intended purpose, that access and quality of care are maintained for TennCare enrollees, and that the General Assembly and the public can have confidence that the state will deliver a TennCare program which is effective and efficient. To that end, the committee's scope includes

- reviewing proposed expenditures for TennCare;
- reviewing eligibility and enrollment standards, provisions of services, facilities, or programs by TennCare providers, and education programs for TennCare enrollees, MCOs, and providers;
- reviewing and evaluating the performance of TennCare MCOs, including their compliance with state contracts and provider agreements; and

- reviewing legislation that will or will potentially impact any area within the scope of the committee.

Oversight Concerns

For years, providers and provider groups have expressed concerns about adequate oversight. Much of their concern stems from years dealing with contractual and financial issues, which they believe have never been resolved. Furthermore, some do not think the state ensures that MCOs and BHOs fulfill the terms of their contracts.

After the collapse of two MCOs (Xantus and TCCN) and the significant financial problems of one of the newest MCOs (Universal), the need for more effective oversight by all entities involved is vitally important to the survival of the TennCare program. As the state attempts to stabilize the program, it must ensure that appropriate controls are in place and appropriately enforced and that information is coordinated and shared.

ANALYSIS OF THE TENNCARE OVERSIGHT DIVISION'S ACTIONS TO IDENTIFY AND ADDRESS THE MCOS' AND BHOS' FINANCIAL PROBLEMS

The mission of the TennCare Oversight Division is to protect the public health and the integrity of the TennCare Program by overseeing, examining, and monitoring health organizations participating in the program. Part of that responsibility is ensuring that the MCOs and BHOs under contract with the state are in compliance with statutory and contractual requirements relating to their financial responsibility and stability. While the division has implemented several measures to assess an MCO's or BHO's financial solvency, these efforts do not seem to protect against financial problems that may have disastrous effects. The financial problems facing the TennCare MCOs have become so significant that, in order to stabilize TennCare, the state assumed all risk for the program for 18 months, beginning July 1, 2002. Under the "stabilization plan," the state assumes the financial risk for the TennCare Program and pays each MCO an administrative fee, as well as paying the MCOs' premium tax. In addition, each MCO is eligible for an additional 2% if it meets performance goals in areas such as network adequacy and generic prescription drug utilization.

Minimum Net Worth

Minimum net worth requirements for MCOs are defined in Section 56-32-212, *Tennessee Code Annotated*, while the TennCare Partners contract delineates minimum net worth for the BHOs. (Net worth is the excess of total admitted assets over total admitted liabilities.) To meet minimum net worth requirements, MCOs and BHOs must maintain a net worth of \$1,500,000 or an amount totaling 4% of the first \$150,000,000 of annual premium revenue as reported on the most recent annual statement filed with the commissioner and one and one-half percent of the annual premium revenue in excess of \$150,000,000.

Each MCO and BHO is required to submit quarterly and annual financial statements as prescribed by the National Association of Insurance Commissioners (NAIC). Division staff

review these reports to determine if a plan is in compliance with its net worth requirement. Discrepancies in net worth are communicated to the plan as well as to the TennCare Bureau, and corrective action is required.

Table 4 presents net worth reported on June 30, 2002. As indicated, Memphis Managed Care, Universal, Premier, and Xantus (which is in receivership) reported deficiencies in their net worth. The financial problems of Universal, Xantus, and TCCN (whose contract was terminated October 31, 2001) are discussed below.

Table 4
Reported Net Worth as of June 30, 2002

MCOs/BHOs	Net Worth Requirement	Net Worth Reported	Excess (Deficiency)
Better Health Plans (1)	\$2,956,800	\$3,350,920	\$394,120
John Deere	\$12,377,685	\$75,854,594	\$63,476,909
Memphis Managed Care/TLC	\$7,201,830	\$4,624,917	(\$2,576,913)
Preferred Health Partnership	\$6,821,720	\$16,270,488	\$9,448,768
OmniCare	\$4,544,249	\$5,416,133	\$871,884
Universal (1) (2)	\$6,522,000	\$5,637,208	(\$884,792)
VHP	\$1,816,510	\$6,506,350	\$4,689,840
Volunteer State	\$16,673,233	\$54,991,616	\$38,318,383
Premier (BHO)	\$6,918,195	\$2,265,149	(\$4,653,046)
Tennessee Behavioral Health (BHO)	\$5,514,875	\$11,652,307	\$6,137,432
Xantus	\$7,998,884	(\$77,237,383)	(\$85,236,267)

Notes:

- (1) These MCOs did not begin operations until July 1, 2001. The net worth requirement has been increased above the statutory minimum based on projected premium revenue.
- (2) Universal has been placed under the administrative supervision of the Commissioner of Commerce and Insurance as a result of identified financial and claims processing operations problems. Further regulatory actions by the department are subject to the Centers for Medicare and Medicaid Services' and the TennCare Bureau's response to the request by Universal for additional funding. The collectibility of this receivable is pending resolution by the Centers for Medicare and Medicaid Services and the TennCare Bureau. If this receivable is deemed uncollectible, the department will adjust Universal's reported net worth from \$5,637,208 to (\$40,349,575).

Division staff also monitor a plan's financial compliance through periodic examinations that include procedures such as

- reconciling annual/quarterly NAIC statements to the trial balance and general ledger of the organization;
- reconciling the NAIC annual statement to the audited financial statements;
- determining if assets are correctly reported as "admitted" or "non-admitted" on the annual statement;

- verifying and testing cash, cash equivalents, short- and long-term investments, premiums receivables, health care receivables, and other assets;
- reviewing methods used to calculate the incurred but not reported (IBNR) claims;
- reconciling premium revenues to payments made by TennCare;
- testing selected capitation payments for accuracy;
- examining the allocation of health care expenses for proper classification on the NAIC annual/quarterly statements; and
- verifying administrative expenses.

We obtained copies of the most recent examination reports for each MCO and BHO during our fieldwork. The findings resulting from those examinations are presented in Appendix 3.

Financially Troubled MCOs

Since the implementation of TennCare, at least three MCOs (Xantus, TCCN, and Universal) have encountered severe financial problems. A brief description of these financial problems is discussed below. Detailed information regarding Xantus and TCCN can be found in Appendices 4 and 5, respectively.

Xantus. The division first notified Xantus of a \$2.3 million net worth deficiency on April 8, 1998. The division closely monitored Xantus and repeatedly notified the plan of its worth deficiencies. When the MCO failed to meet its statutory net worth requirement Xantus and the state entered into a *Confidential Agreed Order of Supervision* on November 30, 1998. Despite close monitoring by the division, Xantus failed to meet the provisions of the Agreed Order, prompting the commissioner to file a *Verified Petition for Entry of Consent Order Appointing the Commissioner of Commerce and Insurance Receiver for Purposes of Rehabilitation* on March 31, 1999. Xantus continues to operate in receivership.

TCCN. TCCN's problems occurred soon after Xantus'. The division issued an *Agreed Order of Supervision* on June 14, 1999, because of TCCN's failure to satisfy its statutory net worth requirements. By the end of 1999, however, TCCN's financial statements showed that the company had adequate net worth to meet its liabilities and its statutory requirements. During the first quarter of 2000, the division began receiving increased and material complaints from providers and other sources regarding a lack of payments or inaccurate payments from TCCN. In April 2000, an operational audit by William M. Mercer, Inc., found that TCCN was experiencing major claims payment performance problems since the conversion of its claims system in December 1999.

On May 10, 2000, the Commissioner of Commerce and Insurance issued a Notice of Administrative Supervision based on problems with TCCN's financial and claims processing system. Throughout supervision, division staff maintained a daily presence at TCCN. In September 2000, supervision was extended through June 30, 2001. The division's analysis of TCCN's financial condition as of June 30, 2000, found a serious net worth deficiency. On

January 3, 2001, the Commissioner of Commerce and Insurance filed an order to rehabilitate TCCN in Davidson County Chancery Court. The Court, however, dismissed the petition. Because TCCN never demonstrated compliance with its statutory net worth requirement, the state terminated TCCN's contract effective October 31, 2001. A petition to liquidate TCCN's assets was granted on November 2, 2001.

Universal Care. Universal Care, one of the programs newest plans, has already experienced financial distress. On September 25, 2001, the division met with Universal regarding concerns about net worth requirements, the medical loss ratio reports, compliance with prompt pay requirements, and administrative costs. At this meeting, Universal agreed to submit daily claims activity reports to the division, and division staff visited on-site to review the reports. Quarterly statements and medical loss ratio reports filed during November and December 2001 identified incompletions and worsening problems of medical loss ratio and net worth deficiency. As a result, division and Comptroller's Office staff moved up their joint examination of Universal, conducting fieldwork from January 14 to February 18, 2002.

On March 22, 2002, the TennCare Bureau notified the MCO of the state's intention to terminate its contract effective April 30, 2002, because of problems identified during the state's oversight of Universal Care. As a result of negotiations, Universal entered into a no-risk agreement with the state on April 12, 2002. In May 2002, the division began tracking Universal's daily cash balances and prior approving all cash disbursements. The division also obtained the services of a consultant to assist in the on-going review of Universal's claims processing. In August 2002, the division performed another on-site examination and contracted for a review of certain claims processing procedures identified as critical. On September 13, 2002, Universal agreed to be placed under administrative supervision by the Commissioner of Commerce and Insurance because of its continued financial and claims processing problems.

Actions Taken to Strengthen Oversight and Enforcement

According to the assistant commissioner, over the last several years, the division has identified statutory gaps in the division's oversight of managed care organizations, including HMOs and BHOs. The division has taken actions, including proposing and achieving new legislation, adopting administrative rules and regulations, and implementing interagency agreements, in an attempt to increase oversight and prevent such serious financial problems in the future. Statutory changes enacted have included the Health Care Consumer Right-to-Know Act and the Fraudulent Insurance Act, as well as amendments to the Health Maintenance Organization Act, the Medical Assistance Act, and the Insurance Holding Company System Act.

Most provider complaints involve MCOs that have experienced or are experiencing financial problems. These complaints range from denied claims, lack of payment for claims to recoupments of claims already approved/paid. In addition, providers believe they have a right to know the financial condition of the plan with which they contract. (Recent changes in legislation should address this concern because financial records of TennCare MCOs will be open to public inspection.) Concerns about the financial stability of the TennCare MCOs are not unique to providers. In order to stabilize the health care plans and ensure the future of the program, the

TennCare Oversight Division advised and the TennCare Bureau proposed that the state assume all risk for the program effective July 1, 2002, through December 31, 2003.

In consultation with other entities involved in the monitoring and enforcement of the TennCare Program, the division should continue to seek out changes in procedures, legislation, etc., that could help it respond as quickly as possible to indications of financial problems of the MCOs and BHOs.

ANALYSIS OF THE TENNCARE OVERSIGHT DIVISION'S EFFORTS TO ENFORCE COMPLIANCE WITH CLAIMS PROCESSING REQUIREMENTS

Claims processing problems have plagued the TennCare program since its inception in 1995. Despite the state's efforts to increase monitoring and enforcement of timely claims processing, some TennCare HMOs have not complied with claims processing requirements. These problems continue to frustrate TennCare providers and, if not addressed, may result in a breakdown of TennCare provider networks.

Timely Claims Processing

The Prompt Pay Act requires that each health maintenance organization ensure that 90% of "clean" (i.e., properly completed by provider) claims for payment for services delivered to a TennCare enrollee are paid within 30 days of the receipt of such claims and that 99.5% of all provider claims be processed within 60 days of receipt.

To determine compliance with the Prompt Pay Act, the division requests that MCOs and BHOs generate a claims data file for processed claims for certain test months. The data file request should include all claims processed through final adjudication, either paid or denied, and capitated claims. In addition, the division requests a claims data file for pending claims and a paid claims report relevant to the test months. The division analyzes these files to determine the payment lag time by subtracting the received date from the paid date for each unique claim. In addition, the division reconciles the total paid per the data file as compared to the total paid per the paid claims report (relevant to the test months).

Although the Prompt Pay Act became effective on October 1, 1999, and the division has been testing for compliance since, a formal policy statement was not issued until May 2, 2001, when the division sent a letter to all MCOs and BHOs detailing DCI and TennCare Bureau policies and procedures relating to the monitoring of compliance with the Prompt Pay Act. Universal Care and Better Health Plans received letters on October 18, 2001, because they entered the program on July 1, 2001. The following procedures became effective on that date:

1. Each quarter the department will request a data file for a selected test month and analyze the data file for compliance.
2. Any deficiencies will be identified and provided to the MCO/BHO in writing.

3. The MCO/BHO will have an opportunity to respond within 10 days of the date of the letter to explain any deficiencies.
4. Any unresolved deficiencies will result in immediate enhanced monitoring procedures by the department, including additional data file requests and/or site visits by department examiners.
5. Should the MCO/BHO fail to correct the deficiencies by the next month's data file submission, the department will levy a \$10,000 administrative penalty.
6. Should the deficiency continue after the month in which the liquidated damages have been assessed, the TennCare Bureau will begin withhold procedures against the MCO's/BHO's monthly capitation payment until the deficiencies are corrected.

We reviewed prompt pay compliance as determined by the division beginning January 2001 through January 2002 for each MCO and BHO. Table 5 shows the MCOs and BHOs that were not in compliance with the Prompt Pay Act and the months in which they were not compliant. Volunteer State Health Plans (BlueCare and VSHP Select) and Better Health Plans were the only MCOs/BHOs that met the prompt pay requirements when tested throughout this timeframe. The results of prompt pay analyses for each MCO and BHO are presented in Appendix 6.

Table 5
MCO/BHO Compliance with Prompt Pay Requirements
January 2001 through January 2002

MCO/BHO	Months Not Compliant with Prompt Pay Requirements	
Better Health Plans (BHP)		
John Deere Health Plans (JDHP)	January 2001	
Memphis Managed Care (MMCC)	April 2001 May 2001	June 2001 January 2002
OmniCare (OHP)	October 2001	
Preferred Health Partnership (PHP)	January 2001 April 2001	
Tennessee Coordinated Care Network (TCCN)	January 2001 April 2001 May 2001	June 2001 July 2001
Universal Care (UCT)	September 2001 October 2001 November 2001	December 2001 January 2002
Vanderbilt Health Plans/Victory Health Plans (VHP)	January 2001 January 2002	
Volunteer State Health Plans (VSHP)		
Xantus (XHT)	January 2001 April 2001	May 2001
Premier Behavioral Systems (Premier)	January 2001 April 2001* July 2001	August 2001 September 2001 October 2001
Tennessee Behavioral Health (TBH)	January 2001 April 2001 May 2001 June 2001	July 2001 August 2001 September 2001 October 2001

* Fee for Service Only claims.

Universal Care has experienced claims processing problems almost since it entered the program on July 1, 2001. State law does not require a TennCare MCO to provide a claims processing plan in order to obtain a Certificate of Authority to operate in Tennessee. In September 2001, TennCare engaged Pacific Health Policy Group to conduct an operational assessment of Universal because of provider feedback and early internal indications of claims processing problems. The assessment indicated that the claims payment issues were largely start-up related. In a January 2002 report to the TennCare Oversight Committee, the TennCare Bureau stated that Universal had made significant progress through December and that it expected the plan to be in full compliance in the coming months. Since that time however, Universal has been placed under the administrative supervision of the Commissioner of Commerce and Insurance because of identified financial and claims processing problems. Commerce and Insurance staff continue to work with Universal to identify and correct claims

processing errors. Consultants hired by the department were on site in August 2002 to assess Universal’s claims processing operations.

To enforce compliance with the Prompt Pay Act, the division can assess an administrative penalty and request that the TennCare Bureau assess liquidated damages, if appropriate. Table 6 shows the history (January 2001 – January 2002) of administrative penalties assessed by the division for failure to comply with prompt pay requirements. At the time the penalties were assessed, the division typically recommended that the TennCare Bureau withhold capitation payments until the deficiencies were corrected, which is consistent with policy. Because of time lags involved in carrying out the compliance tests, allowing for due process, etc., an MCO or BHO may have failed to comply for several months before penalties are assessed. In Universal’s case, the division assessed an administrative penalty in December 2001, but decided not to recommend the withholding of capitation payments because of the company’s serious financial problems.

Table 6
Administrative Penalties Assessed Against MCOs & BHOs
January 2001 Through January 2002

MCO/BHO	Date Levied
Memphis Managed Care	July 12, 2001
Tennessee Coordinated Care Network	July 12, 2001
Universal Care	December 12, 2001
Xantus	July 12, 2001
Premier	December 12, 2001
Tennessee Behavioral Health	July 12, 2001

In addition to the quarterly analysis of claims data, the division has developed a market conduct examination program to focus on claims processing for the purpose of identifying claims processing deficiencies, inefficiencies, or system weaknesses. More specifically, examiners

- determine compliance with the legal requirement for the timely processing of claims;
- test for adjudication accuracy to determine if claims selected were properly paid, denied, or rejected;
- test deductible and co-payments to determine if out-of-pocket payments are accurately calculated;
- test pending claims for claims over 60 days old from date of receipt and determine if the amount of pending claims represents a potential unrecorded material liability;
- determine if the MCO/BHO has the capability to process claims submitted electronically; and
- verify the accuracy of the weekly claims processing reports submitted to the TennCare Bureau.

See Appendix 3 for most recent examination findings.

Independent Reviews

The Prompt Pay Act also established the Independent Review process, which allows providers to seek redress for claims that have been partially or totally denied. When a provider files a complaint (either by phone or by mail) with the division, staff notify the provider in writing of the right to request an independent review. In addition, staff send the provider information explaining the independent review process. (Each health maintenance organization must contract with several persons to act as independent reviewers. These persons are selected by the department's Claims Processing Panel.) We reviewed 44 written complaints and 33 telephone complaints for the period January 1, 2000 through September 10, 2001, and found that the division followed this policy in all cases.

Providers choosing an independent review must submit appropriate documentation to the TennCare compliance officer. However, the division does not have authority to intervene in the resolution of disputed claims but may use information regarding disputed claims to monitor MCO compliance.

The table below lists independent reviews as of August 22, 2001, by decision and by plan. As the table shows, a majority (71%) of the independent reviews were filed against TCCN. The table also indicates that, in most cases, the decision favored the provider. The division summarizes independent review information on a regular basis and, according to division management, information is sent to the TennCare Bureau as well as to staff performing examinations.

Independent Reviews (by Decision and Plan) As of August 22, 2001

	Total	JDHP	MMCC	OHP	PHP	Premier	TBH	TCCN	VHP	VSHP	XHT
Ineligible	24					2		21		1	
MCO to Pay Unpaid Claims	1							1			
N/A	1				1						
Pending	1			1							
Rescinded	1							1			
Reversed MCO's Denial	28					1	2	23			2
Reversed MCO's Denial in Part & Upheld in Part	8				1			4		3	
Settled for MCO	1	1									
Settled for Provider	21			1		1		15		1	3
Settled in Part for MCO and in Part for Provider	1							1			
Upheld MCO's denial	11		1				5	4		1	
TOTAL:	98	1	1	2	2	4	7	70	0	6	5

Conclusion

Efforts to strengthen oversight and enforcement of claims processing have evolved over time. In most cases, these efforts are reactions to serious deficiencies rather than proactive strategies. By the time new requirements are implemented, providers and hospitals may have sustained substantial losses. Providers continually complain about claims processing operations of the TennCare MCOs and are increasingly frustrated with the division's oversight and enforcement efforts.

The Department of Commerce and Insurance, TennCare Oversight Division, should continue to assess claims processing problems and take appropriate action when necessary, including pursuing legislation to strengthen its oversight and enforcement responsibilities regarding claims processing. The division should work with other state agencies (i.e., the TennCare Bureau, Comptroller's Office), the legislature, the MCOs and BHOs, and providers or provider groups to develop proactive strategies to address claims processing issues.

FINDINGS AND RECOMMENDATIONS

Division of Insurance

1. Financial analysis process policies and procedures are applied inconsistently

Finding

The Division of Insurance conducts quarterly and annual financial analyses of insurers domiciled in the state. The purpose of these analyses is to enable the division to identify as quickly as possible insurers in financial trouble and/or engaging in unlawful and improper activities. Based on our review of analysis files, however, the formal and informal policies and procedures in place regarding this process are not applied consistently in all cases. The inconsistent application of policies and procedures, both formal and informal, may hinder the division's ability to detect financially troubled insurers and/or insurers engaging in unlawful and improper activities, thereby endangering the policyholders of Tennessee.

Financial analyses are conducted in accordance with internal policy established by the Division of Insurance in conjunction with guidelines established by the National Association of Insurance Commissioners (NAIC). Division staff reported that the most critical procedures performed in the financial analysis review process are the completion of the Audit Sheet and the Point Sheet in both the annual and quarterly reviews. The completed Financial Analysis Audit Sheet represents the foundation of the analytical process. This function ensures that the analyst reviews the most vital balances, variations, and percentages. The Point Sheet ensures that the analyst's and supervisor's comments and recommendations are written in a systematic manner, enabling the reviewer to obtain a clear understanding of the current financial condition of the

insurance company. By enabling the analyst to detect potential solvency concerns, the Audit Sheet and the Point Sheet help protect policyholders. In our review of 20 companies (testing for attributes on both the 2000 Annual and the March 2001 quarterly financial desk audit analyses), one of the 19 company files (5.3%) that should have had such information did not contain the annual Audit Sheet. The Audit Sheet was present in all other instances on both the annual and quarterly financial analysis reviews. The Point Sheet was present in all company files for both the annual and quarterly financial analyses.

(Throughout this finding, the number of files reviewed will vary by attribute. There are several reasons for these variations. For example, health maintenance organizations are not required to file with the NAIC. Therefore, documentation obtained from the NAIC was not available for the HMOs, and those organizations' files were not included in the reviews of NAIC-related attributes. There are also variations in the number of files for attributes concerning supervisory reviews. In cases where a company's documentation (e.g., the Audit Sheet) was missing, we were unable to verify whether the required analyst and supervisory sign-offs were documented. Therefore, instead of assuming that such sign-offs did not take place, we considered those items not applicable and did not include them in our calculation of items reviewed.)

The Priority Assignment Memorandum provides information concerning an insurance company's assignment of priority and the reasons behind the assignment. The memo ensures that the companies with the most severe financial concerns are analyzed first and in a more in-depth manner. This enables the analyst to detect solvency issues more quickly. All of the 19 company files reviewed contained a Priority Assignment Memo in the annual financial analysis review, as well as an update to the memo reflecting the quarterly financial analysis review.

The division uses the Insurance Regulatory Information System (IRIS) ratio to supplement the Audit Sheet and the Point Sheet and enhance the financial analysis process by providing additional indicators as to the stability of an insurance company. The IRIS ratio, which is calculated annually by the NAIC, is composed of 12 separate ratios for life insurance companies and 11 ratios (with one ratio having two parts) for property and casualty companies. The ratio is used to ascertain an insurance company's financial position. Additionally, each element of the ratios is evaluated separately on the analytical point sheet when a ratio indicates an unusual value. All of the 16 company files reviewed contained the IRIS ratio scores.

The NAIC, in its March 2000 accreditation review, strongly criticized the Insurance Division, specifically citing a lack of adequate review in the financial analysis process by both analysts and supervisors. The division has instituted a sign-off policy that requires the analyst to document and attest to the timeliness and adequacy of work with his or her initials and the date of completion. Supervisors are required to document their review by initialing and dating key procedures, such as the Audit Sheet, the Point Sheet, the Priority Assignment Memo, the Holding Company Checklist, and the CPA Audit Checklist. This ensures that each analytical review receives additional comments and recommendations from supervisors who have more experience in insurance regulation, thus aiding in the detection and resolution of solvency issues.

Combining annual and quarterly financial analysis files reviewed, there were 106 required sign-off areas for the analysts on the Audit Sheets, the Priority Assignment Memos, the CPA Audit Checklist, and the Holding Company Checklist. Nearly 5% (5 of 106) of these areas were not initialed or were initialed at a later date by the analyst. There were 142 sign-off areas for supervisory review on the Audit Sheets, the Point Sheets, the Priority Assignment Memos, the CPA Audit Checklist, and the Holding Company Checklist. Of these sign-off areas, 4 of 142 (2.8%) were not initialed appropriately by a supervisor.

The Financial Analysis Section of the Division of Insurance uses an internal guideline which serves as a timetable for the timely completion of Audit Sheets and Point Sheets for both the annual and quarterly reviews. These deadlines, which vary according to the company's priority assignment, are more stringent than NAIC timeliness guidelines. Two of 19 annual financial analysis files reviewed (10.5%) had neither the Lead Audit Sheet nor the Point Sheet completed in a timely manner based on the dates set forth by the timetable. In addition, the Lead Audit Sheet and the Point Sheet were not reviewed by a supervisor within the stated timeframe in 2 of 19 files (10.5%). In 36.8% (7 of 19) of the quarterly financial analysis files reviewed, the Lead Audit Sheet and the Point Sheet were not completed within the deadline; and nearly three-fourths of the reviews (14 of 19) did not have the supervisory review completed in a timely manner.

Soon after the incident involving the Franklin American Life Insurance Company surfaced in March 2000, the Assistant Commissioner of the Division of Insurance issued a policy statement requiring a net income/loss review of each company based on the current year (as well as the past two years). Testing for adverse financial trends with the Net Income/Loss Two-Year History provides a means to detect declining profitability and impairment of potential net worth. Continued net losses could deplete the company's surplus, thus potentially affecting solvency and endangering policyholders. At the time of our file review, only the annual Audit Sheets for the life insurance companies contained a step addressing the net income/loss review for the current year as well as the previous two years. Audit Sheets for the property and casualty insurance companies and HMOs (Health Maintenance Organizations) did not. As a result, 10 of 19 (52.6%) of the insurance company financial analysis files reviewed did not address the net income/loss two-year history of the company. The Financial Analysis Section has now added a step to the 2002 Audit Sheet for property and casualty insurance companies requiring the analyst to check the net income/loss for the current year as well as the past two years.

All companies' files contained evidence of the Actuarial Opinion as required. In addition to attesting to the adequacy of the company's reserves, the opinion supplements the Audit Sheet in verifying the company's ability to pay claims. In order to comply with NAIC recommendations following the March 2000 accreditation review, analysts are now required to send a quarterly e-mail requesting information from other divisions within the department regarding domestic insurance companies under review. Of the 20 financial analysis files reviewed, 8 (40%) did not contain documentation of this e-mail.

Recommendation

The Division of Insurance should take action to ensure that all financial analysts and supervisors are aware of all policies and procedures (both formal and informal) related to the financial analysis process and hold staff accountable for applying those policies and procedures on a uniform and consistent basis.

Management's Comment

We concur in part. In general, the department disagrees with the conclusion drawn that policies and procedures are applied inconsistently. Overall, the Insurance Division adheres to the National Association of Insurance Commissioners' [hereinafter the NAIC] standards relevant to the review of financial documents and the timing of such reviews, and in many cases complies with standards promulgated by the Insurance Division that exceed the NAIC's requirements. Furthermore, during the timeframe that was reviewed, the Insurance Division was in the process of creating and filling new analyst positions to meet the Insurance Division's "super-strict" deadlines.

The department agrees with the following specific findings:

- "One of the 19 company files (5.3%) did not contain" an audit sheet. The department concurs that this audit sheet was not in the file. The particular audit sheet leading to this statement had been misplaced; however, the audit was completed based on the Insurance Division spreadsheet that tracks this process.
- "Of the sign-off areas, 4 of 142 (2.8%) were not initialed appropriately by the supervisor."
- "Two of 19 annual financial analysis files reviewed (10.5%) had neither the Lead Audit Sheet nor the Point Sheet completed in a timely manner based on the dates set forth by the timetable. In addition, the Lead Audit Sheet and the Point Sheet were not reviewed by a supervisor within the stated timeframe in 2 of 19 (10.5%)."
- "10 of 19 (52.6%) of the insurance financial analysis files reviewed did not address the net income/loss two-year history of the company."
- "Of the 20 financial analysis files reviewed, 8 (40%) did not contain documentation of this e-mail."

The department disagrees with the following specific findings:

- "Nearly 5% (5 of 106) of these areas [on the audit sheet] were not initialed or were initialed at a later date by the analyst." Based on the Insurance Division's procedures implemented March 8, 2000, "the [appropriate document] must be

reviewed, initialed and dated by the employee responsible for performing the supervisory review.” Accordingly, the Insurance Division followed established procedures; the analyst initials were not required. The department believes this is a good suggestion and has implemented a procedure that requires the analyst to initial the top of the point sheets indicating that initial work was completed by that specific analyst.

- “In 36.8% (7 of 19) of the quarterly financial analysis files reviewed, the Lead Audit Sheet and Point Sheet were not completed within the deadline; and nearly three-fourths of the reviews (14 of 19) did not have the supervisory review completed in a timely manner.” The department has reviewed these files and believe 1 of 19, or 5.2% of the quarterly financial analysis files reviewed, were not within the timetable established by the Insurance Division. However, the department maintains that Insurance Division staff did meet the NAIC standard for timely reviews. Documentation of this conclusion is detailed as follows, with supporting documents attached:
- Aetna US HealthCare, Inc. – The analyst review was completed on June 27, 2001. This was a high priority company; based on the NAIC timetable, this review should have been completed by July 6, 2001.
- Erlanger Health Plan Trust – The analyst review was completed on July 3, 2001. This was a low priority company; based on the NAIC timetable, this review should have been completed by August 3, 2001.
- TRH Health Insurance Company–The analyst review was completed on July 3, 2001. This was a medium priority company; based on the NAIC timetable, this review should have been completed by July 6, 2001.
- Farmers Mutual of Tennessee, Tennessee Farmers Assurance Company and Tennessee Farmers Mutual Insurance Company – Each entity’s financial statement was received after the due date of May 15, 2001. The number of days the filing was late is added to the timetable, and, therefore, each review was timely completed.
- The department has reviewed these files and is of the opinion that 10 of the 19 files did not have the supervisory review completed within the timetable established by the Insurance Division; however, these reviews did meet the NAIC standard that the department adheres to. Documentation of this conclusion is detailed as follows, with supporting documents attached:
- Erlanger Health Plan Trust – The Supervisor review was completed on July 3, 2001. This was a low priority company; based on the NAIC timetable, this review should have been completed by August 17, 2001.

- Farmers Mutual of Tennessee, Tennessee Farmers Assurance Company and Tennessee Farmers Mutual Insurance Company – Each entity’s financial statement was received after the due date of May 15, 2001. The number of days the filing was late is added to the timetable, and, therefore, each review was timely completed.

Implementation of Recommendation for Insurance Division Finding 1:

The Insurance Division has included on the property and casualty insurance company audit sheets the required question concerning net income/loss for the current year, as well as for the past two years. In addition, the Insurance Division now requires all analysts to maintain hard copies of initial quarterly electronic mails sent to various areas within the department, as well as any and all responses received.

Furthermore, the Insurance Division has increased its financial analysis staff since the timeframe reviewed by this performance audit. This should help eliminate problems meeting deadlines, as well as decrease the overtime required for Insurance Division staff to meet NAIC accreditation requirements.

Given the improvements that have been made in the Financial Affairs Section – Analytical Unit since the timeframe of the review, the department does not currently plan to suggest any additional action be taken, except to continue to improve the procedures that have been developed.

2. The division does not adequately follow up to ensure that companies correct identified deficiencies

Finding

The division’s examination of an insurance company may result in a list of deficiencies and directives with which the company must comply. The examination process is weakened, however, by the division’s lack of timely, on-site follow-up to ensure that appropriate corrective actions have been taken and that the company has remedied identified problems. Concerns about the division’s examination follow-up system were also raised in the June 1992 performance audit of the Division of Insurance.

When the examiners complete fieldwork, the insurance company receives a draft of the examination report. Before making a report public, the insurance company is given the opportunity to rebut any deficiencies noted by the examiners. The Division of Insurance may accept or reject any recommended changes made by the insurance company in the rebuttal. The Commissioner of the Department of Commerce and Insurance then orders the examination report adopted as filed, with or without modification, with directives (if applicable) to the company.

The division has the authority to invoke sanctions to ensure company compliance. According to division staff, an insurance company's compliance with directives is ascertained in two ways. Letters sent to the company regarding deficiencies identified in the examination report request that the insurance company "submit a letter of response within fifteen (15) days with respect to these recommendations and indicate . . . proposed actions to correct each deficiency." Responses received from the insurance companies outline actions they have taken to remedy identified deficiencies and comply with directives issued by the Department of Commerce and Insurance. The Chief Examiner of the Insurance Division stated that, during the quarterly review, analysts review those deficiencies the company has corrected, those the company is still in the process of addressing, and those that the company has not corrected. However, analysis staff stated that their review is limited to what can be determined through a review of financial statements. Furthermore, in our review of the quarterly analysis files, we found no evidence of follow-up performed by the analysts to monitor the correction of deficiencies noted during the examination process.

Recommendation

Division of Insurance management should implement a process that includes on-site follow-up of serious deficiencies to ensure that those deficiencies have been corrected by the insurance companies. Division staff and department legal staff should coordinate to ensure that sanctions are issued against companies that fail to correct serious deficiencies.

Management's Comment

We concur. The department agrees that a process should be developed that includes post-examination on-site review of serious deficiencies to ensure that insurance companies, following the completion of an examination, have corrected deficiencies.

As stated in the performance audit under Insurance Staffing Issues, the Financial Affairs Section – Examination Unit is only able to perform statutorily mandated examinations on a timely basis with current examiner resources. Given current examiner resources, follow-up reviews may jeopardize the department's statutory mandate to complete an examination as often as once in five years, pursuant to Tenn. Code Ann. § 56-1-408.

Six examiners who have recently been hired will take approximately three to five years to train and qualify. The Department has not been able to conduct financial examinations more frequently than five years due to the necessity to train these new examiners so that reliance can be placed in the work they conduct.

Implementation of Recommendation for Insurance Division Finding 2:

As the audit suggests, the department intends to implement an on-site examination follow up process by July 1, 2003, with procedures that will give insurance companies a reasonable time period to correct each serious deficiency. Successful implementation of this new process will be

dependent upon an adequate level of examination resources, with the primary responsibility of the examination remaining that the department meet the statutory mandate of Tenn. Code Ann. § 56-1-408 to examine each insurance company once every five years.

3. The division did not always ensure that insurance companies met all requirements related to deposits held for the protection of policyholders

Finding

Sections 56-2-103 and 56-2-104, *Tennessee Code Annotated*, require both foreign and domestic insurers to maintain with the department the appropriate deposit, as determined by the lines of business written within the state as well as whether the company is a foreign or domestic insurer. (Foreign insurers are those companies with corporate headquarters in states other than Tennessee; domestic companies are those based in Tennessee.) These deposits are to be held by an appropriate custodian, as defined by Rule 0780-1-46, either in the form of cash or bonds, for the protection of all policyholders and creditors in the United States. However, our review of deposit-related documentation for a sample of 20 insurance companies indicated that the Division of Insurance did not always ensure companies met all requirements. In addition, although the division staff did apparently perform some reviews to determine whether securities were acceptable, the division did not have a formal process to ensure that companies met (and continued to meet) state and departmental requirements, as well as the requirements of their individual depository agreements. Without such a process, policyholders and creditors may be at greater risk if insurance companies experience financial difficulties.

Securities considered acceptable as a deposit include U.S. government obligations, obligations of the State of Tennessee or the state of domicile, and bonds rated within the top three investment grades by any of the recognized securities rating firms (i.e., Moody's or Standard and Poor's). A Division of Insurance staff person reviews securities received to determine if they are acceptable. If this cannot be easily determined (for example, if the security is not U.S. Treasury bonds or other easily identified security), staff may request assistance from a division financial analyst. The analyst may then, for example, determine the investment grade of the security through the use of the NAIC Web site. (Analysts do not have access to Moody's or Standard and Poor's Web sites because the Division of Insurance has not paid to obtain subscriptions to those Web sites.) There was, however, no evidence in the files that analysts had conducted any further checks on any of the securities.

Fifty-four (56.3%) of the 96 securities maintained for deposit by the 20 insurance companies we reviewed were U.S. Treasury Bonds. Of the 42 securities that were not U.S. Treasury Bonds, we determined, by using the NAIC Web site, that 25 (59.5%) were acceptable (i.e., were rated within the top three investment grades). We were unable to determine the status of the remaining 17 securities (40.5%). According to financial analysis staff, if an analyst is unable to verify the grade of a security, the analyst makes no recommendation and advises staff to consult the Director of Financial Affairs. Again, however, there is no evidence of further review or discussion with the director in the files. An additional concern is that a security's

investment grade may change over the years. There is the possibility that a security which fulfilled the investment grade requirement upon receipt no longer has a rating within the top three investment grades. The Division of Insurance does not test securities after receipt to ensure that the securities are still rated at an acceptable level.

The Division of Insurance requires that securities for deposit have a minimum of a two-year maturity date. We checked the securities maintained for deposit by the 20 insurance companies we reviewed to determine whether they fulfilled this requirement. Of the 96 securities examined, 9 (9.4%) did not fulfill the minimum maturity date requirement. We also checked the depository agreements to ascertain whether, for the period from January 1999 to August 2001, those 20 companies were maintaining deposits at the specified level in their agreements. The division does not maintain the spreadsheets detailing deposit data for all months; however, such data were available for 19 months of the 32-month period reviewed. Depository levels fell below the amount specified in the companies' agreements 11 times (2.9%) out of the possible 380 times (19 months for 20 companies). In addition, we found that one insurance company did not have a current depository agreement on file with the Division of Insurance. The division was alerted to this deficiency and remedied the problem.

Recommendation

Division of Insurance management should develop a formal process to ensure that all securities maintained for statutory deposit meet all state and departmental requirements, as well as any specific requirements in companies' individual depository agreements.

Management's Comment

We do not concur. Although the Insurance Division does not verify the value of each security held by the division on an annual basis, each insurance company reviewed in this performance audit, save 1 of the 20 reviewed, maintained a statutory deposit far in excess of the statutory requirement. Additionally, the performance audit concluded that 17 of 42 non-Treasury Bond securities could not be verified as to their rating (with a first three grade requirement). The department's review of the 17 exceptions revealed that 11 were considered by the NAIC to be guaranteed by the full faith and credit of the United States Government, with all ratings being automatic; five securities were state obligations or obligations of subdivisions thereof that were either (a) rated by S&P or Moody, as indicated in the files, or (b) located on the NAIC Securities Valuation Office system. The remaining security was a general obligation bond of the City of Oak Ridge, Tennessee that was not rated; however, another City of Oak Ridge bond was rated by the NAIC as class one.

Based on the department's review, it appears the insurance companies in question maintained amounts that substantially exceed the statutorily required deposit amounts, and the majority of the deposits are obligations of governments. Therefore, the department does not believe that the annual verification of each security provides any materially greater protection for policyholders, or that it would be an efficient use of Insurance Division's resources.

Division of State Audit Rebuttal to Management's Comment

As acknowledged in the response, the Department of Commerce and Insurance does not verify the value of each security held by the division on an annual basis. Although the Department of Commerce and Insurance may not believe the annual verification of each security provides materially greater protection for the policyholders of Tennessee, the failure of the department to ensure that all deposits meet the requirements determined necessary by the department and/or *Tennessee Code Annotated*, whether upon receipt of each security or on an annual basis, represents a risk to the insurance companies' Tennessee policyholders and creditors.

There are two depository levels involved in this finding: the statutory level and the level set by the department and included in the depository agreement between the department and each company. Although the levels of deposit for the companies exceed the statutory level, in 2.9% of the instances we checked for the 19 months reviewed, the levels of deposit were less than the levels per the agreements. Hence, in those cases, the department failed to ensure that the companies were in compliance with their depository agreements, set by the department on a case-by-case basis.

With regard to the issue of the adequacy of the securities held in deposit, Section 56-2-104, *Tennessee Code Annotated*, clearly states that the department may accept bonds of the United States (United States Treasury Bonds), bonds of the State of Tennessee, or bonds of the state of domicile for deposits, without ensuring that the bond is rated within the highest three grades by any of the recognized securities rating firms. Bonds of any agency or instrumentality of the United States and bonds publicly issued by any solvent institution created or existing under the laws of the United States or any state thereof may also be accepted for deposit if rated within the top three investment grades by any of the recognized securities ratings firms. We requested information on the securities that were not U.S. Treasury Bonds to determine the rating grade. The Financial Analysis Section was unable to determine the ratings for 17 (40.5%) of those securities. Further, no documentation was presented for our review, in the files or otherwise, attesting to the rating of these securities. Although the department now states that, de facto, the securities were adequate, no documentation to support that assertion was presented.

4. The division should ensure that staff uniformly follow policies and procedures when conducting examinations of insurance companies or document their reasons for not following those procedures

Finding

According to Examination Section management, insurance company examinations are conducted according to procedures established by the National Association of Insurance Commissioners (NAIC) and contained in the *Financial Conditions Examiners Handbook*. The handbook provides a comprehensive overview of the examination process; provides procedures and forms; and specifies, at a minimum, the attributes, procedures, and forms that should be

included in every examination as well as offering guidelines on the methods and approaches for conducting examinations. Our review of examination working papers, however, indicated that methods used in examination, documentation of items and procedure steps, and the depth of examinations appear to vary depending on the examiner in charge of a particular examination. Inconsistent application of policies and procedures governing the examination process could hinder the Division of Insurance's ability to detect, as early as possible, and take appropriate and timely regulatory action against, those insurers in financial trouble and/or engaging in unlawful and improper activities.

Our review of the working papers of ten examinations performed by division examiners reflects that methods used by each in-charge examiner differ widely. Organization of the working papers varied considerably from examiner to examiner, thus making it extremely difficult to locate documentation for required items and/or procedure steps. In three of the ten examinations reviewed, the working papers did not contain documentation of all of the required NAIC items and/or procedure steps. In two of the ten examinations reviewed, the examination reports did not address all the matters specified by the *Financial Conditions Examiners Handbook* as necessary to the performance and report of every examination. (Similar concerns were also raised in the June 1992 performance audit of the Division of Insurance.) Overall, each examination addressed the same issues. However, methods, depth of the examination, and documentation of items and procedure steps appeared to depend upon the priorities of the in-charge examiner.

Recommendation

Management of the Examination Section of the Division of Insurance should ensure that examiners uniformly and consistently apply the policies and procedures set forth by the *Financial Conditions Examiners Handbook* and that examiners document their reasons for not following the handbook in specific instances.

Management's Comment

We concur in part. The department agrees that any NAIC suggested guideline procedure that has not been implemented by an examiner should be documented as to the reasons the examiner did not perform the suggested guideline procedure.

The department does not concur that examiners must always apply all NAIC suggested guideline procedures in every examination. The NAIC Handbook is a guide to assist in the examination process and requires sound judgment of qualified examiners to complete an effective examination. The NAIC Handbook acknowledges that considerable judgment is required of the examiner when utilizing the handbook; the utilization of particular procedures in the handbook depends upon the size of the insurance company, the type of insurance company being examined, and other factors. The NAIC Handbook states that the examiner may decide to simplify the examination process if such simplification is consistent with sound examination procedures. The NAIC Handbook also recommends that the examiner design his or her

procedures based upon the examiner's risk assessment, such procedures being developed pursuant to the priorities set by the examiner-in-charge.

Furthermore, the performance audit report stated that respecting three of the ten examinations reviewed, the working papers did not contain documentation of all of the required NAIC items and/or procedure steps. It should be noted that two of the three companies whose examinations were reviewed are limited credit life reinsurers. These entities, owned by the ceding insurers' policyholders, are excused from regular examination under Tennessee Code Annotated, Section 56-2-210, but may be examined whenever the commissioner deems it prudent.

In general, the examination procedures and work papers follow the NAIC suggested guidelines regarding examination of insurance companies; however, examiners do not always document the reasons why particular guideline procedures are not followed.

Implementation of Recommendation for Insurance Division Finding 4:

The department plans to notify all examiners by memorandum that any NAIC Handbook suggested guideline procedure that is not implemented should be documented, such documentation stating the reasons the particular guideline was not followed.

5. The division has not been consistent in applying and documenting its insurance admissions process

Finding

As part of the process for permitting an insurance company to conduct business within the state, division staff gather and discuss pertinent information about the company's soundness and ability to serve Tennessee policyholders. However, our review of insurance admissions files for 12 companies indicated that the division was not always consistent in the information it gathered. Furthermore, the files provided no explanation as to why some seemingly relevant information was not obtained for some companies. The failure to obtain all pertinent information for all companies could result in at-risk insurance companies being admitted, thereby potentially endangering the policyholders of Tennessee. The division also did not consistently document specific details concerning its admissions decisions, such as the reasons for denials of admission.

Title 56, Section 2 of *Tennessee Code Annotated* contains the general requirements for insurance companies to conduct business within the state. No insurance company may commence business until it has met the requirements for admission, shown that the company is financially responsible, and received a certificate of authority to do business from the Department of Commerce and Insurance. The Division of Insurance determines the financial responsibility and the fulfillment of minimum requirements through the use of an insurance

admissions application process that culminates in a committee meeting where the decisions regarding admission are made. (The committee consists of senior Division of Insurance staff from both the examination and financial analysis groups.) In the committee meeting, one of three decisions is made regarding the applicant. A company may be “moved,” meaning it has been approved for admission; it may be put on “hold” pending additional information; or the application may be “denied.” In the case of a denial, the insurance company is alerted and given the opportunity to withdraw its application.

Prior to March 2001, the insurance admissions application process was a two-part process, requiring those items outlined in the statutes plus other pertinent information gathered by the Division of Insurance. In order to comply with the provisions of the Gramm-Leach-Bliley Act, as well as National Association of Insurance Commissioners (NAIC) initiatives, the division subsequently adopted the Uniform Certificate of Authority Application (UCAA). The purpose of the UCAA, which requires considerably more information from insurance companies than the previous process, is to make the application process more uniform among states and thus simplify the process for insurance companies. However, in our review of the insurance admissions files, the additional items required were only found sporadically within the files.

We requested the insurance admissions files for 13 companies whose applications were either “moved” or “held.” Companies that applied to do business within the state both before and after the transition to the UCAA were included. The division was unable to locate one of the files, so only 12 files were reviewed. It appears that the criteria employed by the Division of Insurance to determine financial responsibility, as well as the fulfillment of minimum requirements, are applied irregularly. Of the 12 files reviewed, two lacked a completed desk audit performed by a financial analyst, two lacked the company’s AM BEST rating, three lacked the certified annual statement, and one lacked NAIC information regarding regulatory actions. Two files did not contain an actuarial opinion.

The division has also been inconsistent in documenting the admissions decisions made within committee meetings and the reasons for those decisions. In some cases, the reasons for denial of admission were noted in the committee meeting notes; in other cases, the reasons may be noted on the company’s information checklist, which, according to staff, may or may not be kept by the division after the admissions process is completed. In addition, there was no documentation of the votes on admissions decisions for any of the files we reviewed. Such information may be important if a company that has been denied admission challenges the decision or reapplies at a later time.

Recommendation

Division of Insurance management should ensure that, before companies are admitted to do business in Tennessee, staff obtain and review all information required by the Uniform Certificate of Authority Application, as well as other information deemed pertinent by management. Staff should document reasons for exceptions to the normal process. In addition, management should review the process for documenting admissions decisions and develop a formal procedure to ensure that such decisions are adequately documented for all companies.

Management's Comment

We concur in part. The department agrees that documentation listed on the Insurance Division's admissions checklist was, in some instances, not consistently obtained. However, in each of these instances, these inconsistencies were not pertinent to the review in question.

In the performance audit report, it was noted that additional items required by the Uniform Certificate of Authority Application [hereinafter the UCAA] were missing from the Insurance Division's admissions files. It should be noted, however, that the department agreed to accept the UCAA application to make the application process more uniform among states. The Division continues to base the application review on the requirements of the original Tennessee application, not the UCAA. On each of the companies reviewed, the department believes that the decisions made concerning these companies were accurate and appropriate.

Each person attending the meeting currently takes notes at the admissions meetings. The admissions analyst maintains notes of these meetings, so fairly comprehensive documentation of the admissions meetings exists.

Implementation of Recommendation for Insurance Division Finding 5:

The Financial Affairs Section – Analytical Unit now requires the admissions analyst to complete the initial audit sheet on all completed company admissions. In addition, the Insurance Division has reviewed the admission process and made improvements by compiling templates and instructions to help the process be more consistent.

Given the improvements that have been made in the Financial Affairs Section – Analytical Unit since the review, the department does not intend to make further modifications to the admissions process; however, the department intends to continue to review this process with an eye towards making improvements that are efficient and effective.

Division of Fire Prevention - Bomb and Arson Section

It appears that Bomb and Arson Section operations have improved substantially since the section's current director took over in 1998. Section staff and officials from outside the department (e.g., the Tennessee Bureau of Investigation; the federal Bureau of Alcohol, Tobacco, and Firearms; the Tennessee Valley Authority Police; and local arson investigators) have been complimentary regarding the section's level of bomb and arson investigative expertise. In addition, funding received during 2002, related to homeland security and anti-terrorism initiatives, has allowed the department to make further improvements. However, areas still exist where improvements need to be made (or progress continued) in order to increase the section's effectiveness.

6. Training and certification of Bomb and Arson special agents need improvement

Finding

We identified two basic weaknesses in special agents' preparedness to handle their duties investigating arson and bombings: 1) the lack of regular annual training relating to Peace Officer Standards and Training (POST), and 2) the lack of supervisory-related training. (See also a discussion on page 11 regarding the need for more individuals to become Certified Fire Investigators.)

POST Training

Although special agents had POST-related training for calendar years 1999 and 2000, such training for 2001 was cancelled. According to the Director of Bomb and Arson, the reason for the cancellation was budgetary constraints. Section 38-8-111, *Tennessee Code Annotated*, requires local police officers "to complete each calendar year an in-service training course appropriate to the officer's rank and responsibility and the size and location of the officer's department of at least forty (40) hours' duration at a school certified or recognized by the [Tennessee Peace Officer Standards and Training] commission." The Tennessee Peace Officer Standards and Training Commission develops, plans, and implements law enforcement training programs for all local law enforcement officers in Tennessee.

Although state law enforcement agencies are not required to meet POST standards, the Bomb and Arson Director indicated that he tries to keep special agents POST-certifiable as a "good business practice," following the example of the Tennessee Bureau of Investigation's training of its agents. According to the director, POST-related training helps avoid potential lawsuits stemming from charges that agents were unprepared, for example, in cases of questionable shooting deaths. Without such training, not only might the proficiency of special agents be questioned, but the state's potential liability could also increase. The section's policies and procedures do not have training requirements (see Finding 7).

According to the Director of Bomb and Arson, using funding from the department's Homeland Security Initiative and from the U.S. Attorney's Office, the section conducted a one-week ATF-certified Post Blast/Bomb course in September 2002, for 22 of its special agents. The course included night courses in judgmental firearms training and, by training during the day and night, the section was almost able to make up for 2001's missed POST-related training.

Supervisory Training

Both the Director of Bomb and Arson and the TBI Deputy Director indicated that the training provided by the Department of Personnel to their staff is inadequate in the area of management skills. According to them, the training 1) is generic, 2) does not foster the ability to strategically plan operations, and 3) does not provide supervisors with the skills to enable them to manage two different projects simultaneously. The Director of Bomb and Arson stated that lack of supervisory skills training increases the workload of upper management and impedes the

promotions of street-level investigators to supervisors. Although management at both agencies were complimentary of supervisory training provided by the Tennessee Government Executive Institute, that training is only available to senior managers. Special agents interviewed also indicated a lack of emphasis on supervisory training.

Recommendation

The department should ensure that all Bomb and Arson special agents get 40 hours of POST-related training every year. To enhance leadership skills, the department should make available and require supervisory training for all levels of special agents. The department should cooperate with the Department of Personnel in the development and implementation of such training.

Management's Comment

We agree in part. This was a two-part finding and will be addressed in the same sequence as the audit report.

The Lack of Regular Annual Training to Peace Officer Standards and Training (POST).

As set forth in the audit, State law enforcement officers are not required to be POST certified but we believe it is a good business practice. Toward that end, our special agents have received a minimum of 40 hours annually, with the exception of calendar year 2001. During that timeframe the annual fall session was postponed as a direct result of the State's budget crisis. Eventually, the training was cancelled as the State prepared for a shutdown and the furlough of employees. However, we were able to resume the 40-hour training in September 2002 and are hopeful that 2001 was an anomaly. It is clearly our intention to provide this training every year, in addition to semi-annual firearms training and other specialty courses.

The Lack of Supervisory-related Training.

We concur. There is a lack of opportunities for law enforcement supervisors to receive training that is specifically designed to meet the needs of their position. Furthermore, only one of our three supervisors who directly oversees field operations has completed the Tennessee Government Management Institute (TGMI). We will continue to nominate the two Special Agents in Charge for future TGMI classes. However, since the audit, we have made some progress in this area. All supervisors participated in a one-day session relative to the strategic planning process, to include setting goals, establishing priorities and measuring performance of law enforcement initiatives. With assistance from TBI, we were also able to receive no-cost stress management training for our field supervisors and the leader of our Special Operations Response Team. This course is designed exclusively for law enforcement managers and provides them with skills to recognize special agents who may be experiencing burn-out from the job or personal stress related issues that require our attention. Since this training, we have recommended one street agent to attend this course and the feedback from his attendance was positive.

Additionally, we maintain constant dialogue with our counterparts in TBI, ATF and the FBI so that we can be aware of any supervisory training opportunities that become available in the State.

7. Bomb and Arson policies and procedures are incomplete

Finding

The Bomb and Arson Section has incomplete policies and procedures governing its operations. The Director of Bomb and Arson stated that he was in the process of updating these policies and procedures, using those of the Tennessee Bureau of Investigation (TBI) as a model. A comparison of the section's policies and procedures with those of the TBI indicated that the section lacks policies addressing several investigative and non-investigative areas. These deficiencies are described in the tables below.

Criminal Investigative Policy Areas Not Addressed by Bomb and Arson Policies

Area	Related TBI Policies and Procedures
Operational planning to accomplish investigative objectives	TBI 601: Operation Planning
Polygraph examinations	TBI 602: Polygraph Examinations
Transporting prisoners to jail	TBI 603: Prisoner Transport
Cases involving juveniles	TBI 605: Investigative Procedures for Cases Involving Juveniles
Searches and seizures of property	TBI 606: Criminal Process-Search and Seizure
Making arrests	TBI 607: Criminal Process Arrest
Criminal investigation checklist(s) for arson and bombing investigations	TBI 614: Criminal Investigation Checklist
Processing of complaints received by the section on alleged criminal activity	TBI 619: Receiving and Processing Complaints of Criminal Activity
Use of surveillance and undercover equipment	TBI 620: Surveillance and Undercover Equipment
Collection and preservation of evidence	TBI 623: Collection and Preservation of Evidence
Handling of confiscated weapons	TBI 625: Confiscated Firearms and Weapons
Use of drawings, photography, and video recording at crime scenes	TBI 642: Crime Scene Sketching TBI 644: Crime Scene Photography and Video Recording
Proper use of state-issued cellular phones	TBI 916: Cellular Phone Usage

Non-Investigative Policy Areas Not Addressed by Bomb and Arson Policies

Area	Related TBI Policies and Procedures
Training, including POST standards, orientation of new agents, selection of instructors, and remedial training to correct deficiencies in job skills and knowledge	TBI 300: Orientation (In-Processing) TBI 401-410: Staff and Career Development
Property inventory and inspection, including regular accounting of property and inspection of critical equipment (e.g., uniforms, vehicles, weapons)	TBI 104: CALEA Accreditation TBI 501: Property Inventory
Performance evaluations and related grievance process	TBI 319: Employee Performance Evaluation TBI 321: Grievance of Performance Evaluations
Cooperation with other bomb and/or arson agencies (e.g., local and federal)	TBI 102: Mutual Aid
Internal affairs, including investigation of alleged misconduct by agents and related disciplinary actions	TBI 345: Internal Affairs Function
Chain of command, including input of field agents on investigative operations	TBI 100: Director's Authority and Responsibility TBI 109: Unity of Command
Oath of office	TBI 101: Oath of Office
Staff meetings, including discussion of cases	TBI 103: Staff Meetings
Goals and objectives	TBI 112: TBI Goals and Objectives
Professional conduct, including proper personal appearance and proper use of identification	TBI 301: Standards for Employee's Conduct TBI 303: TBI Credentials TBI 350: Personal Appearance
Secondary employment	TBI 305: Secondary Employment
Disciplinary action	TBI 323: Disciplinary Action TBI 324: Dismissals
Promotions	TBI 335: Promotion
Fitness for duty, including peer support counseling	TBI 336: Fitness for Duty
Background investigations for section staff	TBI 339: Background Investigations
Use of vehicles	TBI 502: Use of Bureau Vehicles

An additional issue that needs to be addressed in the section's policies and procedures is the handling of jurisdictional disputes between local police and fire departments during arson investigations. Department staff and local arson investigators interviewed indicated that jurisdictional disputes are, to a varying degree, a problem. State fire marshal officials in other states also indicated some problems in this area. Jurisdictional disputes include disagreement over which local agency conducts an arson investigation and the removal of bodies by fire departments before police departments have time to investigate, thus contaminating crime scenes. Department staff and a local arson investigator indicated that better training of local fire and police departments on arson investigations could help prevent such disputes (see finding 8). According to *Arson in the United States* (1997), by the U.S. Fire Administration, "It is widely

held that arsonists stand more of a chance of getting caught and convicted if fire and police investigators work together on investigating fires.”

Complete and updated policies and procedures are crucial for the consistent and effective conduct of investigative operations. The local ATF Special Agent In-Charge stated updated policies and procedures are “a must” and that “Law enforcement is difficult enough; without proper direction it will be deadly.” According to the TBI Deputy Director,

Policies are something that must be constantly revised to take into account changing procedures and policies with courts, as well as improvements in the areas of technology and evidence handling. Following outdated policies can literally result in the dismissal of your case, based on old case law, or improper handling procedures of evidence, as well as utilizing obsolete or ineffective technology. In addition, failure to have adequate policy can result in civil liability, both to outside individuals, as well as members of your own agency.

Recommendation

The department should update Bomb and Arson Section policies and procedures so that special agents are properly guided in their investigations and can adequately resolve jurisdictional disputes among local investigative agencies.

Management’s Comment

We concur in part. We fully agree that our policies and procedures are incomplete and we are indebted to TBI for allowing us to use their manual as a guide. However, we do not agree that all policies required by TBI, as a separate entity, are required by the Bomb and Arson Section that is governed by departmental policy. For example, TBI Policy Number 916 established procedures for Cellular Phone Usage. To develop a separate policy within the Bomb and Arson Section would be duplicative of a department wide policy already in place. Yet, that policy is listed in the findings as one not currently addressed by this section.

However, since the audit was conducted, much progress has been made in this area. The Bomb and Arson Section currently has 39 policies in place with others in the final draft for review. We have identified approximately 20-25 additional policies that need to be incorporated in our manual. Our goal is to complete this task by June 30, 2003. As an aside, the finding also draws a nexus between having policies in place and resolving jurisdictional disputes among local investigative agencies. Historically, there have consistently been “turf” issues between fire service and law enforcement on a nationwide basis that often surface during the response to the scene of a suspected arson. It would be rare for these disputes to relate in any way to a State agency’s lack of policies and procedures inasmuch as local agencies are not governed by the State Fire Marshal’s Office. However, our special agents are accustomed to these types of issues and work to ensure that all agencies involved in the investigation work in harmony so that the investigation can be successfully completed.

8. Arson-related training for local fire and police departments needs improvement

Although the Bomb and Arson Section did offer such training to local fire and police department staff in 2000 and 2001, both section staff and local investigators indicated that more training is needed. A local director of the International Association of Arson Investigators (IAAI) and a Tennessee Valley Authority Police Inspector specializing in arson also indicated such a need. Thirty-two local investigators in 2000 and 19 investigators in 2001 were trained in classes developed by the section. One local investigator, although praising the training, indicated that more was needed because of new technologies arsonists are using to prevent detection and because of new bomb threats as a result of the September 11, 2001, incidents in New York and Washington, D.C.

Investigations involving suspected arsons are, in most locations in the state, handed off to state investigators because of lack of local expertise. Local investigators must first, however, be able to detect evidence of arson. One special agent stated that many of these investigators are afraid of categorizing a fire as suspected arson because they are not adequately trained to know what to look for. The large number of volunteer fire departments compounds the problem of lack of investigative expertise. Effective detection by local investigators is important, however, because the section does not have the resources to investigate every suspicious fire in the state. The Director of Bomb and Arson indicated that a major purpose of training is to reduce the number of cases that special agents have to investigate. High-priority cases for special agents include suspicious fires or explosions with fatalities or injuries. Low-priority cases include suspicious fires involving vehicles or single out-buildings.

The IAAI Director indicated that arson is especially a problem during times of economic difficulty (for example, individuals cannot make mortgage payments on buildings and thus burn them to get money from insurance companies). According to *Arson in the United States*, “The main factors that influence the ‘winnability’ of an arson case rest with how the fire incident is handled at the beginning and the end of the case . . . if fire department personnel do not properly identify a suspicious fire, then an investigation that could uncover arson never occurs.”

Using funds from the anti-terrorism task force initiative, the Bomb and Arson Section was able, in 2002, to provide training to 24 local police and fire investigators, at little or no cost to the local agencies. In addition, the section provided its 16-hour First Responder course to 58 individuals, through its Knoxville and Jackson offices.

Recommendation

The department should determine the need and demand for particular types of bomb and arson training for local fire and police department personnel by surveying such personnel and by

inquiring how other states are meeting similar training needs. The department should then take steps to provide this training.

Management's Comment

We concur. In order for the Bomb and Arson Section to continue to focus its attention on high priority cases, it is essential that training be administered to local departments. Thus far, in the past three years we have conducted two 2-week courses at the Tennessee Law Enforcement Training Academy (May 2000 and April 2001). Approximately 70 State and local law enforcement officers were trained in these two sessions. A third class was scheduled for April 2002 but was cancelled by the Academy due to lack of training funds throughout the State resulting in a low number of applications. We plan to continue this training.

We are also continuing our 16-hour first responder course that is designed principally for volunteer fire fighters. However, these courses must be conducted at nights and on weekends, to meet these volunteer's schedules, and thus consume overtime appropriations. Further, we are coordinating with the Tennessee Fire Service and Codes Enforcement Academy and providing special agent/instructors to teach portions of courses that deal specifically with first responders/arson issues.

9. Case files and conversations are not properly secured

Finding

Information concerning Bomb and Arson Section cases in paper files and in related conversations is not secured at the central and field offices. Information in paper files is not only unprotected from intentional and unintentional damage or destruction, but also is not easily retrievable. Implementation of the AIMS 2000 computerized case management system will eliminate the need for paper files to store case information, according to section management (see page 13). However, restricting access to areas where case information is stored or can be retrieved (i.e., computer terminals) to authorized personnel will still be needed. In addition, sensitive conversations regarding ongoing cases are not always conducted in enclosed rooms.

Paper Case Files

The Director of Bomb and Arson described security of case files as "terrible." The case file room at the central office does not have floor-to-ceiling walls (the walls end approximately 2 ½ feet from the ceiling) so anybody can climb into the room. In addition, the door can easily be forced open. Several file cabinets do not have locks or have locks that are either broken or whose keys are missing. The director indicated that an ideal and reasonably affordable security system for such files should include, at a minimum, floor-to-ceiling walls and limited access

(including locked doors). Mesh above the ceiling of the secured area would also be useful, as it would help prevent access from above.

The Deputy Director of the Tennessee Bureau of Investigation (TBI) also indicated that such security measures are needed for the protection of case files. The Commission on Accreditation for Law Enforcement Agencies (CALEA) requires the TBI to have such security for its case files. According to CALEA's *Standards for Law Enforcement Agencies*, "The agency should determine the physical security requirements for the facility and decide who is authorized to access agency files. Facility and file security ensure the integrity of the system and the information it contains."

Section management stated that the paper files are not backed up in a remote location. According to the *State of Tennessee Business Resumption Planning: A Guide for Executive Branch Agencies*, as part of the department's Business Resumption Plan, the section needs to have duplicate files in a different secure location in case files at the central office are destroyed. The guide states, "The primary objective of a Business Resumption Plan is to enable an organization to survive a disaster and to reestablish normal business operations." Disasters include those of nature (e.g., earthquakes and severe weather), fires, and terrorism.

Although with the implementation of AIMS 2000 new case files will be backed up electronically, information in existing paper files is still valuable in tracing the criminal history of specific suspects. However, information retrieval from paper files is difficult. Such information has to be retrieved by hand, and one needs a specific timeframe regarding when the case occurred to avoid having to look at several pages of a case log or several case logs. Suspects or other parties to a case (e.g., witnesses) are not individually indexed so a special agent could not easily determine what other bombing or arson cases they had been associated with.

The director stated that he planned to add summary information—case numbers, dates, general descriptions, witnesses, and locations—concerning cases in the approximately 5,000 paper files (as of July 2001) into AIMS 2000. However, he did not plan to add complex information, like chronologies of events, because of lack of staff. Once the case files are sent to archives, such information will not be readily accessible.

Confidential Conversations

The only enclosed rooms at the central office are the director's and assistant director's offices. The special operations room is located in the paper file storage area, and conversations in that room (which have the same low walls as the rest of the area) can easily be overheard by individuals near that room. For example, the director told of an incident where an individual of another section overheard a conversation between a female special agent, who at the time was working undercover, and the Special Operations Response Team (SORT) team leader. That individual innocently asked how the investigation was going. The inadvertent leaking of sensitive information concerning investigations could potentially impair such investigations and endanger special agents. The director had written a memorandum to the commissioner in August 2000 concerning this problem but it was not acted upon.

Recommendation

Department management should assess the level of access to the Bomb and Arson Section's office space and case information, and take action (e.g., providing adequately enclosed facilities) to ensure restricted access to both sensitive documents and case-related conversations. Staff should be careful when discussing investigations and take precautions to help ensure that unauthorized individuals do not overhear case-related conversations. The department should transfer all valuable investigative information in paper case files to AIMS 2000.

Management's Comment

We concur. Physical security can be improved in the Bomb and Arson Section. There is a need to better secure the file room where all open and closed criminal investigative files are maintained. Similarly, there is a need to reinforce the security in two adjacent rooms where evidence, sensitive surveillance equipment and weapons are stored. And finally, there needs to be a secured "squad room" area for special agents to discuss and plan on-going investigations, obtain secured Fax's from TBI, FBI, ATF, etc. and to work on investigative reports for presentations to the District Attorney and/or grand jury.

In order to become compliant with this finding, we will develop a plan to improve security for the Bomb and Arson Section. The Department will work with the Departments of Finance and Administration and General Services to develop appropriate measures and seek to prioritize available funds to ensure the Bomb and Arson Section resides in a secured environment.

Division of Fire Prevention – Administrative Services Section

10. The majority of fire departments do not report fire incident data to the Tennessee Fire Incident Reporting System and the division has no authority to enforce such reporting

Finding

As of September 2001, only a third of Tennessee's 663 fire departments reported fire incident data to the Tennessee Fire Incident Reporting System (TFIRS). TFIRS is used to collect data as part of a local, state, and federal coordinated effort to create a national database on fire incidents. This national database, called the National Fire Incident Reporting System (NFIRS), is managed by the U.S. Fire Administration and facilitates comparison of fire incidents among states. *Tennessee Code Annotated* does not specifically require fire departments to report data to TFIRS and the Division of Fire Prevention has no authority to force fire departments to report. Reporting of fire incident data is important, however, because it can help the division identify departments or areas needing additional training, technical assistance, and fire prevention

education. In addition, some federal fire prevention grants to Tennessee could be negatively impacted if fires are underreported.

According to department staff, the fire departments reporting to TFIRS account for an estimated 50 percent of the state’s population. However, some major fire departments (e.g., Knoxville) were not reporting. In addition, Nashville has apparently not provided useable data since 1996 because of software problems. (Fire departments may submit data on paper, on floppy disk, or as a data file via e-mail, or they can key reports individually or import the file into the TFIRS database.) Exhibit 3 indicates county participation in TFIRS. Appendix 2 indicates participating and nonparticipating fire departments within each county. (Data for 2002 was not available during our audit fieldwork; however, according to staff, the number of reporting departments has not dramatically increased since that time.) Department staff believe that, although only one-third of fire departments report to TFIRS, the sample gathered is large enough so that information in the database, such as causes of fires (by percent) provides a reasonable estimate of the causes of fires statewide. Table 7 shows the number and percentage of reported fires by cause, while Table 8 defines each type of cause. The staff believe that the high percentage of “unknown” is the result of the lack of training of volunteer fire department personnel in determining the causes of fires. (see Finding 8).

Table 7		
Causes of Residential Fires and Deaths Reported to TFIRS		
Calendar Years 1998-2000		
Cause	Fires (9,938)	Deaths (111)
Exposure	4.0 %	1.8 %
Incendiary/Suspicious	11.1 %	9.0 %
Children Playing	2.9 %	1.8 %
Natural	2.1 %	1.0 %
Smoking	3.9 %	5.4 %
Heating	8.5 %	7.2 %
Cooking	17.4 %	4.5 %
Electrical Distribution	8.8 %	8.1 %
Appliances	5.6 %	7.2 %
Other Equipment	0.7 %	0.9 %
Open Flame, Spark	4.8 %	5.4 %
Other Heat	1.9 %	2.7 %
Unknown	28.3 %	45.0 %

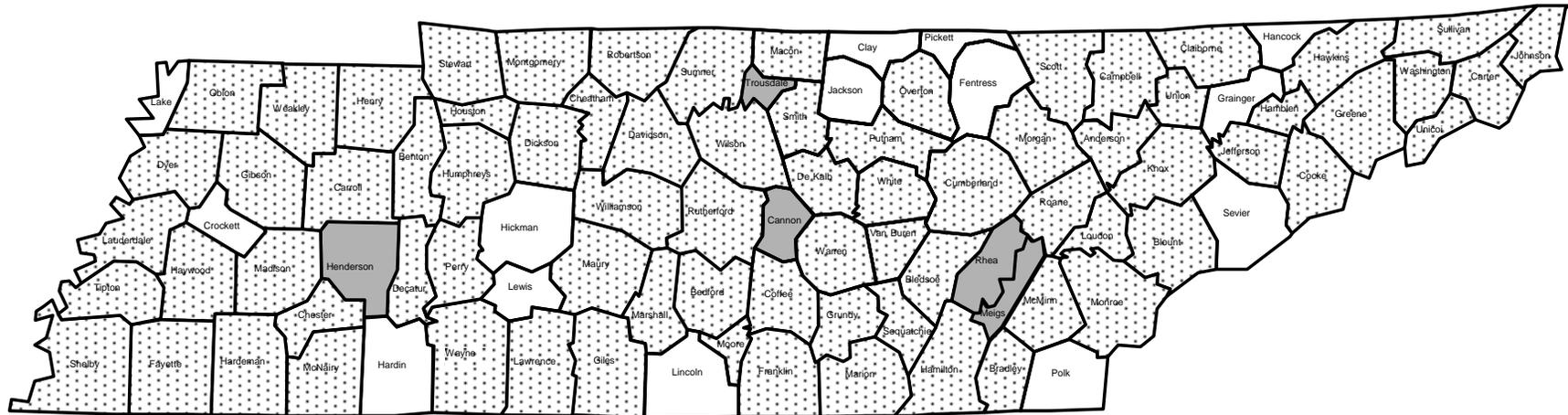
**Table 8
Causes of Fire**

Cause	Definition
Exposure	Caused by heat spreading from another hostile fire
Incendiary/Suspicious	Fire deliberately set or suspicious circumstances
Children Playing	Includes all fires caused by children playing with any materials contained in the categories below
Natural	Caused by sun's heat, spontaneous ignition, chemicals, lightning, static discharge
Smoking	Cigarettes, cigars, pipes as accidental heat of ignition
Heating	Includes central heating, fixed and portable local heating units, fireplaces and chimneys, water heaters as source of heat
Cooking	Includes stoves, ovens, fixed and portable local warming units, deep fat fryers, open grills as source of heat
Electrical Distribution	Includes wiring, transformers, meter boxes, power switching gear, outlets, cords, plugs, lighting fixtures as source of heat
Appliances (including air conditioning/ refrigeration)	Includes televisions, radios, phonographs, dryers, washing machines, vacuum cleaners, hand tools, electric blankets, irons, electric razors, can openers, dehumidifiers, water cooling devices, air conditioners, refrigeration as source of heat
Other Equipment	Includes special equipment (radar, x-ray, computer, telephone, transmitters, vending machine, office machine, pumps, printing press), processing equipment (furnace, kiln, other industrial machines), service, maintenance equipment (incinerator, elevator), separate motor or generator, vehicle in a structure, unspecified equipment
Open Flame, Spark (heat from)	Includes torches, candles, matches, lighters, open fire, ember, ash, rekindled fire, backfire from internal combustion engine as source of heat
Other Heat	Includes fireworks, explosives, heat or spark from friction, molten material, hot material, all other fires caused by heat from fuel-powered objects, heat from electrical equipment arcing or overloading, heat from hot objects not covered by above groups
Unknown	Cause of fire undetermined or not reported

Source: U.S. Fire Administration, Federal Emergency Management Agency.

Exhibit 3

Counties Participating in the Tennessee Fire Incident Reporting System September 2001



County Participation

- No reporting
- Partial reporting
- Complete reporting

Source: Department of Commerce and Insurance.

According to division staff, many states require such reporting and some states, such as Kentucky and Maryland, have provided financial incentives to improve participation rates. Information from computerized fire incident reporting systems is important in targeting fire prevention education efforts and in helping identify training needs for firefighters in particular locations. According to staff of the National Fire Prevention Association (a nonprofit organization whose mission is to reduce fire hazards), information about accidental fire deaths is vital in raising awareness among community leaders and motivating them to find solutions.

Recommendation

The department should take steps to increase TFIRS participation by fire departments, including educating them on the usefulness of fire incident data in fire prevention, and providing technical assistance (e.g., regarding software compatible with TFIRS).

The General Assembly may wish to clarify language in Section 68-102-111, *Tennessee Code Annotated*, to require fire departments to report fire incident data to TFIRS at least annually.

Management's Comment

We concur. However, at the present time, fire departments are not mandated by law to report data to the Tennessee Fire Incident Reporting System (TFIRS). While it is still true that a majority of fire departments do not report to TFIRS, considerable progress has been made since September 2001. By the end of 2001, there were 262 out of 663 departments reporting data. The 1997-2001 average was 206 departments per year reporting data. Due to reorganization, the total number of departments in 2002 has risen to 681. Although 2002 data is incomplete, the number of reporting departments should be at least as many as in 2001, due to the grant program discussed below. Also, Knoxville began reporting in December 2001, and Nashville is switching to the same software that Knoxville has been using successfully.

An encouraging development to help accelerate TFIRS reporting is at the Federal level. As part of the Firefighter Investment and Response Enhancement (FIRE) Act, the Federal Emergency Management Agency (FEMA) administers the Assistance to Firefighter Grant Program. The FEMA grants require fire incident reporting by each recipient. As of December 23, 2002, there were 178 Tennessee departments that received a total of \$11,231,971 in awards. Of these 178 departments, there were 103 that did not report in 2001, but must now participate.

This is the second year of the program. If it continues, a considerable number of non-reporting departments may be brought into TFIRS, since the awards are quite attractive. Because fire and rescue agencies are the local line of defense in the event of a national emergency, we are hopeful that the grant program will continue as part of a comprehensive homeland security strategy. Congress is authorized to award up to \$900 million in 2003, but has not yet appropriated the funds.

11. The department needs to implement a formal, comprehensive fire-prevention education program

Finding

The department does not have a formal, comprehensive fire-prevention education program. Staff indicated that education efforts are informal in nature and included activities such as occasionally providing fire-prevention education in schools, referring requests for such education to local fire departments, and, if requested, providing brochures on fire prevention.

According to *U.S. Fire Death Patterns by State* (March 2001) by the National Fire Protection Association, Tennessee ranked fourth in the country in 1998 in fire deaths per million people while the state ranked third for the 1994-98 average. Although Tennessee fire death rates dropped by more than a fourth from 1980 to 1997, Tennessee's ranking went from 12th in the nation to 3rd highest. An August 2002 edition of the publication indicated that Tennessee's 1995-99 average fire death rate per million was 26.5, again third highest nationally. Tennessee's high ranking is attributed, at least in part, to the fact that Tennessee ranks high on three factors found to be related to fire deaths—poverty, low educational attainment, and smoking. Another factor is the high percentage of population in rural areas, which is typically associated with poverty. Department staff also indicated that poorly maintained heating units are a major cause. Many people tend to not properly maintain these units because of Tennessee's mild winters.

Public fire prevention education does appear to work in reducing accidental fire deaths. For example, educational efforts in South Carolina (including the installation of smoke detectors throughout the state) greatly reduced fire deaths, from 189 in 1986 to 79 in 1999. Fire Prevention staff in Tennessee confirmed that education efforts regarding smoke detector use would have a substantial effect on reducing deaths. Information from the Tennessee Fire Incident Reporting System (TFIRS) indicates a strong relationship between smoke detector use and fatalities. Seventy-five percent of all fire deaths occur in structures with no smoke detectors. Furthermore, fatalities are reduced in half when smoke detectors are present and functioning.

According to *Arson in the United States*, educational efforts can even reduce incidents of arson by juveniles. Lack of supervision is a major cause of children setting fires.

Parents, especially single mothers and other parents facing significant child care obstacles, should be provided with information verbally and in writing about the dangers of leaving children alone, the importance of keeping matches and lighters out of sight and out of reach, and the signs of firesetting behavior and stress in school-age children.

Recommendation

The department should develop and implement a formal, comprehensive fire-prevention education program. Information from TFIRS on the causes of fire deaths in specific locations should be used to target educational efforts.

Management's Comment

We concur. Due to budgetary constraints, the Public Fire Information Officer position was vacant during the audit period. However, the position was filled October 2002. We feel the way to best utilize this position is to be able to furnish the local fire departments with fire prevention materials and education (videos, brochures, coloring books, etc.) so that they can, in turn, teach their communities fire safe behaviors.

The Division also annually sponsors a statewide Fire Prevention Poster Contest for school age children in which a fire safe behavior theme, chosen by the National Fire Protection Association (NFPA), is emphasized. We believe this program is crucial in motivating children to develop and practice fire safe behaviors that can make a difference between life and death in a fire. On Sunday, January 12, 2003, we hosted an award's luncheon attended by approximately 90 individuals including poster contest winners, family members and fire service personnel. During the ceremony, in addition to the poster contest winners, the Public Fire Educator of the Year was honored.

The Division also partners with NFPA, local fire departments and other agencies to implement the "Risk Watch" curriculum in the schools across the state. Risk Watch is a comprehensive injury prevention curriculum developed by NFPA, with co-funding from the Lowe's Home Safety Council. It addresses the eight risk areas that kill or injure the most children each year: motor vehicle crashes; fires and burns; choking, suffocation, and strangulation; poisonings; falls; unintentional firearms incidents; bike and pedestrian hazards; and water hazards. Risk Watch gives children the information and practice they need to recognize and avoid risks. At the present time there are nine counties in Tennessee that have the Risk Watch curriculum in their schools.

The audit finding states that lack of supervision is a major cause of children setting fires. We are also aware of this problem and, as a result, are taking steps to be of assistance to fire departments and schools in their efforts to reduce juvenile fire setting. The Public Fire Information Officer attended a Juvenile Firesetter Intervention Conference in Greenbelt, Maryland in January 2003, in order to learn about the uniqueness, successes, and the difficulties that intervention teams from other countries are having in their struggles to mitigate the worldwide problem of juvenile firesetting.

Division of Fire Prevention - Electrical Inspection Section

12. The Electrical Inspection Section does not periodically review the competency of the 20 cities/counties granted exemption from state electrical inspections

Finding

The department's Electrical Inspection Section contracts with electrical inspectors throughout the state to perform inspections to ensure that structures comply with the state's electrical codes. Pursuant to Section 68-102-143(b)(1), *Tennessee Code Annotated*, the State Fire Marshal may authorize municipalities to perform their own electrical inspections and, thereby, be exempt from the state inspections. Entities requesting exemptions must show that they have adopted, and can enforce, electrical standards that are at least as stringent as those established by the state. Twenty entities—Metro Nashville, Memphis/Shelby County, Chattanooga/Hamilton County, Knoxville, Kingsport, Johnson City, Elizabethton, Morristown, Maryville, Athens, Oak Ridge, Sparta, Jackson, Humboldt, LaFollette, Bartlett, Collierville, Millington, Lookout Mountain, and Watauga—are exempt and have held these exemptions since at least 1984. The Electrical Inspection Section, however, does not periodically review the exempt entities' operations to ensure that their standards and their inspection programs are adequate.

In addition to having no process to periodically verify the exempt entities' competency to perform their own electrical inspections, section management could provide no documentation detailing exactly when the exemptions were granted, what documentation was provided in order to gain the exemptions, or whether the exemptions were granted for a specific period of time. Without oversight and periodic verification of the competency of exempt entities to perform their own electrical inspections, the department cannot ensure that electrical codes are being enforced and that structures are safe for inhabitants.

Recommendation

The department should develop rules and regulations to institute regular periodic verifications of exempt entities to ensure that such entities have the manpower and technical knowledge to enforce state-required electrical codes. Department management should also review current statutory language and, if necessary, prepare proposed legislation for consideration by the General Assembly, to clarify what local governments must do to justify exemptions. In developing rules and regulations and/or preparing proposed statutory language, the department may wish to adopt language similar to that in existing statutes, rules, and regulations concerning building construction safety standards.

Management's Comment

We concur with this finding. The Electrical Inspection Section is coordinating with Legal Counsel in promulgating rules to implement the provisions of *Tennessee Code Annotated*, Section 68-102-143. When rules have been promulgated, procedures will be established to ensure that exempt jurisdictions are audited every three years, to the extent of available human resources, to ensure that they are performing their enforcement functions appropriately, as required by statute.

Division of Fire Prevention - Codes Enforcement Section

13. The Codes Enforcement Section is not performing the required audits of the local governments granted exemptions from state building and fire codes

Finding

The State Fire Marshal establishes and enforces statewide building construction safety standards. By law, local governments can request, and receive, an exemption from these standards if they certify in writing that they have adopted certain building codes (see below) and are adequately enforcing those codes (i.e., through inspections), including performing required reviews of construction plans and specifications. The Codes Enforcement Section is not, however, auditing the records and transactions of these local governments to ensure that they are adequately performing their enforcement functions, as required by Section 68-120-101(b)(3)(A), *Tennessee Code Annotated*. (This provision does not apply to any county having a metropolitan form of government and a population of 100,000 or more in the 1990 or any subsequent federal census.) The statute, which went into effect in 1992, requires the audits to be conducted at least every three years. Without on-site audits of exempt entities, the department cannot be sure that such governments are adequately enforcing minimum building and fire codes. In addition, as the state is ultimately responsible for the enforcement of such building and fire codes, the lack of oversight could have potential legal ramifications.

Currently there are 31 exempt entities (with exemption dates as early as 1982 and as recent as 2001). Entities are listed in order of exemption date:

Alcoa	Pigeon Forge	Bartlett	Brentwood
Johnson City	Kingsport	Shelby County	White House
Maryville	Chattanooga	Paris	Lebanon
Sevierville	Hendersonville	Knox County	Cookeville
Clarksville	Bristol	Jackson	Millington
Knoxville	Collierville	Franklin	Goodlettsville
Madison County	Gatlinburg	Athens	Montgomery County
Oak Ridge	Davidson County	Murfreesboro	

The original exemption application requires the applicant to show the following:

- adoption of versions of the *Standard Building Code* and either the *Standard Fire Prevention Code* or *National Fire Code* that are within six years of the latest published edition;
- any local ordinances amending the adopted codes;
- whether referenced codes or standards are enforced;
- types of occupancies requiring plans review and approval;
- whether written records are kept of reviews and inspections;
- personnel responsible for enforcing codes;
- whether alternatives to codes are permitted and documented; and
- whether concurrent reviews and inspections are performed on state-owned buildings, educational, and day care occupancies.

Current section procedures also require that, prior to granting an exemption, staff conduct a site visit to review documents and conduct an inspection of a building previously inspected by the local entity. Section management could not verify, however, that these site visits were actually conducted for all entities. Once granted, exemptions remain in effect as long as the entity has adopted codes that are within six years of the latest published code and has a review and inspection program that is adequately performing its duties. Current section oversight is limited to requiring exempt governments to fill out a survey questionnaire when new codes are adopted. New rules went into effect on August 26, 2001 and, after a survey of all exempt entities, all entities retained their exempt status.

Recommendation

The department should develop procedures for effectively auditing entities exempted from state building and fire code inspections at least every three years as required by statute, to ensure that such entities are performing their enforcement functions appropriately.

Management's Comment

We concur with this finding. The Codes Enforcement Section is coordinating with Legal Counsel in promulgating rules to implement the provisions of *Tennessee Code Annotated*, Section 68-120-101(b)(3)(A). When rules have been established, procedures will be established to ensure that exempt jurisdictions are audited every three years, to the extent of available human resources, to ensure that they are performing their enforcement functions appropriately, as required by statute.

14. Some Codes Enforcement and Deputy Electrical Inspectors' personnel files lack necessary documentation

Finding

We reviewed personnel files for Codes Enforcement staff (who are state employees) and Deputy Electrical Inspectors (who contract with the department to perform electrical inspections throughout the state). Some of the personnel files reviewed lacked information such as (1) documentation showing that those persons meet the minimum qualifications required for their job classification; (2) a state application—applicable for Codes Enforcement personnel only; and/or (3) an annual evaluation. The lack of such documentation could indicate the existence of employees (state or contract) who do not have adequate qualifications to perform their jobs, as well as a failure by management to adequately oversee the hiring, performance, and training of employees.

A review of Codes Enforcement personnel files found that 11 of 51 files (22%) lacked evidence the employee meets minimum job requirements; 10 of 51 (20%) lacked a state application; and 11 of 43 files (26%) of persons eligible for a fiscal year 2000 evaluation lacked such an evaluation. Our review of Deputy Electrical Inspectors' personnel files indicated weaknesses in documentation of certifications. Specifically, the files for 2 inspectors contracted with since March 1, 1999 and the files for 11 inspectors contracted with before January 1, 1999, did not contain evidence that they had been certified in the one- and two-family dwelling electrical category as required. (Depending on their contract dates, inspectors have different deadlines for achieving certification.) Twenty-seven files also indicated potential noncompliance with regard to certification—these inspectors were required to achieve certification in the general electrical category by January 1, 2002, and had not achieved that certification as of mid-July 2001, when the file review was conducted. Because Deputy Electrical Inspectors are not state employees, they do not fall under Department of Personnel rules requiring annual evaluations. However, section management indicated that field supervisors annually evaluate the inspectors. Three of 68 files (4%) did not have a fiscal year 1999 evaluation and 35 of 74 (47%) lacked a fiscal year 2000 evaluation.

Recommendation

Division of Fire Prevention management should verify that all staff (state staff and contract staff) comply with minimum job requirements, including required certifications, and document that compliance in their personnel files. Management should also ensure that all state employees have a state application on file and that both state and contract employees are evaluated annually.

Management's Comment

We concur in part with this finding. The Electrical Inspections Section and Codes Enforcement Section will audit all personnel files to ensure that state applications are present. Applications will be obtained from the Deputy Electrical Inspectors or Department of Personnel for all missing this information. The Electrical Inspections Section has implemented a plan, where the supervisor rides with each inspector, at least one time annually, thereby establishing a basis to provide an annual evaluation of the inspector's performance. By June 30, 2003, all Deputy Electrical Inspectors will be certified in 1 & 2 Family Dwelling and Electrical General as required, with the proper documentation in each personnel file.

We must point out however, that all positions in the Codes Enforcement Section are civil service positions, and require the processing of a register prior to hiring an employee. Each employee has either submitted an application to the Department of Personnel for scoring, based on education and prior experience, or passed a civil service examination to qualify for these registers, thereby ensuring that minimum job requirements are met for all employees. Codes Enforcement is currently working on updating all job performance plans and ensuring that all employees are evaluated annually.

15. The majority of manufactured houses are being set up without the required anchoring permits and inspections

Finding

Manufactured homes that have not been properly anchored may pose a threat to the homes' occupants and/or persons living nearby. In 1976, the General Assembly passed legislation requiring that manufactured homes be anchored by an installer approved by the State Fire Marshal (i.e., the Commissioner of the Department of Commerce and Insurance) and be inspected for compliance with standards set by the department. Legislation passed in 1981 added a requirement that the installer apply for a permit prior to installing a stabilizing system. Despite these requirements, which have been in place for 20 or more years, our review indicated that few installation permits are being issued and few inspections are being conducted. As a result, the department has no assurance that manufactured houses have been installed properly, by licensed individuals, and in compliance with standards.

In order to determine whether anchoring permits were being issued and inspections being conducted as required, we obtained and analyzed department data on newly installed manufactured housing inspections and permits for the period July 16, 2001, to May 29, 2002. To estimate how many anchoring permits should have been issued (and inspections conducted), we also obtained data on electrical permits and inspections for newly installed manufactured housing, and then compared the two sets of data. (The department's Electrical Permitting System does not currently provide a way to relate electrical permits and inspections to anchoring permits and inspections. To make our comparison, we examined the name and address for each electrical inspection on a new manufactured house installation and made a manual comparison to

the name and address for each anchoring inspection.) Statewide, only 13 percent (2,015 of 16,021) of the new manufactured housing installations that had electrical inspections also had anchoring inspections performed. We also looked in detail at data for five counties (Anderson, Bedford, Bledsoe, Hardin, and Hawkins) spread across the state. For these five counties, the percent of newly installed manufactured houses that obtained the anchoring permits and inspections in addition to electrical permits and inspections ranged from zero to 9 percent, with a five-county total of 31 anchoring inspections compared to 1,057 electrical inspections.

Department staff confirmed that the anchoring permit and inspection program has not worked well. Staff also expressed concerns that the public was unaware of the need for anchoring permits and inspections. However, the department does not appear to have taken action to track compliance with statutory requirements or to improve public awareness of the need for manufactured homes to be properly anchored by licensed individuals. The department's current focus is on inspecting manufactured homes at the factory and on dealer lots and investigating related complaints. Electrical inspectors on contract with the department are responsible for inspecting the anchoring of manufactured housing, once a permit has been applied for and an inspection requested.

Legislation passed in May 2002 significantly amended and strengthened Title 68, Chapter 126, *Tennessee Code Annotated*, in several ways, including (1) requiring that an installation permit be obtained before electricity can be turned on in a manufactured home; (2) requiring the department to ensure that at least 5 percent of manufactured homes installed each year are inspected; and (3) strengthening training requirements for retailers. County clerks will be responsible for selling the installation permit decals and will be required to report monthly to the department . . . “the license numbers of installers and retailers who purchase installation permits and the corresponding permit numbers sold.” These provisions go into effect January 1, 2004. However, unless this new legislation is enforced—unlike the earlier statutes—the department will continue to have little assurance that manufactured housing in the state has been appropriately installed/anchored.

Recommendation

The department should work with manufactured homes builders and retailers to ensure that manufactured homes buyers understand the statutory requirements regarding anchoring permits and inspections, as well as the reasons why correct installation is so important. The department should also work with county clerks, as well as state and local electrical inspectors, to ensure compliance with new legislative requirements. To effectively monitor inspections, the department should make changes to its Electrical Permitting System so that information on electrical and anchoring inspections can be more easily compared.

Management's Comment

We concur with this finding. This has been corrected by a legislative amendment to *Tennessee Code Annotated*, Title 68, Chapter 126, Parts 2 and 4. This will also create a new

section in the Codes Enforcement Section to enforce the requirement of anchoring stabilization systems and inspections of manufactured homes. This amendment will take effect on January 1, 2004.

TennCare Oversight Division

16. The Division of TennCare Oversight needs to establish formal policies for conducting operations

Finding

Policies governing the operations of the TennCare Oversight Division lack formality. The division's policy manual, which includes guidance for performing general office duties (e.g., locating documents) as well as for addressing technical matters (e.g., taking complaints from providers or corresponding with MCOs), is a compilation of memos and e-mails issued by division management. These memos and e-mails often refer to staff members by name (instead of job title) and are casual in tone. While the policies address situations as they arise, it is difficult to determine if a policy rescinds or updates a previous policy. Furthermore, most of the memos and e-mails do not include the date on which the policy goes into effect.

Policies serve as valuable references on numerous matters and assist in the consistent treatment of issues by management and staff. They are definite courses or methods of action which guide present and future decisions. Because the division relies on its policies to perform daily operations and to address statutory responsibilities, the policies should be clear, concise, and consistent.

Recommendation

Division of TennCare Oversight management needs to establish formal, consistent policies that include reference to job level/type rather than staff members' names; clarify whether the policy is new or updates or rescinds a previous policy; and include the date on which the policy goes into effect. When a policy is updated, management should provide staff with the revised version of the entire policy, not just the changes.

Management's Comment

We concur with the recommendation. The division has formalized its policies to include references to job level/type rather than staff members' names; to set out whether a policy is new or an update or rescission; and to include the date the policy goes into effect. The TennCare Division anticipates that the revised policies will be finalized on or before March 1, 2003.

RESULTS OF ADDITIONAL AUDIT WORK PERFORMED

DIVISION OF CONSUMER AFFAIRS

The Division of Consumer Affairs is charged with protecting the public from deceptive business practices as defined in Section 47-18-102, *Tennessee Code Annotated*. Among the division's responsibilities is the maintenance of a consumer "hotline" designed to answer questions about consumer protection laws, refer persons with inquiries regarding other parts of state government to the appropriate department or agency, and assist Tennessee residents with complaints against companies doing business within the state. The Consumer Affairs Division attempts to mediate written consumer complaints through direct correspondence with the businesses in question. If warranted, cases may be referred to the Attorney General's Office for further action. The division also prepares a weekly media column, a quarterly newsletter, the *Buyer Beware List*, and consumer tip sheets.

According to management, the Division of Consumer Affairs, which has 12 staff positions, may receive as many as 70,000 calls each year. However, because of the volume of calls, the division does not keep a record of every call it receives. Complainants who call the hotline are referred to a division consumer specialist or to the appropriate department/agency, if applicable. Callers are encouraged to work out the problem on their own but are told to submit a written complaint (by mail or e-mail) if they are unable to resolve the problem. The division receives an estimated 5,000 to 6,000 written complaints each year.

According to staff of the Consumer Advocate and Protection Division of the Attorney General's Office, most of the state's consumer cases originate with complaints and/or information initially received from, and then referred by, the Division of Consumer Affairs. The director of Consumer Affairs speaks weekly with staff of the Deputy Attorney General. For cases that have reached the trial level, Consumer Affairs staff assisted in gathering information and have served as witnesses. They have also aided in undercover investigations that have subsequently led to enforcement actions.

Staff of the Attorney General's Office stated that the decision on whether to accept a referral from the Division of Consumer Affairs is based on a number of factors:

- whether any specific statutes have been violated,
- the number of consumer victims,
- the possibility of gaining some sort of monetary restitution,
- whether the conduct warrants state action to stop the practice, and
- whether some action by the Attorney General's Office is the most efficient manner of handling the situation.

In most cases, the Director of Consumer Affairs and an attorney in the Attorney General's Office confer before an actual referral is made so that the issues listed above are addressed before the matter is referred. According to Attorney General's Office staff, most cases referred from the Division of Consumer Affairs do not result in litigation. The Tennessee Consumer Protection Act provides for a specialized settlement form called an Assurance of Voluntary Compliance. Most of the Attorney General's consumer protection cases are resolved through this mechanism. The remaining cases are resolved through some other type of settlement.

Our review of 20 Consumer Affairs complaint files indicated that, in general, the files were well organized and contained adequate documentation relating to the two parties involved in the dispute. All of the files reviewed were opened and closed in calendar year 2000. There were seven files (35%) in which the investigator failed to notify the respondent within the three-week window identified as a goal by the division director. (In four of the seven cases, respondents were notified within about a month; the other three files either had no record of the notification date or notification was not sent.) In all, 13 of the 20 cases (65%) were settled. In three cases (15%), the consumer specialist was unable to find the respondent, and nothing further was done to address the complainant's problems. In one case, no action was taken and there was little in the file to indicate what became of the matter. In another case, the division declined to pursue the complaint because of staff's doubts regarding the consumer's honesty. In a third instance, the division recommended that the consumer pursue the insurance company directly because, according to the consumer specialist, the division was powerless to do anything. And finally, the specialist advised another consumer to hire an attorney after mediation was unsuccessful. None of the cases reviewed were referred to the Attorney General's Office, nor was there any evidence of fines levied against offending parties.

CONSUMER INSURANCE SERVICES

The Consumer Insurance Services section of the Division of Insurance handles complaints against insurance agents and companies. When charges are substantiated, the cases are referred to the department's Office of General Counsel. Actions taken against agents or companies may include a warning letter, suspension of license, or ultimately an administrative hearing with the possibility of monetary penalties. Once the investigation is complete, a report is issued. The Director of Fraud and Special Investigations and the Director of Consumer Insurance Services must agree with the findings in the report. Once the directors have agreed on the substance and merit of the investigation, it is forwarded to the Office of General Counsel. Usually, the investigator preparing the report makes a recommendation as to any actions that will be pursued. A consent order is prepared and presented to the subject of the investigation. Administrative hearings are held when the subject of the investigation chooses not to sign the consent order.

The section recorded 3,801 consumer complaints during the year ended June 30, 2002. (In addition, staff handles an estimated 38,000 consumer inquiries each year.) The division attempts to mediate a solution between the two parties. The response from the insurance company/agent is reviewed for consistency with the provisions of the contract and for its applicability under the insurance laws and regulations of Tennessee. In some instances, the

investigator has to state that the complaint is without merit or cannot be resolved, but in such instances, other options or remedies may be suggested to the complainant.

Our review of 39 Consumer Insurance Services files closed during fiscal year 2001 found evidence that each case had been thoroughly investigated. In all cases, the complaint investigators responded to the complaint by contacting the offending agent/agency. With two exceptions, all cases were resolved in three weeks or less. All files reviewed listed a specific resolution, ranging from “lack of jurisdiction” or “company/agent position upheld” to specific actions taken against the company/agent. In one case, an agent’s license was revoked; in two other cases, the agent was “warned” or verbally reprimanded. Five of the files detailed the dollar amount recovered through the complaint process; several others noted that a refund had been paid to the complainant (two files) or that the claim had been settled (six files).

RECOMMENDATIONS

LEGISLATIVE

This performance audit identified the following areas in which the General Assembly may wish to consider statutory changes to improve the efficiency and effectiveness of the Department of Commerce and Insurance's operations.

1. The General Assembly may wish to consider a formal definition of "fire department," which would include training and background screening requirements for firefighters and would delineate between full-time and volunteer fire departments. The General Assembly may also wish to consider giving the Department of Commerce and Insurance authority to intervene when problems arise that threaten fire service in a particular locality.
2. The General Assembly may wish to clarify language in Section 68-102-111, *Tennessee Code Annotated*, to require fire departments to report fire incident data to TFIRS at least annually.

ADMINISTRATIVE

The following areas should be addressed to improve the efficiency and effectiveness of the Department of Commerce and Insurance's operations.

1. The Division of Insurance should take action to ensure that all financial analysts and supervisors are aware of all policies and procedures (both formal and informal) related to the financial analysis process and hold staff accountable for applying those policies and procedures on a uniform and consistent basis.
2. Division of Insurance management should implement a process that includes on-site follow-up of serious deficiencies to ensure that those deficiencies have been corrected by the insurance companies. Division staff and department legal staff should coordinate to ensure that sanctions are issued against companies that fail to correct serious deficiencies.
3. Division of Insurance management should develop a formal process to ensure that all securities maintained for statutory deposit meet all state and departmental requirements, as well as any specific requirements in companies' individual depository agreements.
4. Management of the Examination Section of the Division of Insurance should ensure that examiners uniformly and consistently apply the policies and procedures set forth by the *Financial Conditions Examiners Handbook* and that examiners document their reasons for not following the handbook in specific instances.

5. Division of Insurance management should ensure that, before companies are admitted to do business in Tennessee, staff obtain and review all information required by the Uniform Certificate of Authority Application, as well as other information deemed pertinent by management. Staff should document reasons for exceptions to the normal process. In addition, management should review the process for documenting admissions decisions and develop a formal procedure to ensure that such decisions are adequately documented for all companies.
6. The department should ensure that all Bomb and Arson special agents get 40 hours of POST-related training every year. To enhance leadership skills, the department should make available and require supervisory training for all levels of special agents. The department should cooperate with the Department of Personnel in the development and implementation of such training.
7. The department should update Bomb and Arson Section policies and procedures so that special agents are properly guided in their investigations and can adequately resolve jurisdictional disputes among local investigative agencies.
8. The department should determine the need and demand for particular types of bomb and arson training for local fire and police department personnel by surveying such personnel and by inquiring how other states are meeting similar training needs. The department should then take steps to provide this training.
9. Department management should assess the level of access to the Bomb and Arson Section's office space and case information, and take action (e.g., providing adequately enclosed facilities) to ensure restricted access to both sensitive documents and case-related conversations. Staff should be careful when discussing investigations and take precautions to help ensure that unauthorized individuals do not overhear case-related conversations. The department should transfer all valuable investigative information in paper case files to AIMS 2000.
10. The department should take steps to increase TFIRS participation by fire departments, including educating them on the usefulness of fire incident data in fire prevention, and providing technical assistance (e.g., regarding software compatible with TFIRS).
11. The department should develop and implement a formal, comprehensive fire-prevention education program. Information from TFIRS on the causes of fire deaths in specific locations should be used to target educational efforts.
12. The department should develop rules and regulations to institute regular periodic verifications of exempt entities to ensure that such entities have the manpower and technical knowledge to enforce state-required electrical codes. Department management should also review current statutory language and, if necessary, prepare proposed legislation for consideration by the General Assembly, to clarify what local governments must do to justify exemptions. In developing rules and regulations and/or preparing proposed statutory

language, the department may wish to adopt language similar to that in existing statutes, rules, and regulations concerning building construction safety standards.

13. The department should develop procedures for effectively auditing entities exempted from state building and fire code inspections at least every three years as required by statute, to ensure that such entities are performing their enforcement functions appropriately.
14. Division of Fire Prevention management should verify that all staff (state staff and contract staff) comply with minimum job requirements, including required certifications, and document that compliance in their personnel files. Management should also ensure that all state employees have a state application on file and that both state and contract employees are evaluated annually.
15. The department should work with manufactured home builders and retailers to ensure that manufactured home buyers understand the statutory requirements regarding anchoring permits and inspections, as well as the reasons why correct installation is so important. The department should also work with county clerks, as well as state and local electrical inspectors, to ensure compliance with new legislative requirements. To effectively monitor inspections, the department should make changes to its Electrical Permitting System so that information on electrical and anchoring inspections can be more easily compared.
16. Division of TennCare Oversight management needs to establish formal, consistent policies that include reference to job level/type rather than staff members' names; clarify whether the policy is new or updates or rescinds a previous policy; and include the date on which the policy goes into effect. When a policy is updated, management should provide staff with the revised version of the entire policy, not just the changes.

FUTURE CONSIDERATION

1. The state should evaluate the costs and benefits of developing and implementing statewide building standards for one- and two-family dwellings—weighing the cost of additional regulation and inspection against the potential decrease in structural damage, injury, and loss of life that could result from strengthening standards for residential housing throughout the state.

APPENDIX 1 TITLE VI INFORMATION

All programs or activities receiving federal financial assistance are prohibited by Title VI of the Civil Rights Act of 1964 from discriminating against participants or clients on the basis of race, color, or national origin. In response to a request from members of the Government Operations Committees, we compiled information concerning federal financial assistance received by the Department of Commerce and Insurance, and the department's efforts to comply with Title VI requirements. The results of the information gathered are summarized below.

The Department of Commerce and Insurance currently receives federal funds for two types of activities. First, the department receives funds through the U.S. Department of Justice's Edward Byrne Memorial Grant for its "Project Burn Out" program. For fiscal year 2002, the department received \$32,181, which was passed through the Department of Finance and Administration's Office of Criminal Justice Programs. The department used the funds for crime scene supplies and apparel, weapons, and lease payments on the following: a vehicle equipped to respond to bombing and arson incidents, space on a computer server, and point-to-point protocol accounts to enable field agents to access the state's bomb and arson database from a crime scene. According to the fiscal director, the department reports the total amount spent to the Department of Finance and Administration and records individual expenditures in the State of Tennessee Accounting and Reporting System (STARS).

The department also receives funds from the U.S. Department of Housing and Urban Development (HUD) as part of a cooperative agreement under which Commerce and Insurance staff perform monitoring reviews at factories producing manufactured housing, investigate consumer complaints, and take enforcement actions as needed. For fiscal year 2002, the department received approximately \$204,320 (the department receives a set fee for each manufactured home section shipped into the state and for each section produced in the state). The department submits to HUD a state plan, which details Tennessee's provisions for enforcing federal manufactured home construction and safety standards.

The department has a Title VI Coordinator whose duties include updating and preparing the Title VI Implementation plan, accepting Title VI complaints, investigating and resolving any such complaints along with the department's legal counsel, and tracking Title VI legislation. The department submitted its annual Title VI compliance report and implementation plan update to the Office of the Comptroller of the Treasury on June 21, 2002, as required by statute. The letter submitted by the department stated that the Title VI policies, procedures, complaint procedures, terminology, and monitoring methodology are contained in the department's Title VI compliance plan filed with Comptroller's Office on June 25, 1998. According to the letter, there have been no changes to the plan since that time. The plan (which we reviewed) describes the department's Title VI policy, the responsibilities of the various levels of government, the department's proposed Title VI activities related to public notification of eligible participants, data collection and reporting of participation data, complaint handling, and compliance reviews. Currently, however, many of the Title VI-related activities outlined in the plan are not applicable to the department's federally funded activities (see above) because of the nature of those activities (i.e., bomb and arson investigations and manufactured housing inspections).

According to the Title VI Coordinator and the fiscal director, the department has received no Title VI complaints in the last three years and has performed no compliance reviews. The TennCare Oversight Division of the department does have steps to review the managed care organizations' (MCOs') compliance with Title VI as part of its financial and contract examinations of those MCOs. Based on our review, however, it does not appear that all examinations include this review. For example, only four of the plans (OmniCare, Preferred Health Partnership, Vanderbilt, and Volunteer State Health Plan) listed in Table 3 on page 19 were examined for Title VI compliance.

**Staff of the Department of Commerce and Insurance by Title, Gender, and Ethnicity
As of April 30, 2002**

Title	<i>Gender</i>		<i>Ethnicity</i>			
	<i>Male</i>	<i>Female</i>	<i>White</i>	<i>Black</i>	<i>Asian</i>	<i>Other</i>
Account clerk	2	1	3	0	0	0
Accountancy board investigator	0	1	1	0	0	0
Accounting manager	1	0	1	0	0	0
Accounting technician	1	11	10	2	0	0
Accountant	1	0	1	0	0	0
Assistant commissioner	2	3	4	1	0	0
Actuarial officer	2	0	2	0	0	0
Actuary	4	4	8	0	0	0
Administrative director regulatory boards	1	6	6	1	0	0
Administrative manager regulatory boards	1	4	5	0	0	0
Administrative assistant regulatory boards	5	39	35	9	0	0
Administrative assistant	1	4	3	2	0	0
Administrative services assistant	4	26	27	3	0	0
Administrative services manager	0	1	1	0	0	0
Administrative secretary	1	20	19	2	0	0
Attorney	7	6	11	1	1	0
Audit director	1	0	1	0	0	0
Auditor	7	1	6	2	0	0
Bomb and arson assistant director	1	0	1	0	0	0
Bomb and arson director	1	0	1	0	0	0
Bomb and arson special agent	19	1	20	0	0	0
Bomb and arson special agent in-charge	1	1	2	0	0	0
Building maintenance worker	1	0	1	0	0	0
Board member	71	17	79	8	1	0
Burial services specialist	2	0	2	0	0	0
Codes enforcement program director	1	0	1	0	0	0
Clerk	6	12	13	5	0	0

Staff of the Department by Title, Gender, and Ethnicity (Cont.)

Title	<i>Gender</i>		<i>Ethnicity</i>			
	<i>Male</i>	<i>Female</i>	<i>White</i>	<i>Black</i>	<i>Asian</i>	<i>Other</i>
Computer operations manager	0	1	1	0	0	0
Commissioner	0	1	1	0	0	0
Commission member	30	10	32	7	0	1
Consumer insurance investigator	11	2	11	2	0	0
Consumer insurance services manager	3	0	2	1	0	0
Consumer protection assistant director	1	0	1	0	0	0
Consumer protection director	1	0	1	0	0	0
Consumer protection specialist	4	2	6	0	0	0
Contractor inspector	9	0	9	0	0	0
Data entry operator	0	1	1	0	0	0
Deputy commissioner	2	0	2	0	0	0
Director – agent licensing/continuing education	0	1	1	0	0	0
Director – workmen’s compensation/surplus lines	1	0	1	0	0	0
Distributed computer operator	1	2	1	2	0	0
Electrical inspector supervisor	3	0	3	0	0	0
Electrical inspection director	1	0	0	1	0	0
Executive director – emergency communication board	1	1	2	0	0	0
Executive administrative assistant	0	2	2	0	0	0
Executive secretary	0	4	4	0	0	0
Facilities administrator	1	0	1	0	0	0
Facilities construction assistant director	1	0	1	0	0	0
Facilities construction director	1	0	1	0	0	0
Facilities construction specialist	9	1	8	1	0	1
Facility supervisor	1	0	1	0	0	0
Food services manager	0	1	1	0	0	0
Fire service instructor	2	0	2	0	0	0
Fire safety manager	1	0	1	0	0	0
Fire safety specialist 1	24	2	24	1	1	0
Fire safety supervisor	3	0	3	0	0	0
Fiscal director	0	1	0	0	0	1
Fire service program director	1	0	1	0	0	0
General counsel	1	0	1	0	0	0
Information resource support specialist	3	0	3	0	0	0
Information officer	0	1	0	0	0	1
Information systems analyst	3	2	3	2	0	0

Staff of the Department by Title, Gender, and Ethnicity (Cont.)

Title	<i>Gender</i>		<i>Ethnicity</i>			
	<i>Male</i>	<i>Female</i>	<i>White</i>	<i>Black</i>	<i>Asian</i>	<i>Other</i>
Information systems consultant	0	1	1	0	0	0
Information systems director	1	0	1	0	0	0
Information systems manager	1	0	1	0	0	0
Insurance analysis director	1	0	1	0	0	0
Insurance examiner in-charge – CFE	5	3	7	1	0	0
Insurance examiner	6	4	7	3	0	0
Insurance examination assistant director	1	0	1	0	0	0
Insurance examiner – AFE	6	2	7	1	0	0
Insurance examiner – CFE	1	1	1	1	0	0
Insurance examiner director	1	0	1	0	0	0
Insurance investigation director	1	0	1	0	0	0
Legal services director	0	1	1	0	0	0
Licensing technician	5	40	36	9	0	0
Mail clerk	1	0	0	1	0	0
Mail technician	1	0	0	1	0	0
Manufactured homes inspector	14	1	15	0	0	0
Manufactured homes inspection manager	1	0	1	0	0	0
Manufactured homes inspection supervisor	2	0	2	0	0	0
Motor vehicle commission field investigator	8	5	13	0	0	0
Office supervisor	0	2	2	0	0	0
Personnel analyst	0	1	1	0	0	0
Personnel director	0	1	1	0	0	0
Personnel manager	0	1	1	0	0	0
Personnel technician	0	2	1	1	0	0
Pharmacy board director	1	0	1	0	0	0
Pharmacist	5	0	5	0	0	0
Procurement officer	1	0	1	0	0	0
Regulatory board executive director	4	3	7	0	0	0
Regulatory board field representative	5	7	11	1	0	0
Regulatory boards investigation assistant director	1	0	1	0	0	0
Regulatory boards investigation director	1	0	1	0	0	0
Regulatory board investigator	10	1	10	1	0	0
Regulatory board investigator supervisor	1	0	1	0	0	0
Secretary	1	24	18	6	0	1
Securities examiner	8	2	7	3	0	0
Securities examiner supervisor	2	1	2	1	0	0
Statistical analyst	1	1	2	0	0	0

Staff of the Department by Title, Gender, and Ethnicity (Cont.)

Title	<i>Gender</i>		<i>Ethnicity</i>			
	<i>Male</i>	<i>Female</i>	<i>White</i>	<i>Black</i>	<i>Asian</i>	<i>Other</i>
Statistical clerk	1	0	0	1	0	0
Statistician	1	1	2	0	0	0
TennCare examiner	3	5	6	2	0	0
TennCare examination director	0	1	1	0	0	0
TennCare examination manager	2	0	2	0	0	0
	<u>367</u>	<u>304</u>	<u>577</u>	<u>86</u>	<u>3</u>	<u>5</u>

Appendix 2
Fire Department Participation in the Tennessee Fire Incident Reporting System
As of September 30, 2001

Anderson County

Reporting	Not Reporting
Marlow	Andersonville
Norris	Briceville
Oak Ridge	Claxton
	Clinton
	Lake City
	Medford

Blount County

Reporting	Not Reporting
Blount County	Alcoa
Maryville	Friendsville
	Townsend Area

Bedford County

Reporting	Not Reporting
Bell Buckle	Wartrace
Shelbyville	
Volunteer Fire Service	

Bradley County

Reporting	Not Reporting
Bradley County	Charleston
Cleveland	

Benton County

Reporting	Not Reporting
Big Sandy	Camden
South 40	Chalk Level
	Eva
	Holladay-McIllwain
	Morris Chapel
	Sandy River

Campbell County

Reporting	Not Reporting
Caryville	Campbell County
Jacksboro	Lafollette
Jellico	Pinecrest
	Ridgewood
	White Oak

Bledsoe County

Reporting	Not Reporting
Brayton	Brockdale
Pikeville	Griffith
	Hendon
	Luminary District 7
	Lusk
	Mt. Crest
	Nine Mile
	Rigsby

Cannon County

Reporting	Not Reporting
Auburntown	None
Cannon County	
Woodbury	

Fire Department Participation in the TFIRS (Cont.)

Carroll County

Reporting	Not Reporting
Huntingdon	Atwood
McKenzie	Bruceton
	Carroll County
	Hollow Rock
	McLemoresville
	Trezevant

Claiborne County

Reporting	Not Reporting
Clear Fork	Springdale
Cumberland Gap	
N. Claiborne County	
North Tazewell	
South Claiborne	
Speedwell	
Tazewell/New Tazewell	

Carter County

Reporting	Not Reporting
Elizabethton	Central
Elk Mills Poga	Hampton Valley Forge
Watauga	Roan Mountain
	Stoney Creek
	West Carter County

Clay County

Reporting	Not Reporting
None	Celina
	East Clay County
	Moss
	Mt. Vernon
	Pea Ridge
	West End

Cheatham County

Reporting	Not Reporting
Kingston Springs	Ashland City
	Henrietta
	Mid-Cheatham County
	Pegram
	Pleasant View
	Two Rivers

Cocke County

Reporting	Not Reporting
Cocke County	Centerview
Cosby	Del Rio
Newport	Grassy Fork
	Long Creek
	Parrottsville

Chester County

Reporting	Not Reporting
Henderson	Chester County
	Enville

Coffee County

Reporting	Not Reporting
Manchester	A E D C
	Hickerson Station
	Hillsboro
	New Union
	North Coffee County
	Summitville
	Tullahoma

Fire Department Participation in the TFIRS (Cont.)

Crockett County

Reporting	Not Reporting
None	Alamo Bells Friendship Maury City

DeKalb County

Reporting	Not Reporting
DeKalb County	Alexandria Smithville

Cumberland County

Reporting	Not Reporting
Crossville Fairfield Glade	Cumberland County

Dickson County

Reporting	Not Reporting
Vanleer	Burns Charlotte City of Dickson Claylick Cumberland Furnace Dickson County Rescue Squad Harpeth Ridge Tennessee City White Bluff

Davidson County

Reporting	Not Reporting
Goodlettsville	Metro Nashville

Dyer County

Reporting	Not Reporting
Dyersburg	Dyer County Newbern Trimble

Decatur County

Reporting	Not Reporting
Bath Springs	Decatur County Decaturville Jeanette Parsons Woodlawn Shores

Fayette County

Reporting	Not Reporting
Gallaway Moscow Oakland Somerville	Braden District 15 LaGrange Macon North Fayette County Northeast Fayette County Piperton Rossville West Fayette County Williston

Fire Department Participation in the TFIRS (Cont.)

Fentress County

Reporting	Not Reporting
None	Fentress County

Grainger County

Reporting	Not Reporting
None	Bean Station Blaine Rutledge Thorn Hill Washburn

Franklin County

Reporting	Not Reporting
Cowan	Alto Oak Grove
Crow Creek Valley	Belvidere
Decherd	Broadview
Fourth District	Capitol Hill
Keith Springs	Estill Springs
Lexie Crossroads	Huntland
N. Franklin Co.	Sewanee
Winchester	

Greene County

Reporting	Not Reporting
Caney Branch	Camp Creek
Greeneville	Cedar Creek
Ore Bank	DeBusk
St. James	McDonald
Sunnyside	Midway
Town of Mosheim	Mosheim
United	Newmansville
	South Greene
	Tusculum

Gibson County

Reporting	Not Reporting
Bradford	Gibson
Dyer	Gibson County
Milan	Humboldt
Rutherford	Medina
	Milan Army
	Ammunition Plant
	Trenton
	Yorkville

Grundy County

Reporting	Not Reporting
Gruetli-Laager	Altamont
Pelham Valley	Beersheba Springs
	Coalmont
	Monteagle Fire and Rescue
	Palmer
	Southeast Grundy Co. Rescue
	Tracy City
	White City

Giles County

Reporting	Not Reporting
Elkton	Ardmore
Pulaski	Giles Co. Fire and Rescue
	Minor Hill

Hamblen County

Reporting	Not Reporting
Morristown	E. Hamblen Co.
N. Hamblen Co.	S. Hamblen Co.
W. Hamblen Co.	

Fire Department Participation in the TFIRS (Cont.)

Hamilton County

Reporting	Not Reporting
Dallas Bay	Chattanooga
Signal Mountain	East Ridge
	Flat Top
	Highway 58
	Lookout Mountain
	Mowbray
	Red Bank
	Sale Creek
	Sequoyah
	Soddy Daisy
	Tri-Community
	Waldens Ridge

Hawkins County

Reporting	Not Reporting
Church Hill	Bulls Gap
Mt. Carmel	Carters Valley
	Clinch Valley
	Goshen Valley
	Holston Army
	Ammunition Plant
	Lakeview
	Persia
	Rogersville
	Stanley Valley
	Striggersville
	Surgoinsville

Hancock County

Reporting	Not Reporting
None	Blackwater Vardy
	Camps
	Panther Creek
	Snake Hollow
	Sneedville
	Treadway

Haywood County

Reporting	Not Reporting
Haywood County	Eurekaton Hillville
	Stanton
	Woodland-Union

Hardeman County

Reporting	Not Reporting
Bolivar	Grand Junction
Middleton	Grand Valley
Toone	Hickory Valley
	Hornsby
	New Castle
	Saulsbury
	Silerton District
	Whiteville

Henderson County

Reporting	Not Reporting
Henderson Co.	None
Lexington	
Scotts Hill	

Hardin County

Reporting	Not Reporting
None	Hardin County
	Savannah

Henry County

Reporting	Not Reporting
Henry	Cottage Grove
Paris	Mansfield
Paris Landing	Oakland
	Puryear
	Springville

Fire Department Participation in the TFIRS (Cont.)

Hickman County

Reporting	Not Reporting
None	Bon Aqua Centerville Hickman Co. Rescue Squad Pinewood

Jefferson County

Reporting	Not Reporting
Dandridge Jefferson City New Market	Kansas Talbott Lakeway Central White Pine

Houston County

Reporting	Not Reporting
Erin	Tennessee Ridge

Johnson County

Reporting	Not Reporting
First District Mountain City Second District Shady Valley	Butler Doe Valley Dry Run Neva Trade

Humphreys County

Reporting	Not Reporting
Waverly	Bold Springs/ Poplar Grove Humphreys County McEwen New Johnsonville

Knox County

Reporting	Not Reporting
Karns	Heiskell Knoxville Rural Metro

Jackson County

Reporting	Not Reporting
None	Dodson Branch Fairview Flynns Lick Gainesboro City Granville Cooperative Jackson County Central Jennings Creek Nameless South Side West End

Lake County

Reporting	Not Reporting
None	Ridgely Tiptonville

Fire Department Participation in the TFIRS (Cont.)

Lauderdale County

Reporting	Not Reporting
Ripley	East Lauderdale Co. Gates Halls Henning NW Lauderdale Co. West Lauderdale Co.

Loudon County

Reporting	Not Reporting
Greenback Loudon County Philadelphia	Lenoir City Loudon Tellico Village

Lawrence County

Reporting	Not Reporting
Crossroads Ethridge Henryville Loretto Fire and Rescue New Prospect	Center Point Gandy Iron City Lawrence Co. Rescue Squad Lawrenceburg Leoma SE Lawrence County St. Joseph Summertown West End West Point

Macon County

Reporting	Not Reporting
Lafayette Red Boiling Springs	Macon Co. Rescue Squad

Lewis County

Reporting	Not Reporting
None	Howenwald Lewis County

Madison County

Reporting	Not Reporting
Jackson	Madison County

Lincoln County

Reporting	Not Reporting
None	Fayetteville Lincoln County Petersburg

Marion County

Reporting	Not Reporting
Battle Creek Crossroads Jasper Sequatchie South Pittsburg Mountain Whitwell	Foster Falls Haletown Kimball Mullins Cove New Hope Orme South Pittsburg Suck Creek Mountain Sweetens Cove West Valley Whitwell Mtn. Fire and Rescue

Fire Department Participation in the TFIRS (Cont.)

Marshall County

Reporting	Not Reporting
Berlin	Chapel Hill
Cornersville	Lewisburg
Farmington/ Richcreek	Belfast
Five Points	Mooreville

McNairy County

Reporting	Not Reporting
Bethel Springs	Adamsville
Finger	Eastview
McNairy County	Guys
Ramer	Michie
Selmer	Milledgeville
	Stantonville

Maury County

Reporting	Not Reporting
Culleoka	Columbia
Mt. Pleasant	Maury County
Theta	Spring Hill

Meigs County

Reporting	Not Reporting
Decatur	None
Meigs County	

McMinn County

Reporting	Not Reporting
Englewood	Athens
Etowah	Calhoun
	Claxton Community
	Etowah Rural
	McMinn County
	Niota

Monroe County

Reporting	Not Reporting
Madisonville	Ball Play
Sweetwater	Christenburg
	Citico
	Coker Creek
	Conasauga Valley
	Hopewell
	Mt. Vernon
	North Monroe County
	Notchey Creek
	Rafter
	Tellico Plains
	Tri Community
	Turkey Creek
	Vonore

Montgomery County

Reporting	Not Reporting
Montgomery Co.	Clarksville
	Fort Campbell

Overton County

Reporting	Not Reporting
Livingston	Allons
	Alpine
	Fairground
	Hardys Chapel
	Hilham
	Monroe
	Mountain Fire and Rescue
	Muddy Pond
	Rickman

Fire Department Participation in the TFIRS (Cont.)

Moore County

Reporting	Not Reporting
Lynchburg	Jack Daniels

Perry County

Reporting	Not Reporting
Cedar Creek	Flatwoods
Pineview	Linden
Pope	Lobelville
	Perry County Rescue Squad

Morgan County

Reporting	Not Reporting
Wartburg	Burrrville
	Chestnut Ridge
	Clear Fork
	Coalfield
	Deer Lodge
	Joyner
	Oakdale
	Petros
	Sunbright
	Sunbright Area

Pickett County

Reporting	Not Reporting
None	Pickett County

Obion County

Reporting	Not Reporting
Hornbeak	Kenton
Obion	Obion County Rescue Squad
South Fulton	Rives
Union City	Samburg-Reelfoot
	Troy
	Union City Rural

Polk County

Reporting	Not Reporting
None	Copperhill
	East Polk County
	West Polk County

Putnam County

Reporting	Not Reporting
Algood	Baxter
Cookeville	Putnam
Monterey	

Rutherford County

Reporting	Not Reporting
Murfreesboro	Almaville
Rutherford Co.	Christiana
Salem-Blackman	Eagleville
Smyrna	Fosterville
Walter Hill	Kittrell
	Lascassas
	LaVergne
	Rockvale
	Southeast Rutherford

Fire Department Participation in the TFIRS (Cont.)

Rhea County

Reporting	Not Reporting
Dayton	None
Graysville	
Rhea County	
Spring City	

Scott County

Reporting	Not Reporting
Oneida	East 63
	Huntsville
	Mid County
	Paint Rock
	Pine Hill
	Seventh District
	South Scott County
	Winfield

Roane County

Reporting	Not Reporting
Blair	E. Roane County
S. Roane County	Harriman
	Kingston
	Midtown
	Oliver Springs
	Rockwood
	W. Roane County

Sequatchie County

Reporting	Not Reporting
Cagle Fredonia	Lone Oak
Dunlap	
Lewis Chapel	
Southend	

Robertson County

Reporting	Not Reporting
Adams	Cross Plains
Orlinda	Greenbrier
Robertson County	Ridgetop
Springfield	South Forks Services
White House	

Sevier County

Reporting	Not Reporting
None	Catons Chapel
	English Mountain
	Gatlinburg
	Northview
	Pigeon Forge
	Pittman Center
	Sevierville
	Seymour
	Walden Creek
	Wears Valley

Shelby County

Reporting	Not Reporting
Arlington	Collierville
Bartlett	Memphis
Germantown	
Millington	
Shelby County	

Sumner County

Reporting	Not Reporting
Gallatin	Millersville
Hendersonville	Mitchellville
Westmoreland	Number One
White House	Portland
	Shackle Island
	Sumner County

Fire Department Participation in the TFIRS (Cont.)

Smith County

Reporting	Not Reporting
Carthage	Forks River Gordonsville Rock City-Rome Smith County South Carthage

Tipton County

Reporting	Not Reporting
Brighton Covington Covington Rural Munford Quito Three Star	Charleston Garland Gilt Edge Mason

Stewart County

Reporting	Not Reporting
Dover Indian Mound Stewart County	Bumpus Mills Leatherwood/ Brownfield N. Stewart County

Trousdale County

Reporting	Not Reporting
Hartsville	None

Sullivan County

Reporting	Not Reporting
Avoca Bluff City Bristol Kingsport	Area 421 Emergency Services Bloomingdale East Sullivan County Hickory Tree Piney Flats Sullivan County Tri City Region Airport Warriors Path West Sullivan County

Unicoi County

Reporting	Not Reporting
Erwin	Limestone Cove Southside Unicoi

Union County

Reporting	Not Reporting
Luttrell Sharps Chapel	Maynardville Paulette

Wayne County

Reporting	Not Reporting
Waynesboro City	Beech Creek Clifton Collinwood Cypress Inn Highway 69 Lutts Ovilla Southgate Topsy Wayne County

Fire Department Participation in the TFIRS (Cont.)

Van Buren County

Reporting	Not Reporting
Fall Creek Falls Spencer	Cedar Grove

Weakley County

Reporting	Not Reporting
Gleason Greenfield Latham/Dukedom Martin Ore Springs-Como Palmersville Sharon	Dresden Sidonia Weakley County Rescue Squad

Warren County

Reporting	Not Reporting
McMinnville N. Warren County	Campaign and Rock Island Centertown Collins River Morrison Viola Community

White County

Reporting	Not Reporting
Bon De Croft Doyle North End	Cassville Central View Cherry Creek Eastland Hickory Valley Mt. Gilead Sparta

Washington County

Reporting	Not Reporting
Embreeville Johnson City Jonesborough Limestone	Fall Branch Gray Nolichucky Valley Sulphur Springs

Williamson County

Reporting	Not Reporting
Nolensville	Arrington Brentwood Fairview College Grove Flat Creek/ Bethesda Franklin Williamson Co. Rescue Squad

Wilson County

Reporting	Not Reporting
Lebanon Wilson County	Watertown

APPENDIX 3

Summary of Findings from Recent MCO/BHO Examinations as of July 31, 2002

John Deere Health Plan, Inc. (JDHP)

For the Period October 1, 1999 – December 31, 1999

1. JDHP did not process all claims selected for testing in accordance with the TennCare contract. Only 44 of 50 claims in the sample were processed within 60 days. Furthermore, in April 2001, JDHP did not process all claims within 60 days of receipt. The TennCare contract requires an MCO to process 100% of all claims within 60 days.
2. One of the 26 paid claims was not paid in accordance with the information on the payment system.
3. One claim was processed for a person who was not a JDHP enrollee.
4. JDHP did not apply the 180-day timely filing requirement to hospital claims.
5. The current pend report identified 12 claims that had been in JDHP's possession for more than 60 days.
6. The explanations of benefits (EOBs) provided to enrollees did not agree with the information recorded in the claims processing system for 4 of the 5 EOBs selected.
7. The written notice of the results of the claims adjudication given to providers did not agree with the information recorded in the claims processing system for 4 of the 5 EOBs selected for testing.
8. Six of the claims were not stamped with the date received.

During the examination period, JDHP subcontracted with vendors for dental and vision services. Because the subcontractors processed claims for their services, pharmacy, dental, and vision claims were not included in JDHP's pool of claims and were not tested for compliance.

Memphis Managed Care Corporation (MMCC) d/b/a TLC Family Care Health Plan

For the Period January 1, 1998 – March 31, 1999

1. MMCC did not process claims in the sample in accordance with Section 2-18. of the TennCare contract. Ten percent of clean claims in the sample were processed within 30 days, 14% of clean claims were processed within 40 days, and 34% of all claims in the sample were processed within 60 days.
2. Three claims were paid with incorrect amounts because of non-system, manual errors.
3. Co-payment accumulation is not performed by the Diamond Claims System and, therefore, it could not be readily determined whether out-of-pocket payments were within maximum annual out-of-pocket liability limitations.
4. Peterson reviewed a sample of 50 claims and determined that 2 claims were inappropriately denied. (Commerce and Insurance retained Peterson Worldwide, LLC, a consulting group, to review MMCC's financial operations and denied and pending claims.)
5. A current aged pending claims report as of April 29, 1999, indicated 49% of the aged pending claims were 61 days or older (per Peterson's report).
6. EOB statements are not currently being provided to uninsured and uninsurable enrollees.
7. Of the 46 hard copy claims requested, one claim was not received and 6 of the hard copy claims reviewed contained data elements that did not match the system claims data.

8. MMCC did not report reliable claims aging data on its weekly claims processing reports submitted to the state. While the examiners were on site, MMCC corrected the reports that calculate the aging of processed claims.
9. Claims are not electronically controlled until they are actually adjudicated.

MMCC subcontracts with the following vendors for the provision of specific benefits and the processing and payment of related claims: MIM Health Plans Inc. (pharmacy benefits manager) and IPA (vision). Because the subcontractors processed claims for these benefits, these claims were not included in MMCC's pool of claims.

OmniCare Health Plan, Inc. (OHP)

For the Period April 1, 2000 – June 30, 2000

Claims Processing Market Conduct Exam:

1. The data file provided by OHP could not be reconciled to the general ledger to within an acceptable limit.
2. OHP did not process claims in accordance with the TennCare contract. Ninety-six percent of all claims in the sample were processed within 60 days. The TennCare contract requires an MCO to process 100% of all claims within 60 days.
3. One of the 50 claims tested contained incorrect or missing data elements.
4. Three of the 50 claims tested were improperly denied.
5. OHP paid incorrect amounts for 2 of the 50 claims tested.
6. One claim was correctly denied; however, OHP's claims system indicated a paid amount.
7. The claims status report submitted to TennCare on a weekly basis is not prepared correctly.

Limited Scope Financial Exam:

1. OHP's originally submitted NAIC Statement for the Quarter Ended June 30, 2000 understated claims payable by \$811,661. The understatement resulted in a statutory net worth deficiency of \$679,608 for June 30, 2000. UA-TN (OPH's parent company) purchased \$900,000 preferred stock in OHP to fund the statutory net worth deficiency.
2. The medical loss ratio reports filed through September 30, 2000 revealed several discrepancies. The incurred but not reported (IBNR) component of the medical loss ratio report was not based on actuarial studies or previous historical payment patterns of medical claims. Administrative costs of \$23,500 related to the claims processing fee of a pharmacy subcontractor was improperly included in the medical loss ratio report as medical expenses. Drug payments of \$90,407 related to dates of service prior to July 1, 2000 were improperly included in the medical loss ratio report as medical expenses.
3. Subsequent to the examination period, OHP failed to notify Commence and Insurance that it had amended the management agreement with UA-TN. Amended management agreements requires the prior approval of the department.
4. OHP incorrectly reported \$252,222 in funds held in escrow by providers as an admitted asset. Under NAIC guidelines, funds held in escrow are not readily available for the payment of claims and therefore should be classified as non-admitted assets.
5. Support for collection of \$295,954 in accounts receivable due from providers was not provided and had been adjusted from net worth.

6. Premium revenues as of June 30, 2000 incorrectly included amounts improperly accrued in premium revenue for the year ended December 31, 1999 that were never collected. Premium revenues of \$6,200 had been adjusted from net worth.

Title VI:

1. OHP is in compliance with Title VI.

During the examination period, OHP subcontracted with vendors for the provision of pharmacy benefits (MIM Health Plans, Inc.), dental services (Doral Dental), and vision services (Block Vision). Because the subcontractors processed claims for their services, pharmacy, dental, and vision claims were not included in OHP's pool of claims and were not tested for compliance.

Preferred Health Partnership of Tennessee, Inc. (PHP)

For the Period January 1, 1996 – December 31, 1997

Claims Processing:

Commerce and Insurance tested a sample of 100 claims received by PHP from January 1, 1997 through December 31, 1997. Section 2-18. of the TennCare contract requires 95% of clean claims to be processed within 30 calendar days of receipt, with the remaining 5% to be processed within the next 10 calendar days. The contract also requires the MCO to process *all* claims, clean and non-clean, within 60 calendar days of receipt. The results of the testing were as shown below.

1. PHP adjudicated and considered all claims sampled clean; however, only 35 of the 100 claims sampled from PHP's claims processing system were timely adjudicated in accordance with Section 2-18. of the TennCare contract. The following is a summary of results:
 - 35 claims (35%) within 30 days of receipt,
 - 77 claims (77%) within 40 days of receipt,
 - 97 claims (97%) within 60 days of receipt, and
 - 3 claims (3%) beyond 60 days of receipt.
2. PHP had not yet implemented electronic billing for its providers as of January 1, 1997, as required by TennCare contract Sections 2.2.g. and 2.18.
3. Three of 100 (3%) claims in the sample tested were denied inappropriately by PHP.
4. PHP is not coordinating member out-of-pocket limits with its behavioral health and substance abuse service provider, Tennessee Behavioral Health, Inc (TBH). This could potentially cause PHP's TennCare members to exceed their annual out-of-pocket limitations since both PHP and TBH charge co-payments.

Enrollee Complaints and Appeals (formerly Grievances):

1. PHP has submitted internal grievance policies and procedures to the Bureau of TennCare as required under Section 2-9. of the TennCare contract. Based upon a sample of enrollee complaints and appeals reviewed by the examiners, PHP appears to be in compliance with Section 2-9. of the TennCare contract.

Financial Reporting and Analysis:

1. For the year ended December 31, 1997, PHP reported a loss of (\$5,201,730) on its 1997 NAIC Annual Statement and its certified financial statements filed with the department on May 1, 1998.

PHP reported total TennCare related revenues of \$111,245,404, investment revenues of \$1,369,035, net medical expenses of \$104,676,262 (equal to 94.1% of total reported TennCare revenues), and administrative and tax expenses of \$13,139,907 (equal to 11.8% of total reported TennCare revenues).

2. PHP was not in compliance with the minimum net worth requirement as prescribed in Sections 2-10.e.4. and 2-2.f. of the TennCare contract and Sections 56-32-212 and 56-32-216, *Tennessee Code Annotated*. PHP's net worth, as adjusted during the examination, was deficient by \$5,458,395 on December 31, 1997. However, PHP corrected this deficiency as of March 31, 1998, through capital contributions of \$7.8 million from its ultimate parent, Covenant Health.

Effective April 8, 1997, Section 56-32-212, *Tennessee Code Annotated*, was amended to revise the minimum net worth required to be maintained by HMOs operating in Tennessee. The new requirement is the greater of \$1,500,000 or 4% of the first \$150 million of annual premium revenues, and 1.5% of the annual premium revenue in excess of \$150 million, as reported on the entity's most recent NAIC Annual Statement. Existing HMOs were permitted a percentage phase-in until July 1, 1998, to meet the full minimum net worth requirement. This phase-in was 50% of the minimum net worth on December 31, 1997, and 75% from January 1, 1998 through June 30, 1998. All of PHP's premium revenues are derived from the TennCare Program

PHP's TennCare revenues were adjusted as a result of this examination to \$111,014,598. Accordingly, PHP's exam-adjusted minimum net worth requirement was revised to \$4,440,584, or 4% of \$111,014,598. The revised statutes require PHP to maintain at least 50% of this requirement (or \$2,220,292) on December 31, 1997, 75% of this requirement (or \$3,330,438) from January 1, 1998 through June 30, 1998, and 100% as of July 1, 1998. PHP's net worth as of December 31, 1997, was revised to (\$3,238,103); however, Covenant Health's infusion of \$7.8 million as of March 31, 1998, corrected this deficiency.

3. During March 1998, the state executed an agreement with PHP settling all saving disputes for Calendar Years 1994 through 1996, at which time PHP operated as a PPO under a provider risk agreement with the state. PHP was granted a certificate of authority to operate as an HMO effective January 1, 1997. As an HMO, PHP is no longer required to calculate a savings or loss each year and may retain as administrative costs or profits any amounts not paid for medical services or premium taxes.

The compromise agreement executed between PHP and the state during March 1998, stipulated that the state would accept \$3,134,337 from PHP as settlement in full of its savings dispute with the state for calendar years 1994 through 1996. PHP had already paid \$1,855,428 to the state at the time of the agreement, and later paid in the remainder as agreed.

Marketing Plan:

PHP has submitted all marketing plans and materials to the Bureau of TennCare for approval in accordance with the TennCare contract. The Bureau of TennCare has provided TDCI with copies of all correspondence evidencing approval of PHP's marketing plans and materials for the period under examination.

Provider Agreements:

1. Section 2-18. of the TennCare contract lists the minimum requirements that PHP's executed provider agreements must contain. Certain provider agreements obtained and tested from PHP did not contain the provisions required under Sections 2-18.j., k., l., y., ee., and ll., of the contract.

Provider Complaints, Disputes and Arbitration:

1. PHP's monthly provider appeals' logs for 1997 were reviewed and a sample was selected for testing. Of approximately 802 appeals tracked in PHP's log for 1997, only 122 indicated that a resolution had been reached as of the date of fieldwork (May 1998). From July 1997 through December 1997, 590 appeals were entered in the log, and only 11 of these indicated a resolution date. Management was queried and responded that a significant backlog of unresolved provider appeals existed due to company downsizing and the unavailability of staff to handle the provider appeals. Therefore, PHP is not properly responding to provider disputes and appeals in accordance with its internal policies and procedures, and as required under Section 2-18.ee. of the contract.

Subcontracts and Other Statutory Approvals Required:

1. As of December 31, 1997, PHP had submitted all subcontracts to the TennCare Bureau for approval as required under Section 2-10. of the TennCare contract, but had not submitted a pharmacy subcontract to TDCI, as required by Section 56-32-203(c), *Tennessee Code Annotated*.
2. PHP received an approval from the Bureau of TennCare on February 23, 1998 for a revised member handbook; however, this handbook has not been submitted to TDCI for approval as required under Sections 56-32-203(b)(5) and (c), *Tennessee Code Annotated*. This constitutes a change in the evidence of coverage made available to plan enrollees, which must be submitted to TDCI for approval.

Title VI:

1. PHP evidenced to the examiners that it has adopted policies and procedures to monitor compliance with Title VI of the 1964 Federal Civil Rights Act and that PHP is in full compliance with Section 2-25. of the contract effective July 1, 1996, as amended by TennCare contract amendment number 2.

Premier Behavioral Systems of Tennessee, LLC

For the Period July 1, 1998 – June 30, 2000

Claims Processing Exam:

1. Premier incorrectly paid 9 of 60 claims reviewed.
2. Premier improperly denied 3 of 60 claims reviewed.
3. Premier inadequately reported encounter data required by the TennCare Partners contract. The encounter data did not include all revenue, procedure, and diagnosis codes.
4. Of 51 Regional Mental Health Institute claims reviewed, Premier improperly denied 29 claims.
5. Premier is not in compliance with Section 56-32-226(b), *Tennessee Code Annotated*, requirements for timely adjudication of claims.

Limited Scope Financial Exam:

1. Premier did not provide the examiners with requested information, specifically the general ledgers of an affiliate, which support the allocation of administrative expenses on the NAIC Financial Statements.
2. Premier understated Incurred But Not Reported (IBNR) at June 30, 2000. TDCI non-admitted unsupported health care receivables. Both items resulted in Premier's June 30, 2000, net worth being overstated and adjusted by TDCI.

Other Deficiency:

1. Premier did not include in the provider agreements all requirements specified by Section 3.9.2 of the Partners contract.

Tennessee Behavioral Health

For the Period July 1, 1998 – June 30, 2000

Claims Processing Exam:

1. TBH incorrectly paid three of 60 claims reviewed.
2. TBH improperly denied two of 60 claims reviewed.
3. Proper adjudication could not be determined for three of 60 claims.
4. Proper claims processing lags could not be ascertained for four of 60 claims reviewed.
5. TBH inadequately reported encounter data required by the TennCare Partners contract. The encounter data did not include all revenue, procedure, and diagnosis codes.
6. Of 50 Regional Mental Health Institute claims reviewed, TBH incorrectly paid 18 claims.
7. Of 50 Regional Mental Health Institute claims reviewed, TBH improperly denied 26 claims.
8. Of 50 Regional Mental Health Institute claims reviewed, two claims did not contain all of the dates of service billed on the claim in TBH's claims processing system.
9. TBH is not in compliance with Section 56-32-226(b), *Tennessee Code Annotated*, requirements for timely adjudication of claims.

Financial Exam:

1. TBH did not provide the examiners with requested information, specifically the general ledgers of an affiliate, which support the allocation of administrative expenses on the NAIC Financial Statements.
2. TDCI non-admitted unsupported health care receivables of \$707,718. This item resulted in TBH's June 30, 2000, net worth being overstated and adjusted by TDCI.

Other Deficiencies:

1. TBH did not include in the provider agreements all the requirements specified by the TennCare Partners contract Section 3.9.2.
2. TBH is non-compliant with Section 3.4.2.9 of the TennCare Partners contract regarding the explanation of benefits to participants.

VHP, Inc.

For the Period October 1, 1995 – June 30, 1997

Claims Processing:

The Division sampled and tested 112 claims received by VHP for dates of service of July 1, 1996 through June 30, 1997. Of the 112 claims tested, 81 (72%) of the claims were paid and 31 (28%) were denied. All claims sampled were adjudicated and the results follow:

1. One hundred percent of all claims sampled for Julian date testing were entered into the Diamond system with the correct date of receipt.

2. Thirty-eight percent of all claims sampled from VHP's claims processing system were timely adjudicated in accordance with Section 2-18. of the TennCare contract:

19% were processed within 30 days of receipt,
19% were processed within the next 10 days of receipt,
43% were processed within 41 -60 days of receipt, and
19% were processed after sixty days from receipt.

(All claims were considered clean and thus 95% were required to be processed within 30 calendar days of receipt with the remaining 5% to be processed within 40 calendar days of receipt. Section 2-18 requires all claims submitted be processed within sixty (60) days.)

3. One hundred percent of all claims sampled were accurately adjudicated based on eligibility and timely filing.
4. Ninety-four percent of all denied claims sampled were denied validly.
5. Seventy-five of all claims sampled were correctly priced in accordance with the Diamond system and provider contracts. Seven claims were incorrectly priced per the system of which four were incorrectly paid and three were denied. Twenty-one claims were incorrectly priced according to the provider contracts of which 13 were incorrectly paid and eight were denied. In addition, one claim that was priced correctly according to the system and provider contract was incorrectly paid. Therefore, 84% or 94 of all claims sampled were paid correctly.
6. One hundred percent of all claims sampled subject to deductibles/co-pays were paid correctly.
7. Eighty-seven percent of all system claims sampled when compared to the original hard-copy claims matched without exception.
8. During the examination period, electronic billing was not available to providers.

Enrollee Grievances:

1. VHP submitted revised grievance/complaint policy and procedures to the Bureau of TennCare on July 31, 1997. All grievances sampled were processed in accordance with the Daniels v. Wadley Consent Order, TennCare Rule 1200-13-12.11, and TennCare contract's Section 2-9 as amended by Amendment Number 3, effective January 1, 1997.

Financial Reporting and Analysis:

1. For the year ended December 31, 1995, VHP reported a net loss from TennCare operations totaling \$1,116,158. However, VHP also reported losses associated with subsidiary operations equal to \$3,174,818, which when combined with VHP's net loss relative to TennCare operations, resulted in VHP's reported net loss of \$4,290,976.
2. For the year ended December 31, 1996, VHP reported net income from TennCare operations totaling \$1,644,888. However, VHP reported losses associated with subsidiary operations equal to \$5,585,200, which when offset by VHP's net income relative to TennCare operations, resulted in VHP's reported net loss of \$3,940,312.
3. VHP's net income relative to TennCare operations for the first six months of 1997 totaled \$291,653. However, VHP reported losses associated with subsidiary operations equal to \$1,350,282, which when offset by VHP's net income relative to TennCare operations, resulted in VHP's reported net loss of \$1,058,629 for the period January 1, 1997 through June 30, 1997.

4. The Division's examination adjusted VHP's reported net worth at June 30, 1997 of \$3,974,068 to \$3,371,143 which satisfied VHP's minimum net worth requirement pursuant to Sections 2-10.e.4 and 2-2.f of the TennCare Contract and Sections 56-32-212 and 56-32-216, *Tennessee Code Annotated*.

Marketing Plan:

VHP's marketing plan and materials for the 1995 change period were submitted to and approved by the TennCare Bureau. VHP has not submitted any additional marketing materials to the TennCare Bureau.

Provider Agreements:

1. Section 2-18. of the TennCare contract lists the minimum requirements that VHP's executed provider agreements must contain. None of the provider agreements reviewed for compliance with Section 2-18 completely complied with Section 2-18 requirements. Several requirements were excluded from all agreements; several requirements were included in some agreements but excluded from other agreements; the agreements have not incorporated Amendment 2 and Amendment 3 changes to Section 2-18; one VHP requirement contained in several agreements directly violated a Section 2-18 requirement; and another requirement did not fully incorporate a Section 2-18 requirement.

Subcontracts:

1. VHP has not submitted two of its four subcontracts to the TennCare Bureau for approval, as required by Section 2-10. of the TennCare Contract.

Title VI:

1. VHP complied with all requirements of Section 2-25 of the TennCare Contract except for inquiring as to the race and/or national origin of its providers.

Volunteer State Health Plan (VSHP)

For the Period January 1, 2000 – March 31, 2000

Claims Processing Market Conduct Exam:

1. VSHP did not process 100% of all claims within 60 days of receipt.
2. Two of 44 denied claims did not reflect all denial reasons.
3. The coinsurance or deductible was not properly calculated on two claims.
4. The data reported on two claims was not correctly entered into the claims processing system.
5. The Claims Status Report submitted to TennCare on a weekly basis was not prepared correctly.
6. Adequate documentation was not maintained for all provider complaints.
7. Control of incoming claims was not established immediately in the mailroom.

Limited Scope Financial and Compliance Exam:

1. Outstanding checks were incorrectly reported as liability.
2. Claims Payable was significantly overstated.

Title VI:

1. VSHP is in compliance with Title VI.

VSHP subcontracted with vendors for pharmacy claims processing (AdvancePCS, Inc.) and dental services (Doral Dental). Because the subcontractors processed claims for these benefits, pharmacy and dental claims were not included in the population of VSHP claims from which claims were selected for testing. The claims processing by subcontractors were analyzed only for compliance with timely claims processing requirements of Section 2-18 of the TennCare contract.

Appendix 4
Summary of Regulatory Actions for Xantus (formerly known as Phoenix Health of Tennessee [PHT])
April 8, 1998 – November 19, 2001

DATE	ACTION
April 8, 1998	DCI notifies PHT of a \$2.3 million “reported” net worth deficiency based on combined 1997 revenue of PHT and Health Net and requests that PHT provide a plan of corrective action within 30 days (May 8, 1998). First deficiency notice.
April 13, 1998	PHT disputes DCI’s calculation of the minimum net worth. PHT claims the required net worth should be calculated on basis of PHT’s 1997 revenue only, disregarding Health Net’s 1997 revenue.
April 27, 1998	DCI internal memo expresses concerns regarding (1) PHT’s net worth deficiency and the increase in the deficiency to \$6,496,758 should the federal income tax receivable of \$4,148,529 be non-admitted; (2) PHT’s anticipated net loss of \$500,000 for the 1 st quarter of 1998; and (3) PHT’s inability to achieve a medical loss ration of 80% or less (required to pay off the debt acquired in the Health Net acquisition/merger pursuant to PHT’s pro forma financial statement).
April 30, 1998	DCI forwards PHT’s dispute letter dated April 13, 1998 to the F&A Commissioner.
May 27, 1998	DCI requests the TennCare Bureau verify PHT’s assertions that it expects to receive approximately \$4 million in additional adverse selection payments for 1996 and 1997.
May 28, 1998	The TennCare Bureau tells DCI that it cannot substantiate PHT’s estimate of additional adverse selection payment.
June 4, 1998	DCI sends letter demanding PHT submit within 30 days a plan to correct the \$2.3 million “reported” net worth deficiency. PHT is notified that DCI does not accept PHT’s net worth calculation. Second deficiency notice.
July 6, 1998	PHT requests a 30 day extension of the deadline to submit the plan of correction based on PHT’s alleged inability to locate a policy position paper published by the NAIC.
July 13, 1998	DCI is advised to seek the opinion of the Attorney General on the legality of using the combined revenue of PHT and Health Net to calculate minimum net worth.
July 13, 1998	In an internal memo to the DCI Commissioner, the Deputy Commissioner recommends PHT’s request for a 30-day extension be denied or granted only on the condition of no further extensions. PHT had more than 90 days to correct the deficiency (although statute allows 30 days). The phase in for the new net worth requirement, which was completed July 1, 1998, increased PHT’s “reported” net worth deficiency from \$2.3 to \$4.1 million. The memo notes that PHT continues to lose money and its financial position is significantly worse than projected in the pro forma financial statements filed with the Health Net acquisition/merger.
July 20, 1998	TDCI grants PHT an extension of 31 days from the date of its request for an extension (7/6/98), resulting in a due date of August 6, 1998, for the plan of correction. PHT is advised that its current financial position is significantly worse than projected in the pro forma financial statements filed as part of the Health Net acquisition/merger.
July 23, 1998	DCI decides not to seek an Attorney General’s opinion on the issue of PHT’s minimum net worth calculation.
August 6, 1998	PHT’s newly-hired controller requests an additional one week extension to complete the plan of correction based on (1) his recent hiring; (2) the interference of DCI’s recent examination of PHT with PHT’s staff working on the plan; and (3) the CEO’s out-of-town commitments.
August 7, 1998	DCI grants PHT a one-week extension and advises PHT to correct the net worth deficiency by August 13, 1998. Third deficiency notice.
August 13, 1998	PHT submits a corrective action plan. First corrective action plan.
August 14, 1998	DCI internal memo regarding preliminary review of PHT’s corrective action plan relative to the pro forma financial statements indicate the following concerns: (1) PHT reported negative cash of \$1.1 million at 6/30/98; (2) PHT accrued \$7.2 million more in adverse

	selection payments than allowed by DCI; (3) PHT proposed \$20 million of capital investments into PHT - \$10 million from the Nations Bank line of credit and \$10 million from the sale of stock; and (4) claims liability was reduced by \$6 million from the 2 nd and 3 rd quarter in 1998.
August 14, 1998	DCI internal memo regarding preliminary review of 1 st Quarter 1998 NAIC Statement indicates PHT's "reported" net worth deficiency as \$5 million. PHT's corrective action plan indicates a net loss for 1998 of \$7.3 million and a net worth deficiency of \$11 million at 12/31/98. PHT proposes to correct the net worth deficiency by infusing \$10.5 million of additional capital by 12/31/98 and operating more efficiently. PHT also attempts to renegotiate the use of funds provision in the \$22.5 million line of credit with Nations Bank to allow statutory equity and/or working capital infusions in subsidiaries. In the memo, DCI concludes that PHT's proposed corrective action plan does not rectify the current net worth deficiency and is so contingent in nature that it does not present reliable evidence the PHT's net worth deficiency will be corrected "in the foreseeable future – if at all".
August 18, 1998	DCI notifies the F&A Commissioner that PHT is significantly out of compliance with Section 2-10.e.4 of the State's TennCare Contract and recommends a hearing be set.
September 3, 1998	DCI internal memo regarding preliminary review of 2 nd Quarter NAIC Statement indicates "reported" net worth deficiency on face of statement of \$5.5 million and after adjustments due to non-admitted assets and claims payable an adjusted net worth deficiency of \$33.2 million. The memo notes that the financial statements indicate PHT is in serious financial distress.
September 4, 1998	DCI internal memo concurs with F&A Commissioner's recommendation to require PHT to obtain a capital infusion of \$5 million by 9/15/98 and to correct any further net worth deficiency by 12/15/98.
September 9, 1998	DCI notifies PHT that its proposed plan of correction, as set forth in the 8/13/98 letter, does not rectify the net worth deficiency and lacks specificity and that DCI cannot accept unsupported and contingent possibilities to cure a significant net worth problem. PHT must present evidence by 9/25/98 that a capital infusion of \$5 million was obtained. PHT must also present evidence by 12/15/98 that any further net worth deficiency has been rectified.
September 14, 1998	DCI asks PHT if its claims appeals process has been revised.
September 17, 1998	DCI requests that the TennCare Bureau subject PHT to a 10% capitation withhold should PHT fail to meet the \$5 million capital infusion requirement by 9/25/98.
September 17, 1998	Results of a TennCare Bureau provider survey of PHT indicates PHT's providers are refusing to accept new patients and PHT does not know who is participating in its provider network.
September 22, 1998	DCI informs F&A Commissioner that PHT's net worth deficiency at 7/1/98 is a minimum \$3 million and may be as high as \$30 million due to non-admitting certain receivable. (Calculation based only on PHT's premium revenue reported on the Annual Statement.)
September 22, 1998	PHT questions DCI's net worth calculations. Since the issue is being addressed by the Attorney General, PHT requests the deadline for the \$5 million capital infusion be extended until the AG opinion is rendered.
September 23, 1998	DCI responds to attorney's request for calculation of PHT's net worth deficiency.
September 23, 1998	The TennCare Bureau notifies PHT of a 10% withhold if PHT does not provide by 9/25/98 evidence of curing its net worth deficiency.
September 30, 1998	The TennCare Bureau notifies PHT that its 9/22/98 request for an extension to cure net worth deficiency has been denied.
October 13, 1998	DCI internal memo notes State of Mississippi findings of PHM's (Phoenix Health of Mississippi) net worth deficiency.
October 15, 1998	DCI internal memo mentions that PHT may have taken TennCare money to cure the Mississippi deficiency.
October 23, 1998	Memo from DCI Deputy Commissioner to DCI Commissioner and F&A Commissioner discusses the State of Mississippi's concerns regarding Phoenix's ability to continue.

October 30, 1998	DCI internal memo discusses review of PHT's 1 st and 2 nd Quarter 1998 NAIC Statements. First Quarter "reported" net worth of \$2.1 million "adjusted" to \$4.7 million resulting in adjusted net worth deficiency of \$10 million at 3/31/98 and \$11.7 million at 7/1/98. Second Quarter "reported" net worth of \$1.6 million "adjusted" to \$26.2 million resulting in "adjusted" net worth deficiency of \$31.4 million at 6/30/98 and \$33.2 million at 7/198 (net worth adjusted for certain non-admitted receivables and claims payables). Draft letter and draft examination report sent to F&A Commissioner, DCI Commissioner, and Health Commissioner.
November 3, 1998	Draft working copy of Agreed Order of Supervision sent to F&A Commissioner, DCI Commissioner, and Health Commissioner.
November 5, 1998	Revised working copy of Agreed Order of Supervision sent to F&A Commissioner, DCI Commissioner, and Health Commissioner.
November 12, 1998	DCI Commissioner notifies F&A Commissioner that a Notice of Administrative Supervision places PHM under supervision of the Mississippi Insurance Department.
November 30, 1998	A Confidential Agreed Order of Supervision is issued, appointing Joseph P. Keane as Supervisor effective 11/30/98 and expiring 2/26/99.
December 10, 1998	DCI notifies PHT of review of PHT's 1 st and 2 nd Quarter 1998 NAIC Statements. First Quarter "reported" net worth of \$2.1 million "adjusted" to (\$4.7 million) resulting in adjusted net worth deficiency of \$10 million at 3/31/98 and \$11.7 million at 7/1/98. Second Quarter "reported" net worth of \$1.6 million "adjusted" to (\$26.2 million) resulting in "adjusted" net worth deficiency of \$31.4 million at 6/30/98 and \$33.2 million at 7/198 (net worth adjusted for certain non-admitted receivables and claims payables). DCI requests that PHT respond by 12/31/98. First deficiency notice for 1st and 2nd Quarters, 1998.
December 10, 1998	DCI sends PHT a draft examination report for the period 7/1/96-3/31/98.
December 17, 1998	PHT discusses progress toward correcting examination deficiencies. (i.e., searching for additional investment capital; in the process of implementing KPMG's operational recommendations; a 12-day turnaround for member appeals; and is revising provider agreements).
December 21, 1998	DCI memo concerns the release of PHT's September and October 10% Withholds by the Dept. of Health.
January 8, 1999	DCI is advised that the terms of the Agreed Order require DCI to keep 3 rd Quarter NAIC Statement confidential.
January 14, 1999	PHT prefers that DCI release the Amended 3 rd Quarter NAIC Statement without explanation of the Order of Supervision.
January 15, 1999	Supervisor notifies PHT of review of PHT's 3 rd Quarter NAIC Statement. "Reported" net worth of (\$3.4 million) "adjusted" to (\$30.4 million) resulted in a net worth deficiency of \$37.5 million at 9/30/98. (Net worth adjusted for certain non-admitted receivables.) PHT must provide a written plan for correcting the net worth deficiency by 1/29/99. First deficiency notice for 3rd Quarter 1998.
January 27, 1999	First HCFA conference call includes Health Deputy Commissioner and TennCare Bureau Director.
January 29, 1999	XHT submits amended 3 rd Quarter NAIC Statement and a written plan for correcting the net worth deficiency. XHT also submits a proposed TennCare Provider Agreement for review and approval.
January 29, 1999	DCI requests the Commissioner of Mississippi Department of Insurance provide copies of all filings received from Xantus Corp. and any affiliates.
February 2, 1999	DCI accepts XHT's amended 3 rd Quarter NAIC Statement as filed.
February 5, 1999	XHT requests that the Commissioner of Health close XHT enrollment until further notice.
February 9, 1999	Peterson briefing includes officials from DCI and Health.
February 12, 1999	TennCare Bureau notifies XHT that all deficiencies previously identified in 1/26/99 correspondence have been corrected. The Bureau will release withholds for 11/98 and 12/98.
February 12, 1999	State of Arkansas submits copies of Xantus Corp. filings to DCI.

February 17, 1999	XHT submits a written plan for correcting the net worth deficiency to the State Comptroller. The document included two financial projection spreadsheets that were not previously filed with DCI.
February 22, 1999	DCI officials meet with XHT to negotiate terms of the agreed order.
February 22, 1999	Second HCFA briefing includes DCI and Health officials. DCI Deputy Commissioner reviews the restructuring plan provided by PHT.
February 23, 1999	Peterson Worldwide, LCC faxes information to DCI that reflects a g/l balance sheet net income of (\$13.1 million) for 1998.
February 26, 1999	Draft Peterson Report is issued.
February 26, 1999	DCI officials meet with XHT to negotiate the Agreed Order. XHT says its trying to close the books for 1998 and will file the 1998 Annual NAIC Statement with DCI by the deadline date (3/1/99). XHT explains the filing may need revision after accounting for 1998 is finalized (by 3/5/98).
March 1, 1999	First Modified Agreed Order of Supervision for XHT is issued and appoints Kevin O'Brien as supervisor. The Agreed Order was signed 2/26/99.
March 4, 1999	DCI examiner notes that XHT did not file its actuarial statement on time (3/1/99).
March 4, 1999	DCI requests the actuarial statement. XHT official will check on the status. XHT told DCI that independent auditors want to delay their actuarial estimate until April in order to have more paid claims lag data (and have a more accurate prior-year estimate).
March 4, 1999	DCI apprises F&A Commissioner of the 12/13/98 NAIC filing, the reported net loss of \$27 million for 1998, and the potential adjusted net worth deficiency of \$50 million.
March 5, 1999	DCI learns from F&A that XHT's pharmacy account with MIM Health Plans is past due \$5,073,912 as of 3/5/99 and \$6,254,748 as of 3/8/99.
March 11, 1999	DCI notifies XHT of incomplete filing of the 1998 Annual Statement – missing actuarial statement, SVO certification, notes to financial statements, and Medicare supplement.
March 15, 1999	DCI internal memo discusses review of 4 th Quarter and Annual 1998 NAIC Statements. At 12/31/98, "reported" net worth of (\$24.4 million) "adjusted" to (\$43.1 million) resulted in adjusted net worth deficiency of \$50.7 million. (Net worth adjusted for certain non-admitted receivables.)
March 17, 1999	DCI provides XHT a proposed amendment (Third Party Modified Agreed Order of Supervision) to the Administrative Supervision Order proposing to incorporate Xantus Corporation (XC) as a party to the Order of Administrative Supervision to reflect and incorporate the responsibility of XC for the financial and operational aspects of the XHT HMO.
March 24, 1999	In response to the 3/11/99 notification for incomplete filing, XHT tells DCI that the actuary will provide the actuarial statement only after KPMG (XHT's outside auditors) has completed its claims payable analysis.

**Xantus Rehabilitation-Court Actions
March 31, 1999 – November 19, 2001**

Davidson County Court	
March 31, 1999	<ul style="list-style-type: none"> • Appointment of Special Deputy Receiver, David Manning • Appointment of Special Deputy Receiver, Manny Martins • Verified Petition for Entry of Consent Order Appointing DCI Commissioner Receiver for Purposes of Rehabilitation; and Injunction
April 1, 1999	<ul style="list-style-type: none"> • Rehabilitator's Motion for Approval of Continued Payment • Agreed Order Approving of Continued Payment • Motion to Set Aside Restraining Order and/or Lift Stay • Order Lifting Stay
May 28, 1999	<ul style="list-style-type: none"> • Initial Report of Special Deputy Rehabilitators
June 17, 1999	<ul style="list-style-type: none"> • Xantus Corp.'s Proposal for Continued Rehabilitation of XHT
June 22, 1999	<ul style="list-style-type: none"> • Notice of Filing of Proposal for Rehabilitation and Request for Status Conference
June 24, 1999	<ul style="list-style-type: none"> • Petitioner's Response to Xantus Corp.'s Proposed Plan of Rehabilitation
September 2, 1999	<ul style="list-style-type: none"> • Proposed Plan for Operation and Reorganization of Xantus during Rehabilitation • Motion for Scheduling Order
September 3, 1999	<ul style="list-style-type: none"> • Report of the Special Deputy Rehabilitators
September 13, 1999	<ul style="list-style-type: none"> • Response of MIM Health Plans, Inc., to Petitioner's Motion for Scheduled Order • Motion of MIM Health Plans, Inc., to Modify Proposed Plan for Operation and Reorganization of Xantus during Rehabilitation
October 8, 1999	<ul style="list-style-type: none"> • Motion of MIM Health Plans, Inc., to Intervene as a Party in Rehabilitation of Xantus • Petitioner's Motion for Protective Order • Petitioner's Memorandum in Support of Motion for Protective Order
October 27, 1999	<ul style="list-style-type: none"> • MIM Health Plans, Inc.'s, Reply in Support of Motion to Expedite Discovery
October 29, 1999	<ul style="list-style-type: none"> • Proposed Plan for Payment of Pre-Rehabilitation Provider Debt • Notice of Hearing with Respect to Previously Filed Motion of MIM Health Plans, Inc., to Modify Proposed Plan for Operation and Reorganization of Xantus during Rehabilitation
November 5, 1999	<ul style="list-style-type: none"> • Memorandum Submitted on Behalf of the Pharmacists Association in Support of Proposed Plan • Comments and Objections of MIM Health Plans, Inc., with Respect to Proposed Plan for Operation and Reorganization of Xantus during Rehabilitation
November 9, 1999	<ul style="list-style-type: none"> • Provider Committee's Response to Deputy Rehabilitators Proposed Plan for Payment of Pre-Rehabilitation Provider Debt
November 12, 1999	<ul style="list-style-type: none"> • Presentation by the Special Deputy Receiver for Xantus
November 16, 1999	<ul style="list-style-type: none"> • Memorandum and Order
December 30, 1999	<ul style="list-style-type: none"> • Motion for Approval of Third Party Contractors' Fees • Motion for Approval of Interim Fees of Special Deputies
January 6, 2000	<ul style="list-style-type: none"> • Order Approving to File Fees Summaries of Outside Counsel and Litigation Support Contractors, and Approving the Filing under Seal of Invoices Containing Detailed Descriptions of Services
January 14, 2000	<ul style="list-style-type: none"> • Supplement to Proposed Plan for Rehabilitation of Xantus
January 18, 2000	<ul style="list-style-type: none"> • Order
January 19, 2000	<ul style="list-style-type: none"> • Memorandum and Order
Court of Appeals	
January 20, 2000	<ul style="list-style-type: none"> • Notice of Extraordinary Appeal and Motion for Immediate Stay • Application of the State of Tennessee for Extraordinary Appeal by Permission Pursuant to Tenn. R. P. 10, Including Motion for Immediate Stay
January 21, 2000	<ul style="list-style-type: none"> • Supplement to Application of the State of Tennessee for Extraordinary Appeal by Permission Pursuant to Tenn. R. P. 10, Including Motion for Immediate Stay Order

January 27, 2000	<ul style="list-style-type: none"> • Order
February 25, 2000	<ul style="list-style-type: none"> • Brief of Appellant, State of Tennessee, ex rel. Anne B. Pope • Appendix to Brief of Appellant, State of Tennessee, ex rel. Anne B. Pope • Motion to File Amicus Curiae Brief Of the Bureau of TennCare • Notice of Filing Appendix to Amicus Curiae Brief Of the Bureau of TennCare • Appendix to Amicus Curiae Brief Of the Bureau of TennCare • Motion of the Tennessee Health Care Campaign to participate as Amicus Curiae in Support of the Petitioner/Appellant • Brief of Amicus Curiae Tennessee Health Care Campaign • Brief of the Providers' Committee and Appendix • Notice of Filing of Affidavits (Providers' Committee) • Motion of Providers' Committee for Court to Consider Post-Judgment and other Facts Not in the Appellate Record • Brief of Xantus Corporation
March 6, 2000	<ul style="list-style-type: none"> • Order (Oral Argument) • Brief of James F. Blumstein, Amicus Curiae
March 9, 2000	<ul style="list-style-type: none"> • Reply Brief of Appellant, State of Tennessee, ex rel. Anne B. Pope • Reply Brief of the Bureau of TennCare
May 17, 2000	<ul style="list-style-type: none"> • Order (Reverse Chancellor and Remand for Further Proceedings)
May 31, 2000	<ul style="list-style-type: none"> • Motion for Award of Fees
June 30, 2000	<ul style="list-style-type: none"> • Order
July 26, 2000	<ul style="list-style-type: none"> • Mandate of the Court of Appeals Issued to Chancery Court
Davidson County Court	
August 30, 2000	<ul style="list-style-type: none"> • Order Approving Motion to File Fee Summaries of Outside Counsel and Litigation Support Contractors, and Approving the Filing under Seal of Invoices Containing Detailed Description of Services
September 18, 2000	<ul style="list-style-type: none"> • Status Report of Rehabilitation of Xantus Healthplan of Tennessee, Inc. • Renewed Application for Approval of Fees of Special Deputy Rehabilitators, Outside counsel, and Third-Party Contractors
September 29, 2000	<ul style="list-style-type: none"> • Motion to Admit Pro Hoc Vice • Answer
October 5, 2000	<ul style="list-style-type: none"> • Notice of Filing Appointment of Special Deputy Receiver Richard K. Sandstrom
March 8, 2001	<ul style="list-style-type: none"> • CONFIDENTIAL Report and Recommendation of Special Master John C. Neff on the Renewed Application for Approval of Fees
March 19, 2001	<ul style="list-style-type: none"> • Fourth Status Report of Rehabilitation of Xantus Healthplan of Tennessee, Inc.
March 22, 2001	<ul style="list-style-type: none"> • Commissioner's Response and Objections to Report and Recommendation of Special Master • Response of Peterson Consulting to the Initial Report and Recommendation of the Special Master
April 12, 2001	<ul style="list-style-type: none"> • Samuel H. Howard and Xantus Corporation's Motion to Set • Samuel H. Howard and Xantus Corporation's Petition for an Order Terminating Rehabilitation
April 23, 2001	<ul style="list-style-type: none"> • Petitioner's Response in Opposition to Samuel H. Howard and Xantus Corporation's Motion to Set
April 25, 2001	<ul style="list-style-type: none"> • Rehabilitation Update and Notice of Potential Third Phase of the Plan of Rehabilitation for Xantus Healthplan of Tennessee, Inc.
May 9, 2001	<ul style="list-style-type: none"> • Report and Recommendation of Special Master John C. Neff on the Renewed Application for Approval of Fees of Peterson and Sandstrom
May 15, 2001	<ul style="list-style-type: none"> • Motion for Approval of Fees of Special Deputy Rehabilitators, Outside Counsel, and Third Party Contractors
June 5, 2001	<ul style="list-style-type: none"> • Application for Approval of Fees of Special Master John C. Neff

	<ul style="list-style-type: none"> • Application for Approval of Fees of Counsel for the Special Master • Motion for Approval of Fee Application for Special Master John C. Neff and Counsel to Special Master
June 8, 2001	<ul style="list-style-type: none"> • Response and Objections of Peterson Consulting to the Report NS Recommendation of the Special Master • Response and Objections of Peterson Consulting to the Report and Recommendation of the Special Master John C. Neff on the Renewed Application for Approval of Fees of Peterson and Sandstrom
June 29, 2001	<ul style="list-style-type: none"> • Supplement to Report and Recommendation of the Special Master John C. Neff on the Renewed Application for Approval of Fees of Peterson and Sandstrom and Recommendation as to Auditors Report and Recommendation of the Special Master John C. Neff on the Renewed Application for Approval of Fees of Peterson and Sandstrom Report and Recommendation of the Special Master John C. Neff on the Renewed Application for Approval of Fees of Peterson and Sandstrom
July 9, 2001	<ul style="list-style-type: none"> • Response to Motion for Approval of Fee Application for Special Master and Counsel and Renewed, Continuing, and Supplemental Objections to Reports and Recommendations of Special Master and to the Conduct of the Special Master Proceedings
July 16, 2001	<ul style="list-style-type: none"> • Response and Objections to Supplement to Report and Recommendation of the Special Master on the Renewed Application for Approval of Fees of Peterson and Sandstrom
July 27, 2001	<ul style="list-style-type: none"> • Memorandum of Law Regarding Authority for Sale of Xantus Healthplan of Tennessee, Inc., Pursuant to TCA 56-9-303(e)
August 3, 2001	<ul style="list-style-type: none"> • Agreed Order Re-Setting Hearing on Sam Howard's Petition to Terminate Rehabilitation • Notice of Filing Transcript and Motion to Supplement Petitioner's Response to Questions From the Court
August 31, 2001	<ul style="list-style-type: none"> • Petitioner Samuel H. Howard's Responses to Receiver's First Set of Interrogatories • Petitioner Samuel H. Howard's Responses to Receiver's First Request for Production of Documents
September 17, 2001	<ul style="list-style-type: none"> • Plan for Rehabilitation of Xantus Healthplan of Tennessee, Inc., Pursuant to TCA 56-9-303(3)
September 27, 2001	<ul style="list-style-type: none"> • Deposition of Jimmy Blisset
October 1, 2001	<ul style="list-style-type: none"> • Motion for Order Establishing Notice to be Given of Plan of Rehabilitation, Hearing on Plan and Time for Response
October 2, 2001	<ul style="list-style-type: none"> • Deposition of Sam Howard
October 3, 2001	<ul style="list-style-type: none"> • Deposition of Peggy Seay
October 5, 2001	<ul style="list-style-type: none"> • Deposition of Glen Page
October 10, 2001	<ul style="list-style-type: none"> • Deposition of John Lyle • Response to Petition of Samuel H. Howard for an Order Terminating Rehabilitation
October 11, 2001	<ul style="list-style-type: none"> • Deposition of Stefan Boedeker • Notice of Filing • Petitioner's Brief in Opposition to Sam Howard's Petition to Terminate Rehabilitation
October 12, 2001	<ul style="list-style-type: none"> • Samuel H. Howard's Memorandum in Support of Petitioner for an Order Terminating Rehabilitation • Report and Recommendation of Special Master John C. Neff on the Plan for Rehabilitation Filed by Commissioner Anne B. Pope
October 15, 2001	<ul style="list-style-type: none"> • Draft Transcript of October 15, 2001 Hearing
October 16, 2001	<ul style="list-style-type: none"> • Draft Transcript of October 16, 2001 Hearing
October 17, 2001	<ul style="list-style-type: none"> • Transcript of October 17, 2001 Hearing
October 19, 2001	<ul style="list-style-type: none"> • Draft Transcript of October 19, 2001 Motion Hearing
October 26, 2001	<ul style="list-style-type: none"> • Transcript of October 26, 2001 Chamber Conference • Transcript of October 26, 2001 Hearing
October 29, 2001	<ul style="list-style-type: none"> • Transcript of October 29, 2001 Hearing

October 29, 2001	• Summary of Manny Martins' Testimony at October 26 and 29, 2001 Hearing
October 30, 2001	• Transcript of October, 30, 2001, Hearing
November 7, 2001	• Agreed Scheduling Order
November 19, 2001	• Agreed Order

As of December 2002, according to the TennCare Bureau Web site, Xantus continues to be on a "no-risk" reimbursement for reasonable cost in accordance with the contract amendment between Xantus and the TennCare program.

APPENDIX 5
Summary of Regulatory Actions for
Access MedPlus/Tennessee Coordinated Care Network (TCCN)
June 14, 1999 – March 1, 2002

DATE	ACTION
June 14, 1999	DCI issues Agreed Order of Supervision as a result of TCCN's failure to meet statutory net worth requirements. Order affords Commissioner greater access to TCCN records and operations. A supervisor is appointed.
August 6, 1999	Supervisor issues First Supervisor Directive. TCCN was previously directed to file a plan of correction to remedy its net worth deficiency on or before July 14, 1999. The plan filed was incomplete, so TCCN was directed not to expend any funds paid to TCCN pursuant to the retroactive cap increase for FY 1999, without the prior written approval of the supervisor.
September 9, 1999	Supervisor issues Termination of Supervisor Directive, terminating August 1999 directive. Because of continued statutory net worth deficiencies, DCI extends supervision of TCCN by issuing First Amended Agreed Order of Supervision.
November 9, 1999	DCI issues Second Amended Agreed Order of Supervision (thereby extending supervision of TCCN), because of continued statutory net worth deficiencies.
November 30, 1999	Supervisor issues Supervisor's Second Directive. TCCN did not file a complete plan of correction as directed. Claims processing defects are noted. TCCN and its management company are directed not to incur any expense or other financial liability or expend any funds paid by the state for marketing or advertising activities, without the Supervisor's prior written approval or until Supervisor terminates this directive.
January 12, 2000	DCI issues Third Amended Agreed Order of Supervision due to continuing statutory net worth deficiencies, extending supervision of TCCN.
January 20, 2000	DCI issues Fourth Amended Agreed Order of Supervision effective through midnight, February 2, 2000, due to continuing statutory net worth deficiencies.
February/March 2000	DCI issues Letter of Examination for on-site review of all TCCN's financial and claims processing operations.
April 2000	DCI notifies TCCN of defects in claims processing operations and financial operations and schedules an evidentiary hearing. TCCN submits an information systems service recovery cure plan, a claims processing initiative plan, a provider recontracting/pricing cure plan, and a member services cure plan.
May 10, 2000	DCI issues Notice of Administrative Supervision due to TCCN's net worth and claims processing deficiencies. Under authority of Section 56-9-101 et seq., <i>Tennessee Code Annotated</i> , TCCN is placed under Administrative Supervision. TCCN must meet its statutory minimum net worth requirements, comply with its cure plans, demonstrate that its telephone customer service center is meeting industry minimums, and demonstrate it established an interim internal audit function no later than May 19, 2000. TCCN and its management company are required to cooperate with DCI and the Supervisor. A new supervisor is appointed. During the period of supervision, TCCN may not make any disbursements or engage in any of a detailed list of business transactions without prior approval of the Commissioner or the Supervisor.
May 22, 2000	Supervisor issues Supervisor's First Directive and Cease and Desist Order. TCCN is directed to pay management fees to Medical Care (MCMC) rendered May 2000. TCCN is also ordered to cease and desist making payments to MCMC pursuant to its management agreement based upon any methodology used to calculate the management fee payable to MCMC that may include amounts of money not actually paid to TCCN by the state.
September 20, 2000	DCI issues First Amended Agreed Notice of Administrative Supervision to extend May 10 th Order of Administrative Supervision until DCI can verify that TCCN has: (a) met its statutory minimum net worth requirements; (b) met its statutory claims processing

	requirements; and (c) established an internal audit function. Supervision expires June 30, 2001, unless parties agree to extend.
January 3, 2001	DCI submits Verified Petition for Appointment of Receiver to Chancery Court of Davidson County.
January 17, 2001	Chancery Court issues Memorandum Opinion dismissing the petition to rehabilitate TCCN and directing attorneys to prepare an order consistent with the memorandum opinion. The memo concludes that TCCN had met its statutory net worth requirement, notes that TCCN is correcting its claims processing problems, and dismisses the Commissioner's concerns that TCCN's provider network has diminished.
January 26, 2001	The Chancery Court files an order dismissing the petition to appoint a receiver for the purpose of rehabilitating TCCN.
March 2001	Schaller Anderson assists in the evaluation of TCCN's progress in implementing its claims processing system. DCI hires Reden and Anders to assist in the actuarial analysis of TCCN's financial status.
May 10, 2001	DCI issues Confidential Notice of Administrative Hearing to determine if conditions giving rise to Administrative Supervision continue to exist. A hearing is scheduled for June 20-22, 2001.
May 18, 2001	DCI issues First Set of Interrogatories and First Set of Requests for Production of Documents, requiring TCCN to specify all reasons it believes it complies with statutory minimum net worth requirements, statutory claims processing requirements, and internal audit function requirements.
June 4, 2001	TCCN issues First Set of Interrogatories and First Set of Production requests to DCI.
June 6, 2001	DCI provides Notice of Witness, giving notice of witnesses it intends to call at the hearing.
June 8, 2001	DCI files Memorandum of Law to address the issue of which party has the burden of proving that TCCN does or does not comply with the requirements of the First Amended Agreed Notice of Administrative Supervision. The memo concludes that TCCN has that burden.
June 11, 2001	DCI answers TCCN's First Set of Interrogatories stating that DCI has evidence which indicates TCCN does not meet statutory net worth requirements, claims processing requirements, or internal audit function requirements.
June 19, 2001	DCI issues Second Amended Agreed Order of Supervision and Final Order. TCCN agrees to extend Administrative Supervision to March 1, 2002. The Second Amended Agreed Order of Supervision will become the Final Order.
July 2001	DCI advises Finance and Administration (F&A) Deputy Commissioner of the Second Amended Agreed Notice of Supervision and updates the current status of TCCN's claims processing and financial position.
August 2001	DCI updates F&A Deputy Commissioner of the status of TCCN's financial position, claims processing issues, and provider network claims, and provider network issues.
September 19, 2001	F&A Commissioner and Deputy Commissioner give written notice to TCCN of the state's intent to terminate TCCN's provider risk agreement effective October 31, 2001, unless TCCN provides sufficient proof of contractual compliance. TCCN must submit past due audited financial statements for FY 2000 and NAIC Quarterly Financial Statements for the period ended June 30, 2001.
October 2, 2001	TCCN sends counterproposal to F&A Commissioner and Deputy Commissioner.
October 5, 2001	F&A Deputy Commissioner sends letter to TCCN regarding information requested in the September 19, 2001, letter.
October 12, 2001	TCCN files NAIC quarterly financial statements for the period ended 6/30/01 and reports negative net worth of \$53.8 million. F&A Deputy Commissioner acknowledges receipt of certain information.
October 2001	Draft KPMG report is issued, as well as the draft TCCN Financial Statements for December 31, 2000, and 1999.
October 16, 2001	F&A Deputy Commissioner gives TCCN written confirmation that its contract with the state will end October 31, 2001.
October 17, 2001	DCI issues Memorandum of Law in Support of Motion for Temporary Restraining Order

	<p>and/or Mandatory Injunctive Relief seeks an order from the court directing AmSouth Bank to preserve funds in the approximate amount of \$5.7 million currently held in MCMC's account and/or to return said funds to TCCN's account.</p> <p>DCI issues Motion for Temporary Restraining Order and/or Mandatory Injunctive Relief for the same reasons as stated above.</p> <p>Chancery Court of Davidson County issues an Order Granting Injunctive Relief. The Court denies seizure before TCCN is granted a hearing, but issues a temporary restraining order to avoid waste, preferential payments and liquidation of assets and to preserve the status quo pending the hearing on the request for seizure. The hearing is scheduled for October 18, 2001. The Court also issues an Order for Filings to be made Under Seal to preserve confidentiality.</p> <p>DCI issues Verified Petition for Appointment of Receiver for Purposes of Liquidation and Injunction to appoint the Commissioner as Liquidator.</p>
October 18, 2001	<p>The Chancery Court of Davidson County issues an Order of Seizure of Respondent TCCN; an Order Setting Hearing on Request for Liquidation or Rehabilitation; and an Order Lifting Confidentiality of Filings. TCCN, MCMC, and AHS are enjoined from waste or disposition of TCCN's property, or the destruction, deletion, modification, or waste of its records, databases, or computer files; enjoined from transaction of TCCN's business except with the Commissioner's written consent, etc. Any bank, savings and loan association, financial institution or other person, which has on deposit, in its possession, custody, or control, any funds, accounts, and any other TCCN assets must immediately transfer custody and control to the Commissioner. The Order is effective until entry or denial of an order of liquidation or rehabilitation, unless otherwise ordered. A hearing on the Commissioner's Verified Petition for Liquidation is set for November 2, 2001.</p> <p>MCMC, TCCN's management company, terminates over 200 of its 300 employees. Staff from the Tennessee Receivers Office begin assisting the Supervisor on-site (at the office of TCCN).</p>
October 19, 2001	Approximately 279,000 enrollees are removed from TCCN and are transferred to VSHP Select.
November 1, 2001	Synertech of Harrisburg, PA, is selected to process claims under liquidation.
November 2, 2001	Chancery Court of Davidson County issues a Final Order Appointing the Commissioner for Purposes of Liquidation of Respondent TCCN and a Permanent Injunction.
December 2001	The liquidator established procedures for unpaid claims liabilities. Schaller Anderson of Phoenix, Arizona, is selected to assist the Special Deputy in monitoring the activities of Synertech.
December 12, 2001	Commissioner submits Recommended Procedure for Evaluation of Litigation Previously Instituted by TCCN Against the State and State Officials to determine the appropriate disposition of litigation prior to liquidation. DCI recommends an attorney for evaluating and determining whether the three pending lawsuits filed by former management of TCCN should be pursued or abandoned.
January 4, 2002	Pershing and Yoakley of Knoxville, TN, are selected to review the appropriateness of methods and processes of TCCN in Liquidation, to assist in the preparation of a database of previously paid claims, and to prepare reports to support filings to the Chancery Court.
January 7, 2002	Informal creditors meeting is held between the Special Deputy and a staff member of TCCN in Liquidation and representatives of the Tennessee Medical Association, the Tennessee Hospital Association, and the Hospital Alliance of Tennessee.
March 1, 2002	The deadline for providers to file claims under the liquidation of TCCN.
Late Spring/Early Summer 2002	Anticipated debt establishment.

APPENDIX 6

Results of Prompt Pay Analyses of MCOs/BHOs January 2001-January 2002

Numbers in **bold** indicate noncompliance with the Prompt Pay Act.

Better Health Plans

	Within 30 days	Within 60 days	Greater than 60 days
July 2001	100.00%	100.00%	0.00%
October 2001	95.93%	97.86%	2.14%
October 2001 (after review of resubmitted data)	98.83%	99.91%	0.09%
November 2001	96.68%	98.20%	1.80%
November 2001 (after review of initial analysis)	99.09%	99.96%	0.04%
January 2002	99.31%	99.99%	0.01%

John Deere Health Plans

	Within 30 days	Within 60 days	Greater than 60 days
January 2001	89.20%	98.20%	1.80%
April 2001	96.82%	99.77%	0.23%
July 2001	96.54%	99.74%	0.26%
October 2001	98.13%	99.85%	0.15%
January 2002 JDHP Medical	92.33%	99.77%	0.23%
January 2002 JDHP Drug	99.00%	99.66%	0.34%

Memphis Managed Care

	Within 30 days	Within 60 days	Greater than 60 days
January 2001	97.10%	99.70%	0.30%
April 2001	82.66%	99.19%	0.81%
May 2001	80.99%	99.30%	0.70%
June 2001	87.37%	98.93%	1.07%
July 2001	94.39%	99.58%	0.42%
October 2001	97.56%	99.76%	0.24%
December 2001	95.03%	99.59%	0.41%
January 2002	74.28%	98.81%	1.19%

OmniCare

	Within 30 days	Within 60 days	Greater than 60 days
January 2001	97.30%	99.93%	0.07%
April 2001	96.02%	99.57%	0.43%
July 2001	96.97%	99.72%	0.28%
October 2001	85.29%	93.32%	6.68%
November 2001	97.99%	99.54%	0.46%
January 2002	99.53%	99.82%	0.18%

Preferred Health Partnership

	Within 30 days	Within 60 days	Greater than 60 days
January 2001	95.20%	98.80%	1.20%
April 2001	86.07%	99.78%	0.22%
May 2001	91.22%	99.97%	0.03%
July 2001	90.42%	99.94%	0.06%
October 2001	95.09%	100.00%	0.00%
January 2002	98.80%	99.93%	0.07%

Premier

	Within 30 days	Within 60 days	Greater than 60 days
January 2001	69.90%	99.50%	0.50%
April 2001 Fee for Service Only	84.04%	99.21%	0.79%
April 2001 Fee for Service & Community Mental Health Centers (CMHC) Capitated Claims	92.84%	99.65%	0.35%
July 2001 Fee for Service Only	73.41%	96.63%	3.37%
July 2001 Fee for Service & CMHC Capitated Claims	85.66%	98.18%	1.82%
August 2001 Fee for Service Only	83.58%	94.88%	5.12%
August 2001 Fee for Service & CMHC Capitated Claims	89.35%	96.68%	3.32%
September 2001 Fee for Service Only	88.41%	97.39%	2.61%

September 2001 Fee for Service & CMHC Capitated Claims	94.44%	98.75%	1.25%
October 2001 Fee for Service Only	90.45%	97.97%	2.03%
October 2001 Fee for Service & CMHC Capitated Claims	95.16%	98.97%	1.03%
November 2001 Fee for Service Only	98.23%	99.96%	0.04%
November 2001 Fee for Service & CMHC Capitated Claims	99.09%	99.98%	0.02%
January 2002 Fee for Service Only	97.40%	99.95%	0.05%
January 2002 Fee for Service & CMHC Capitated Claims	98.51%	99.97%	0.03%

Tennessee Behavioral Health

	Within 30 days	Within 60 days	Greater than 60 days
January 2001	58.90%	99.30%	0.70%
April 2001 Fee for Service Only	73.09%	99.56%	0.44%
April 2001 Fee for Service & CMHC Capitated Claims	87.92%	99.80%	0.20%
May 2001 Fee for Service Only	54.57%	99.10%	0.90%
May 2001 Fee for Service & CMHC Capitated Claims	72.46%	99.45%	0.55%
June 2001 Fee for Service Only	67.74%	99.20%	0.80%
June 2001 Fee for Service & CMHC Capitated Claims	78.30%	99.49%	0.51%
July 2001 Fee for Service Only	79.05%	96.64%	3.36%
July 2001 Fee for Service & CMHC Capitated Claims	87.35%	97.97%	2.03%

August 2001 Fee for Service Only	85.11%	93.49%	6.51%
August 2001 Fee for Service & CMHC Capitated Claims	89.80%	95.54%	4.46%
September 2001 Fee for Service Only	86.73%	97.36%	2.64%
September 2001 Fee for Service & CMHC Capitated Claims	93.12%	98.63%	1.37%
October 2001 Fee for Service Only	88.03%	98.32%	1.68%
October 2001 Fee for Service & CMHC Capitated Claims	93.43%	99.08%	0.92%
November 2001 Fee for Service Only	96.62%	99.89%	0.11%
November 2001 Fee for Service & CMHC Capitated Claims	97.92%	99.93%	0.07%
January 2002 Fee for Service Only	94.67%	99.92%	0.08%
January 2002 Fee for Service & CMHC Capitated Claims	96.33%	99.94%	0.06%

Tennessee Coordinated Care Network

	Within 30 days	Within 60 days	Greater than 60 days
January 2001	82.60%	95.70%	4.30%
April 2001	73.29%	85.58%	14.42%
May 2001	84.68%	93.79%	6.21%
June 2001	85.83%	95.29%	4.71%
July 2001	86.41%	96.31%	3.87%

Universal Care

	Within 30 days	Within 60 days	Greater than 60 days
July 2001	99.80%	99.85%	0.15%
September 2001	52.01%	99.63%	0.37%
October 2001	60.10%	95.60%	4.40%
November 2001	77.43%	95.90%	4.10%
December 2001	61.20%	95.60%	4.40%

January 2002	80.38%	90.52%	9.48%
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VHP (Vanderbilt Health Plans/Victory Health Plans)

	Within 30 days	Within 60 days	Greater than 60 days
January 2001	93.70%	98.20%	1.80%
April 2001	98.60%	99.83%	0.17%
July 2001	98.66%	99.98%	0.02%
October 2001	99.04%	99.96%	0.04%
January 2002	98.35%	99.34%	0.50%

Volunteer State Health Plan

	Within 30 days	Within 60 days	Greater than 60 days
January 2001	98.60%	99.97%	0.03%
April 2001	99.32%	99.97%	0.03%
July 2001 VSHP Select	99.85%	100.00%	0.00%
July 2001 BlueCare	99.35%	99.95%	0.05%
October 2001 VSHP Select	99.31%	99.95%	0.05%
October 2001 BlueCare	99.57%	99.99%	0.01%
January 2002 VSHP Select	98.58%	99.90%	0.10%
January 2002 BlueCare	99.14%	99.78%	0.22%

Xantus

	Within 30 days	Within 60 days	Greater than 60 days
January 2001	96.70%	99.10%	0.90%
April 2001	95.40%	96.53%	3.47%
May 2001	96.75%	97.89%	2.11%
June 2001	96.60%	99.50%	0.50%
July 2001	99.44%	99.79%	0.21%
October 2001	99.52%	99.74%	0.26%
January 2002	95.00%	99.45%*	0.55*%

* DCI rounded these numbers to 99.5% and 0.5% respectively.