WEST VIRGINIA LEGISLATIVE AUDITOR

PERFORMANCE EVALUATION AND RESEARCH DIVISION

Special Report

Office of Insurance Commissioner

The Insurance Commission Takes Longer to Resolve Many Consumer Complaint Cases than Its Internal Policy Recommends, But Has Resolved a Higher Percentage of Cases in a Timely Manner During Recent Years

Although the West Virginia Legislature Has Not Addressed Credit Scoring Through Legislation, the Insurance Commission Has Developed a Set of Guidelines Governing Its Use

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May 15, 2005

The Honorable Edwin J. Bowman
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129 West Circle Drive
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The Honorable J.D. Beane
House of Delegates
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Dear Chairs:

Pursuant to the West Virginia Sunset Law, we are transmitting a Special Report on the Office of Insurance Commissioner, which will be presented to the Joint Committee on Government Operations on Sunday, May 15, 2005. The issues covered herein are "The Insurance Commission Takes Longer to Resolve Many Consumer Complaint Cases that Its Internal Policy Recommends, But Has Resolved a Higher Percentage of Cases in a Timely Manner During Recent Years;" and "Although the West Virginia Legislature Has Not Addressed Credit Scoring Through Legislation, the Insurance Commission Has Developed a Set of Guidelines Governing Its Use."

We transmitted a draft copy of the report to the Office of Insurance Commissioner on May 2, 2005. We held an exit conference with the Office of Insurance Commissioner on May 9, 2005. We received the agency response on May 10, 2005.

Let me know if you have any questions.

Sincerely,

John Sylvia

JS/wsc

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Although the present law does not establish a time standard for the Commission to resolve complaints, the Commission has an internal policy to resolve complaints within 30 to 45 days.

Although the present law does not establish a time standard for the Commission to resolve complaints, the Commission has an internal policy to resolve complaints within 30 to 45 days. The Legislative Auditor's staff drew a random sample of 100 complaint cases filed during CY 2003 that were resolved after the 45-day limit. The Insurance Commission generally receives around 2,000 complaints annually. The types of complaints from consumers or health care providers include discontinued coverage by an insurance company, and premium increases. Most complaints are against insurance companies for non-payment of a claim. In many of these cases, the financial implications for consumers or health care providers are hundreds or thousands of dollars, the refore, the need for a timely resolution of the complaint is important. **The Legislative Auditor finds that although the Commission has improved its timeliness in recent years, it continues to struggle to resolve complaints in a timely manner, with over 40% of complaint cases taking longer than 45 days.**

It is clear that the Commission can, since the passage of Senate Bill 418, fine insurance companies that do not respond in a timely manner to inquiries regarding complaints.

The Commission specifies in its legislative rules (CSR §114-14-5) a time frame of 15 days for an insurance company to respond to an inquiry from the Commission regarding a complaint. An analysis of a sample of complaints with untimely resolutions shows that in two-thirds of these cases insurance companies, consumers, or health care providers contributed to the untimely resolution by not responding in a timely manner to inquiries by the Commission. The Commission is responsible for the untimely resolutions in the remaining third of the cases. Although the Commission presently has no control on how timely consumers and health care providers respond to the Commission's investigation of a complaint, it has statutory authority (*WVC* §33-11-6) to impose financial penalties on insurance companies that are in violation of the provisions of the rule. The Commission has taken disciplinary action against one insurance company that violated the rule to provide information within 15 working days regarding a complaint. It is clear that the Commission can, since the passage of Senate Bill 418, fine insurance companies that do not respond in a timely manner to inquiries regarding complaints. The Commission mentions the 15-day time limit in its initial letter informing insurance companies of a complaint filed against them. The Commission does not inform companies of this requirement when sending letters for follow-up information requests. The Insurance Commission should inform insurance companies of the 15-day time limit when responding to any information request related to complaint cases.

The Commission could also examine its internal procedures for processing complaints, and use more aggressive enforcement efforts with its licensees, as methods to reduce the number of late cases.

The complaint process is handled by the West Virginia Insurance Commission's Consumer Services Division. The Consumer Services Division consists of nine employees who receive inquiries and complaints through telephone inquiries, walk in visits or written correspondence.

The complaint process is handled by the West Virginia Insurance Commission's Consumer Services Division. The Consumer Services Division consists of nine employees who receive inquiries and complaints through telephone inquiries, walk in visits or written correspondence. Six of the Division's employees are complaints examiners. The Commission's Consumer Services staff has a workload of over 300 complaint cases per worker, in addition to the responsibility of answering telephone inquiries. Considering that the Commission has been unable to resolve all complaint cases within 45 days, additional complaints examiners could alleviate this problem. Recent legislation aimed at privatizing the workers' compensation system has led to the transfer of 275 former employees of the Workers' Compensation Division to the Insurance Commission. Since the Commission is in the process of incorporating these new employees, it would be possible to create additional claims examiners positions, utilizing the new staff members.

Issue 2: Although the West Virginia Legislature Has Not Addressed Credit Scoring Through Legislation, the Insurance Commission Has Developed a Set of Guidelines Governing Its Use.

Information gathered by the West Virginia Insurance Commission indicates that the majority of insurance companies operating in the state use some form of credit scoring.

Available studies completed by state agencies in Texas and Virginia indicate that credit scoring is a reliable predictor of insurance claims. At the same time, some consumer groups have expressed concern that the use of credit scoring may serve as a barrier to access insurance for some classes of people. Research completed by the Federal Home Loan Mortgage Corporation indicates that minority borrowers are more likely to experience credit problems than white borrowers. This concern is among the reasons why many states prohibit the use of credit scores as the only reason for terminating a policy.

Information gathered by the West Virginia Insurance Commission indicates that the majority of insurance companies operating in the state use some form of credit scoring. The National Association of Mutual Insurance Companies (NAMIC) analyzes state laws governing the use of credit scoring. According to the NAMIC, 48 states have taken some form of legislative or regulatory action restricting the use of credit scoring. While the West Virginia Legislature has not passed any bills restricting the use of credit scoring, the

NAMIC stated that West Virginia is one of the twenty-four (24) states it considers as having based its regulation of credit scoring on the NCOIL Model Act. Congress enacted the Fair Credit Reporting Act (15 USCA §1681) in 1970. The Act allows insurers to use credit reports in insurance underwriting without disclosing this to consumers unless the insurer is taking an adverse action. The insurance industry views credit scoring as a useful tool to identify the level of financial responsibility displayed by an individual, which impacts the chance that an individual will file an insurance claim.

During the Fall of 2004, the Commission sent a request for information and documents concerning the use of credit scoring by insurance companies that write 1% or more of the automobile liability and homeowners insurance in West Virginia. The Commission concluded that the majority of insurance companies operating in the state use some form of credit scoring. The Commission has released Informational Letter Number 142A in August 2003, which summarizes the guidelines for the use of credit scoring information by insurance companies. The Commission drafted Informational Letter Number 142A following the model legislation prepared by the NCOIL. The letter contains sixteen (16) requirements for companies utilizing credit reports or scoring. The Insurance Commission requests credit scoring information from companies by completing an annual survey. The Insurance Commission clearly has sought to review and regulate the use credit scoring by companies operating in the state according to the principles set forth in the NCOIL's Model Act.

Recommendations:

1. The Insurance Commission should inform insurance companies of the 15-day time limit when responding to any information request related to complaint cases.

2. The Insurance Commission should utilize the provisions of Senate Bill 418 and impose financial penalties on companies that fail to respond to information inquiries regarding complaint cases in a timely manner.

Review Objective, Scope and Methodology

Objective

The objective of this report is to determine if the Insurance Commission resolves complaints within the 30 to 45-day time frame specified by the Commission's case-management policy, and to determine if the Commission adequately regulates the use of credit scoring in the state.

Scope

The scope of this review extended from calendar years 1999-2004.

Methodology

The Legislative Auditor's Office obtained information from the West Virginia Insurance Commission to document the number of complaints received by the Commission each year, the length of time required to resolve each case and the Commission's complaint processing procedures. The Legislative Auditor's staff gathered more detailed information regarding the reasons for complaint filings, the types of insurance policies involved, and the reasons for the late resolution of complaint cases, from a sample drawn from complaint cases filed during calendar year 2003 and resolved in more than 45 days. The Legislative Auditor's staff randomly selected and reviewed a sample of 100 complaint cases.

The West Virginia Insurance Commission provided information on the use of credit scoring by companies operating in the state, as well as the Commission's regulatory policies. The National Association of Mutual Insurance Companies (NAMIC) was the source of information regarding state laws governing the use of insurance scoring. Part of its analysis has involved the identification of states that have enacted legislation based on the National Conference of Insurance Legislators (NCOIL) Model Act for credit scoring legislation. The Legislative Auditor's staff consulted the NCOIL's Model Act, as well as the Insurance Commission's Informational Letter Number 142A, which was derived from the Model Act. Studies completed by the Texas Department of Insurance and the Virginia State Corporation Commission's Bureau of Insurance provided information on the validity of credit scoring as a predictor of insurance claims. The Legislative Auditor's staff also reviewed credit scoring bills introduced into the West Virginia Legislature from calendar years 1999 to 2005.

This audit was conducted in accordance with Generally Accepted Government Auditing Standards.

Issue 1

The Insurance Commission Takes Longer to Resolve Many Consumer Complaint Cases than Its Internal Policy Recommends, But Has Resolved a Higher Percentage of Cases in a Timely Manner During Recent Years.

The Insurance Commission generally receives around 2,000 complaints annually. The types of complaints from consumers or health care providers include discontinued coverage by an insurance company, and premium increases.

Issue Summary

The Insurance Commission generally receives around 2,000 complaints annually. The types of complaints from consumers or health care providers include discontinued coverage by an insurance company, and premium increases. However, most complaints are against insurance companies for non-payment of a claim. In many of these cases, the financial implications for consumers or health care providers are hundreds or thousands of dollars, therefore, the need for a timely resolution of the complaint is important.

The Commission recognizes the importance of resolving complaints in a timely manner. Although the present law does not establish a time standard for the Commission to resolve complaints, the Commission has an internal policy to resolve complaints within 30 to 45 days. In addition, to facilitate the complaint process, the Commission specifies in its legislative rules (CSR §114-14-5) a time frame of 15 days for an insurance company to respond to an inquiry from the Commission regarding a complaint. The Legislative Auditor finds that although the Commission has improved its timeliness in recent years, it continues to struggle to resolve complaints timely, with over 40% of complaint cases taking longer than 45 days. The Commission resolved approximately 12% of complaint cases within 46 to 60 days and an additional 12% of cases within 61 to 90 days. The Commission resolved nearly 13% of cases in 91 to 180 days, while taking one year or longer to resolve less than 1% of cases. An analysis of a sample of complaints with untimely resolutions shows that in two-thirds of these cases insurance companies, consumers, or health care providers contributed to the untimely resolution by not responding in a timely manner to inquiries by the Commission. The Commission is responsible for the untimely resolutions in the remaining third of the cases. Although the Commission presently has no control on how timely consumers and health care providers respond to the Commission's investigation of a complaint, it has statutory authority (*WVC* §33-11-6) to impose financial penalties on insurance companies that are in violation of the provisions of the rule. The Commission has taken disciplinary action against only one insurance company that violated the rule to provide information within 15 working days regarding a complaint. Also, the Commission's Consumer Services staff has a workload of over 300 complaint cases per worker, in addition to the responsibility of answering telephone inquiries. **Staffing needs are a concern to the Commission and**

The Legislative Auditor finds that although the Commission has improved its timeliness in recent years, it continues to struggle to resolve complaints timely, with over 40% of complaint cases taking longer than 45 days.

should be addressed.

Description of the Insurance Commission's Complaint Process

The Consumer Services Division consists of nine employees who receive inquiries and complaints through telephone inquiries, walk in visits or written correspondence. Six of the Division's employees are complaints examiners. According to the Insurance Commission, the Consumer Services Division's responsibilities are as follows:

> *To assist all West Virginia consumers, insurance companies, and their agents with any insurance questions they may have. The division acts as a liaison between the insurance consumers of West Virginia and the insurance industry, working as an independent third party to help disputes. The division receives inquiries and complaints through telephone inquiries, walk in visits, and written correspondence. The division performs an evaluation of each formal complaint by obtaining documentation, reviewing the facts, determining fulfillment of contractual obligations, and identifying if any statutory violations have occurred. The Complaints Examiner then recommends the proper resolution that is in compliance with the laws and regulations of the State of West Virginia.*

It is important to note that the Consumer Services Division of the Insurance Commissioner's Office, which evaluates complaints received by the Commission, is not the same as the Office of Consumer Advocacy, which is a different division of the Insurance Commissioner's Office.

A representative of the Commission described complaint outcomes:

> *Some* [complaint] *resolutions result in the refunding of premiums, the restoration of a cancelled contract, claims payments being made, or a contract being rescinded.*

If appropriate, the Commission's Legal Division investigates further. The Legal Division works with other divisions when legal assistance is needed.

It is important to note that the Consumer Services Division of the Insurance Commissioner's Office, which evaluates complaints received by the Commission, is not the same as the Office of Consumer Advocacy, which is a different division of the Insurance Commissioner's Office. The passage of Senate Bill 418 during the Legislative Session of 2005 changed the functions of the Office of Consumer Advocacy by giving it an expanded role regarding disputes between insurance companies and third parties. Senate Bill 418 also gave third

parties the ability to file administrative complaints with the Commission in lieu of filing bad faith lawsuits. The Office of Consumer Advocacy may act on issues raised by complaints but does not process complaints received by the Commission. That is the task of the Consumer Services Division. The Division and its complaint-processing procedures are the focus of this issue.

The Commission's standards for processing and resolving consumer complaints are not established in the Code, but rather by an informal internal policy. The Legislative Auditor recognizes that the establishment of an internal performance goal shows the Commission's concern for timely responses to consumer complaints.

The Insurance Commission Could Resolve Complaint Cases in a More Timely Manner By Penalizing Insurance Companies For Not Adhering to the 15-Day Time Limit When Responding to the Commission's Inquiries Regarding Claims.

The Insurance Commission's Administration Services Manager described the Commission's standards and time frames for complaint processing:

> *While there are no statutory time frames for our Consumer Services Division to conclude complaint files, the Commission has an internal goal of resolving files within 30-45 business days. Time frames can fluctuate depending on the complexity of the issue and whether other parties, both internal and external, are required to provide additional information to conclude. A file may remain open in those instances when the Commission has responded to the consumer and the consumer has stated that they will be sending in additional information for reconsideration.*

The Commission's legislative rules (CSR §114-14-5) specify a time frame of 15 days for an insurance company to respond to an inquiry from the Commission, regarding a claim.

The Commission's standards for processing and resolving consumer complaints are not established in the *Code*, but rather by an informal internal policy. The Legislative Auditor recognizes that the establishment of an internal performance goal shows the Commission's concern for timely responses to consumer complaints. A time frame of 30 to 45 days does not seem unreasonable, given that some complaint cases have hundreds of pages of records by the time the Commission resolves them. Consumers have no guarantee of how long they may have to wait for the Commission to resolve their complaints, but the Commission's informational brochure explaining the process for filing complaints says, *"An inquiry usually takes about 60-days, depending on the complexity of the case."* In reality, the time frames for resolving many cases have greatly exceeded 45 days (see Table 1).

The Commission's legislative rules (CSR §114-14-5) specify a time frame of 15 days for an insurance company to respond to an inquiry from the Commission, regarding a claim:

5.2. Answer of inquiries from insurance department. – Every insurer, upon receipt of any inquiry from the Insurance Department respecting a claim shall, withing fifteen (15) working days of receipt of such inquiry, furnish the department with a response to the inquiry.

The Commission's legislative rules (CSR §114-14-9) specify penalties for failing to comply with the agency's rules:

> *9.1. Penalty. — Any person who fails to comply with any provision of this regulation shall, after notice and hearing, be found to be transacting insurance in an illegal, improper or unjust manner. The commissioner may, pursuant to section eleven, article three, chapter thirty-three, sections six, seven and eight, article eleven, chapter thirty-three and section twenty-five, article twelve, chapter thirty-three of the Code of West Virginia of 1931, as amended, refuse to renew, or may revoke or suspend the license of any such person or, in lieu thereof, the commissioner may, at his discretion, order such person to pay to the state of West Virginia a penalty in a sum not to exceed that imposed by said sections of said code, and the commissioner may, pursuant to section eleven, article two, chapter thirty-three of said code, order such person to discontinue such illegal, improper or unjust transaction of insurance and to adjust and pay obligations as they become due.*

West Virginia Code §33-11-6 provides details on the penalties that are available to the Commission when enforcing the Commission's statutes, rules or regulations, including the dollar amount in financial penalties:

> *(a) Require the payment to the state of West Virginia of a penalty in a sum not exceeding one thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of ten thousand dollars, unless the person knew or reasonably should have known he was in violation of this article, in which case the penalty shall be not more than five thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of fifty thousand dollars in any six month period. (b) Revoke or suspend the license of such person if he knew or reasonably should have known that he was in violation of this article.*

It is clear that the Commission can fine insurance companies that do not respond in a timely manner to inquiries regarding complaints. The Commission has taken disciplinary action against one company that failed to respond to information inquiries within the 15-day time frame.

It is clear that the Commission can fine insurance companies that do not respond in a timely manner to inquiries regarding complaints. **The Commission has taken disciplinary action against one company that failed to respond to information inquiries within the 15-day time frame.** This company failed to respond to the Consumer Services Division in 6 out of 58 complaint cases. Prior to the passage of Senate Bill 418 during the 2005 legislative session, the Commission had authority to take disciplinary action against a company regarding claims handling issues only if the company's conduct constituted a "general business practice." The Commission's Market Conduct Unit began operations in late 2002, but prior to this, no means to identify patterns of "general business practices existed. Senate Bill 418 enables the Commission to penalize companies for one intentional violation even if no pattern of "general business practice" exists.

The Commission mentions the 15-day time limit in its initial letter informing insurance companies of a complaint filed against them. The Commission does not inform companies of this requirement when sending letters for follow-up information requests.

The Commission mentions the 15-day time limit in its initial letter informing insurance companies of a complaint filed against them. The Commission does not inform companies of this requirement when sending letters for follow-up information requests. **The Legislative Auditor recommends that the Commission inform insurance companies of the 15-day time limit when responding to any information request related to complaint cases.**

Table 1 illustrates the number of days it took the Commission to resolve consumer complaint cases from calendar years 1999-2004. The percentage of cases closed within 45 days increased within the last two years and reached a peak of 58.8% of total cases opened during CY 2003. As of October 2004, 53.3% of cases had been resolved within 45 days. This did not take into account 242 cases that were still open. During CY 1999, the first year examined in this report, a substantial percentage of complaint cases remained open for extended periods of time, in excess of 90 days. Six-hundred-eighty-five (685) cases, or 35.3%, remained unresolved for 91-180 days. Four percent (4.0%) or 79 cases required over one year to close. The percentage of long-term open cases was improved by CY 2003. By then, only 12.8% or 290 cases required 91-180 days to resolve and only 2 cases remained open for one year or longer. This improvement occurred while the total number of complaints increased by 327 from the CY 1999 total. While the Insurance Commission made considerable progress towards improving its performance, over 40% of cases were not resolved within the internal time frame of 30-45 days during CY 2003. **Considering that some parties to disputes may be entitled to monetary awards in the form of premium reductions or claims payments, the resolution of complaint cases in an expedient manner is important.**

In the Insurance Commission's formal response to this report, the Commission informed the Legislative Auditor's Office that the Commission has no authority to rule on complaint cases involving Health Maintenance Organizations (HMOs) which are not subject to the Unfair Trade Practices Act (UTPA). The Commission also has no authority to rule on complaint cases involving company-sponsored health insurance plans formed under the federal Employee Retirement Income Security Act (ERISA). Thirty-one complaint files included in the sample of 100 cases used by the Legislative Auditor's staff were cases that the Commission has no formal authority. The time frame of 30 to 45 days does not, therefore, apply in those cases. The Commission accepts these complaints as a service to consumers and sometimes advocates on their behalf with HMOs and ERISA plans, but cannot issue binding orders in these cases.

Table 1
Number of Days to Resolve Consumer Complaint Cases:
Calendar Years 1999-2004

Calendar Year	0-30 days	31-45 days	46-60 days	61-90 days	91-180 days	1 Year or More to close	Still Open	Total	% of Cases Closed 30-45 Days
1999	390 (20.1%)	139 (7.2%)	134 (6.9%)	292 (15.1%)	685 (35.4%)	79 (4.1%)	0	**1,937**	**27.3**
2000	457 (21.7%)	161 (7.6%)	183 (8.7%)	485 (23.0%)	571 (27.1%)	35 (1.7%)	0	**2,105**	**29.4**
2001	577 (22.5%)	279 (10.9%)	325 (12.7%)	502 (19.6%)	636 (24.8%)	43 (1.7%)	0	**2,566**	**33.4**
2002	625 (25.3%)	359 (14.5%)	298 (12.1%)	549 (22.2%)	488 (19.8%)	13 (0.5%)	0	**2,469**	**39.9**
2003	926 (40.9%)	407 (18.0%)	270 (11.9%)	281 (12.4%)	290 (12.8%)	15 (0.7)	2	**2,264**	**58.8***
2004	672 (30.1%)	269 (15.2%)	199 (11.3%)	243 (13.8%)	130 (7.4%)	0 (0%)	242	**1,764**	**53.3***

Source: PERD analysis of complaint data provided by the Insurance Commission. All totals to date as of October 2004

**Calculations do not include open cases.*

Reasons for Delays in Processing Consumer Complaints: Analysis of 100 Sample Complaint Cases from CY 2003

The Commission resolved 41.2% of complaint cases filed during CY 2003 later than the 45-day internal time frame. The Legislative Auditor's staff drew a random sample of 100 complaint cases filed during CY 2003 that were resolved after the 45-day limit. The objective was to determine why the Commission was unable to resolve consumer complaints within the 30-45-day time frame set for itself, and what impact the delays had on claimants. Tables 2 and 3 illustrate data on consumer complaint cases, organized according the types of insurance policies involved.

Table 2 summarizes the reasons for complaint filings from the 100 sample cases. The Legislative Auditor's staff identified four basic reasons for complaint filings. The first three reasons listed in Table 2 accounted for all but one complaint. Health insurance complaints accounted for 54 complaint cases from the sample, which is the largest source of complaints. The number of complaints for other types of insurance coverage was fairly evenly distributed. Medical providers filed 10 of these 54 complaints, while insured individuals filed the remaining 44. Forty (40) of the health insurance complaints resulted from an insurance company's refusal to pay a medical claim. Homeowners insurance accounted for another 18 of the 100 sample complaint cases. Nine (9) of those cases resulted from an insurance company's refusal to pay for damage to a home. There were 15 life insurance complaints and 13 personal auto complaints. Overall, 63 of the 100 sample complaint cases resulted from an insurance company's refusal to pay a claim.

Table 2
Reasons for Complaint Filings By Type of Insurance Policy

Reasons for Complaint	Life Insurance	Health Insurance	Homeowners	Personal Auto	Total
Discontinued Coverage	6	3	5	2	16
Premium Increase	3	11	4	2	20
Non-Payment of Claim	5	40	9	9	63
***Agent Misconduct**	1	0	0	0	1
Total	**15**	**54**	**18**	**13**	**100**

Source: PERD analysis of complaint files provided by the Insurance Commission.

**One agent's former employer filed a complaint against him because he failed to follow the proper procedures for bringing clients with him when he accepted employment with a new company.*

Table 3 illustrates the relationship between the length of time complaint cases were late in being resolved and the factors contributing to their late resolution. The Commission closed 33 of the sample complaint cases within 60 days. This meant that the Commission closed about one-third of late cases within 15 days of the 45-day time limit. Health insurance complaints accounted for over half of all complaints that required over 120 days to resolve (12 out of 22). Forty percent (40%) of the cases drawn from the sample took more than 90 days to resolve, which is well in excess of the Commission's time standard.

The basic reasons why the Commission was late in resolving complaint cases shed light on its ability to resolve future cases in a more timely manner. Reasons A and B deal with delays caused by the late receipt of information from insurance companies, in either the form of the initial response to a complaint (Reason A), or as a follow-up information request (Reason B). Since insurance companies are licensees of the Commission, the Commission can influence companies through the use of penalties. Thirty-seven (37) of the 100 sample complaint cases fall into this category. ReasonD deals with delays caused by the Commission and its procedures, which include review by complaints examiners and a possible review by the Commission's Legal Division. Thirty-four (34) cases fall into this category. Only Reason C deals

with a cause of delay that is completely out of the control of the Commission. Reason C represents delays caused by a request for follow-up information from a complainant or health care provider (29 cases). Since neither consumers orphysicians are regulated by the Commission, it has little influence over the time in which they provide information. The basic conclusion is that either the insurance company and/or the Commission is responsible for the delay in a total of 71 cases out of the 100 that were resolved in more than 45 days. The Commission could, therefore, examine its internal procedures for processing complaints, and use more aggressive enforcement efforts with its licensees, as methods to reduce the number of late cases. **The Legislative Auditor therefore recommends that the Insurance Commission seek to examine its complaints processing procedures and identify ways in which it can process complaint cases in a more expeditious manner, adhering to its own 45-day time limit. The Legislative Auditor further recommends that the Insurance Commission consider imposing financial penalties, as permitted by Senate Bill 418, on insurance companies that fail to respond to information inquiries regarding complaint cases in a timely manner.**

The basic conclusion is that either the insurance company and/or the Commission is responsible for the delay in a total of 71 cases out of the 100 that were resolved in more than 45 days.

Table 3
Factors Contributing to Delays in Closing Complaint Cases By Type of Insurance Policy

	Life Insurance				Health Insurance				Homeowners				Personal Auto				Total
Reasons for Delays	A	B	C	D	A	B	C	D	A	B	C	D	A	B	C	D	
46-60 Days	1	2		1	3	3	7	1	1		2	6	2			4	33
61-90 Days	1	1		2	4	1	9	4				1		3		1	27
91-120 Days	1	2	1	1	3		4	3				2	1				18
Over 120 Days				2	1	5	2	4	1		4	1	1			1	22
Total	**3**	**5**	**1**	**6**	**11**	**9**	**22**	**12**	**2**		**6**	**10**	**4**	**3**		**6**	**100**
	15				**54**				**18**				**13**				

Reasons for delays:

A. Insurance company late making initial response to complaint.

B. The Insurance Company was late responding to the Commission regarding a follow-up information request.

C. The complainant or a health care provider was late responding to the Commission regarding a follow-up information request.

D. Cases processed by the Commission in longer than 45 days.

Source: PERD analysis of complaint files provided by the Insurance Commission.

The Extent to Which Delays Are Caused by Insurance Companies

The Legislative Auditor recognizes a combination of factors work to delay the resolution of some complaint cases. While information received late is a contributing factor, as illustrated in Table 3, the Commission's own procedures are another. Table 4 illustrates just how late companies responded when contacted by the Commission, using an analysis of the sample complaint cases with late responses from companies. During the complaint process the Commission contacts the insurance company involved in a complaint case and requests information. The Commission makes an initial request from the company to "*... provide documented evidence to substantiate your position.*" The Commission may also make follow-up information requests to assist in determining the outcome of a case. Table 4 illustrates the time it took insurance companies to reply to the initial response letter and any follow-up information requests. The initial letter requests that the companies respond within 15 working days (which applies to all Commission information requests), but subsequent letters do not specify this time frame.

During the complaint process the Commission contacts the insurance company involved in a complaint case and requests information. The Commission makes an initial request from the company to "... provide documented evidence to substantiate your position."

There were 20 out of the 100 sample cases that could have been resolved late, at least in part, due to the company's failure to respond to the initial request of information within the 15-day time frame specified by the Commission's legislative rules. Seventeen (17) cases received late responses to Commission requests for follow-up information.

There were 20 out of the 100 sample cases that could have been resolved late, at least in part, due to the company's failure to respond to the initial request of information within the 15-day time frame specified by the Commission's legislative rules.

A substantial number of late responses (14 out of 37) from insurance companies were no more than 7 days late. The remaining 23 responses were 8 or more days late, which could have had a substantial effect on the Commission's ability to resolve a complaint case in a timely manner. The median response time for initial letters was 15 days late, which indicated that half of complaint cases with late initial letter responses received responses that were 15 or more days late. Responses to follow-up information requests were somewhat more timely, where the median response time was 8 days late. The median length of time by which insurance companies responded late to the Commission's information requests highlights the need for the Commission to inform companies of the 15-day time limit in all of its correspondence, and it needs to consider imposing financial penalties.

Table 4
Insurance Company Response Time to Insurance Commission Requests for Information

Number of Days Late	Initial Letter Response	Follow-Up Information Request
1-7	7	7
8-16	4	5
17-30	2	2
31-60	3	2
61 and above*	4	1
Total	**20**	**17**

**The two longest response times for initial letters were 150 and 115 days late, while the response to one follow-up information request was 76 days late.*

The median response times were 15 days late for initial letters and 8 days late for follow-up information requests.

No complaint cases received late responses from the insurance company for both the initial letter and follow-up information requests.

Source: PERD analysis of complaint files provided by the Insurance Commission.

There were examples of late responses from insurance companies that resulted in the late payment of medical claims. On one occasion the company responded 75 days late to the initial letter. This delayed the final order which resulted in the payment of a claim for a $915 multiple biopsy procedure.

Complainants Are Sometimes Kept Waiting for Financial Awards When the Commission Resolves Cases Late

There were examples of late responses from insurance companies that resulted in the late payment of medical claims. On one occasion the company responded 75 days late to the initial letter. This delayed the final order which resulted in the payment of a claim for a $915 multiple biopsy procedure. In another complaint case, the insurance company was 115 days late in responding to the initial letter. The final order in this case resulted in payment for a Magnetic Resonance Imaging procedure (the average hospital charge for this procedure is $650) that the Commission ruled as medically necessary.

As illustrated in Table 3, there are occasions when due to the complexity of a case or delays caused by Commission procedures result in the late resolution of a case.

As illustrated in Table 3, there are occasions when due to the complexity of a case or delays caused by Commission procedures result in the late resolution of a case. Theses delays have nothing to do with insurance companies. In one case, the Commission was 17 days late in resolving the case but awarded the complainant over $18,000 in survivor's benefits after reviewing the life insurance policy. Another case was 27 days late but the Commission awarded the complainant a reduction in his homeowners deductible by $1,500.

As some of these cases illustrate, claimants and health care providers who file complaints are sometimes waiting for payments for medical procedures, life insurance survivor's benefits and other claims that can amount to substantial sums.

In the case of homeowners insurance complaints or when insurance companies discontinue insurance coverage, the Commission often rules in favor of companies. With respect to the other types of insurance and categories of decisions, the frequency of rulings in favor of claimants or defending insurance companies displays no clear bias towards one party or the other.

The Commission's Decisions Show No Signs of Bias

Table 5 shows the outcome of the Commission's decisions regarding the 100 sample complaint cases. In the case of homeowners insurance complaints or when insurance companies discontinue insurance coverage, the Commission often rules in favor of companies. With respect to the other types of insurance and categories of decisions, the frequency of rulings in favor of claimants or defending insurance companies displays no clear bias towards one party or the other. The number of rulings in favor of each party is split fairly down the middle with respect to life, health or personal auto insurance. Twenty five (25) out of the 48 health insurance complaints, dealing with either premium increase or non-payment of claims, resulted in a ruling in favor of the complainant. The same holds true for 7 out of 13 personal auto insurance and 6 out of 14 life insurance complaints that dealt with either discontinued coverage, premium increases or non-payment of claims. There is, therefore, a good chance that when the Commission is late resolving a complaint case, that an individual will be kept waiting for some form of financial compensation.

Table 5
Commission Decisions Regarding Sample Complaints

	Life Insurance		Health Insurance		Homeowners		Personal Auto		Total
Decisions	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	
Discontinued Coverage	1	2		6		7	1	2	19
Premium Increase	1	2	5	3	1	2	1	1	16
Non-Payment of Claim	3	5	20	20	1	7	5	3	64
Agent Misconduct	1								1
Total	6	9	25	29	2	16	7	6	100

Source: PERD analysis of complaint files provided by the Insurance Commission.
A. Outcome in favor of complainant, which can be a health care provider in health insurance complaint cases.
B. Outcome in favor of insurance company.

The Staffing Level of the Insurance Commission's Consumer Services Division May Have Contributed to the Number of Complaint Cases Resolved Later Than 45 Days

As mentioned earlier, the Insurance Commission's Consumer Services Division currently has a staff that includes six (6) complaints examiners. Considering that during CY 2003, the Commission received 2,264 complaints, each examiner had to consider an average of 377 cases that year.

As mentioned earlier, the Insurance Commission's Consumer Services Division currently has a staff that includes six (6) complaints examiners. Considering that during CY 2003, the Commission received 2,264 complaints, each examiner had to consider an average of 377 cases that year. One examiner's position was vacant for part of the year as well. Another problem was that examiners also had to deal with telephone inquiries, in addition to formal written complaints. During CY 2004, the number of complaints received fell to 1,764, which still averaged 294 complaint cases per examiner. The Commission would be better able to adhere to its 45-day time limit for resolving complaints if each examiner had a lighter workload. Given that the Commission tends to received around 2,000 complaints per year, the Consumer Services Division could use an additional complaints examiner. The Division's Director stated:

> *In the past four years we have had four vacancies in the Insurance Complaint Specialist positions created by retirement or promotion. This has created additional work for the remaining examiners through increased telephone inquiries and having to handle the caseload of their former co-workers, in addition to their own caseload. As of March 16, 2005, all of the Insurance Complaint Specialist positions are filled which seems to be able to handle the current workload at a satisfactory and professional level. With the expansion of recent legislation* [the transfer of Workers' Compensation Division employees to the Insurance Commission] *it is possible that the division may see an increase and would at that time need to appropriate additional resources to ensure that we continue to meet the needs of our consumers. The Commission is currently in the process of transitioning many WC employees to our agency and may be able to draw upon these additional resources to meet any expanding demand that may occur.*

Considering that the Commission has been unable to resolve all complaint cases within 45 days, additional complaints examiners could alleviate this problem.

Considering that the Commission has been unable to resolve all complaint cases within 45 days, additional complaints examiners could alleviate this problem. Recent legislation aimed at privatizing the workers' compensation system (Senate Bill 1004) has led to the transfer of 275 former employees of the Workers' Compensation Division to the Insurance Commission. Senate Bill 1004 also makes the Commission responsible for receiving complaints related to

workers' compensation, since it created the Employers' Mutual Insurance Company to provide workers' compensation insurance and the Commission will regulate it as an insurance company. Since the Commission is in the process of incorporating these new employees, it would be possible to create additional claims examiners positions, utilizing the new staff members. **The Legislative Auditor recommends that the Commission consider allocating some of the new employees transferred from the Workers' Compensation Division to complaints examiner positions.**

Conclusion

Although the commission has increased the percent of total cases closed within 30-45 days, it has frequently failed to reach this internal policy goal. Closer adherence to the 15-day time frame for insurance companies to respond to Commission inquiries regarding claims, specified by the Commission's legislative rules, would facilitate the timely resolution of a larger number of complaint cases. The Commission's complaint processing procedures, including a possible review by its Legal Division, are a contributing factor to the resolution of claims later than 45 days. The workload of complaints examiners is another factor that contributes to the late resolution of complaint cases.

Recommendations:

1. The Insurance Commission should inform insurance companies of the 15-day time limit when responding to any information request related to complaint cases.

2. The Insurance Commission should utilize the provisions of Senate Bill 418 and impose financial penalties on companies that fail to respond to information inquiries regarding complaint cases in a timely manner.

3. *The Insurance Commission should consider allocating some of the new employees transferred from the Workers' Compensation Division to complaints examiner positions.*

Issue 2

Although the West Virginia Legislature Has Not Addressed Credit Scoring Through Legislation, the Insurance Commission Has Developed a Set of Guidelines Governing Its Use.

Issue Summary

Information gathered by the West Virginia Insurance Commission indicates that the majority of insurance companies operating in the state use some form of credit scoring. Available studies completed by state agencies in Texas and Virginia indicate that credit scoring is a reliable predictor of insurance claims. The National Association of Mutual Insurance Companies (NAMIC) analyzes state laws governing the use of credit scoring. Part of its analysis has involved the identification of states that have enacted legislation based on the National Conference of Insurance Legislators (NCOIL) Model Act for credit scoring legislation. The NCOIL adopted the Model Act on November 22, 2002. The Act was intended to establish guidelines for the use of credit scoring for personal, but not commercial, insurance. It's objective was to provide protection to consumers regarding the use of credit information. According to the NAMIC, 48 states have taken some form of legislative or regulatory action restricting the use of credit scoring. While the West Virginia Legislature has not passed any bills restricting the use of credit scoring, the NAMIC listed West Virginia as one of twenty-seven (27) states who "*....have approved laws or regulations that either replicate the basic NCOIL model language for each of these five factors, or address the underlying issue in some way.*" The NAMIC further stated that West Virginia is one of the twenty-four (24) states it considers as having based their regulation of credit scoring on the NCOIL Model Act.

While the West Virginia Legislature has not passed any bills restricting the use of credit scoring, the NAMIC listed West Virginia as one of twenty-seven (27) states who "....have approved laws or regulations that either replicate the basic NCOIL model language for each of these five factors, or address the underlying issue in some way."

Background to the Use of Credit Scoring By Insurance Companies

Congress enacted the Fair Credit Reporting Act (15 USCA §1681) in 1970. The Act allows insurers to use credit reports in insurance underwriting without disclosing this to consumers unless the insurer is taking an adverse action. The Federal Trade Commission defines credit scoring as follows:

> *A credit scoring system awards points for each factor that helps predict who is most likely to repay a debt. A total number of points–a credit score–helps predict how creditworthy you are, that is, how likely it is that you will repay a loan and make the payments when due.*

The insurance industry views credit scoring as a useful tool to identify the level of financial responsibility displayed by an individual, which impacts the chance that an individual will file an insurance claim, as illustrated by a statement issued by the Insurance Information Institute:

People who manage their finances well tend to also manage other important aspects of their lives responsibly, such as driving a car. Combined with factors such as geographical area, previous crashes, age and gender, insurance scores enable auto insurers to price more accurately, so that people less likely to file a claim pay less for their insurance than people who are more likely to file a claim.

Insurance scores are confidential rankings based on credit history information. They are a measure of how a person manages his or her financial affairs. People who manage their finances well tend to also manage other important aspects of their lives responsibly, such as driving a car. Combined with factors such as geographical area, previous crashes, age and gender, insurance scores enable auto insurers to price more accurately, so that people less likely to file a claim pay less for their insurance than people who are more likely to file a claim. For homeowners insurance, insurers use other factors combined with credit such as the home's construction, location and proximity to water supplies for fighting fires.

Insurance scores predict the average claim behavior of a group of people with essentially the same credit history. A good score is typically above 760 and a bad score is below 600. People with low insurance scores tend to file more claims. But there are exceptions. Within that group, there may be individuals who have stellar driving records and have never filed a claim just as there are teenager drivers who have never had a crash although teenagers as a group have more accidents than people in other age groups.

Most people benefit from insurance scoring because most consumers manage their debt well and therefore have good credit scores. Credit-related activities within the last 12 months are given most weight.

Insurers need to be able to assess the risk of loss — the possibility that a driver or a homeowner will have an accident and file a claim — in order to decide whether to insure that individual and what rate to set for the coverage provided. The more accurate the information, the closer the insurance company can come to making appropriate decisions. Where information is insufficient, applicants for insurance may be placed in the wrong risk classification. That means that some good drivers will pay more than they should for coverage and some bad drivers

will pay less than they should. The insurance company will probably collect enough premiums between the two groups to pay claims and expenses, but the good drivers will be subsidizing the bad.

The insurance industry feels that the additional information on individuals that credit scoring provides enables them to more accurately set premiums for those who are more likely to file claims.

The insurance industry feels that the additional information on individuals that credit scoring provides enables them to more accurately set premiums for those who are more likely to file claims.

2004 Credit Survey Demonstrates Most West Virginia Insurance Companies Use Credit Scoring

The Commission concludes that the majority of insurance companies operating in the state use some form of credit scoring.

During the Fall of 2004 the Commission sent a request for information and documents concerning whether or not insurance companies in our state use credit scoring in any manner whatsoever to Insurance Companies writing 1% or more of the automobile liability insurance and homeowners insurance. The Commission concludes that the majority of insurance companies operating in the state use some form of credit scoring. According to a West Virginia Insurance Commission representative:

If an insurer elects to implement credit scoring then the company will notify the rates and forms division by means of a rate, form or rule filing explaining how the credit score will be used in calculating premium or determining eligibility. That having been said, the rates and forms division conducted a credit scoring survey during the Fall of 2004 and questioned all of the insurance companies writing 1% or more of the automobile liability insurance and homeowners insurance in our State. This totaled 33 insurance companies with a certain amount of overlap given that some insurance companies are our major writers in both automobile and homeowners. All companies that were surveyed responded and identified those lines of insurance where credit scoring was used. Of the 33 companies only 5 did not use a form of credit scoring or financial responsibility scoring in either setting rates or determining eligibility. Therefore, although I do not have the information available, I suspect that the majority of insurance companies doing business in our State use credit scoring or a variation thereof.

Studies Have Shown That Credit Scoring Predicts Claim Losses

The Texas Department of Insurance concluded that credit scores provides insurers with additional predictive information, distinct from other rating variables, which an insurer can use to better classify and rate risks based on differences in claim experience.

Some studies have examined the validity of credit scoring as a predictor of insurance claims. The Texas Department of Insurance issued a report in January, 2005. The report contained three basic findings:

1. *The Department concluded that credit score provides insurers with additional predictive information, distinct from other rating variables, which an insurer can use to better classify and rate risks based on differences in claim experience.*
2. *For personal auto liability insurance, the Department concluded that class (which reflects the age, gender and marital status of the driver combined with usage of the vehicle) was consistently a more important rating variable for predicting claim experience. After class, credit score, driving record, and territory appeared as important rating variables. However, their ordering varied by insurer.*
3. *For homeowners insurance, the Department concluded that credit score was one of several important rating variables for predicting claim experience. However, the Department was unable to draw definite conclusions regarding the relative ranking of rating variables.*

Virginia's Bureau of Insurance determined in 1999 that credit scoring has been found to be statistically correlated to losses.

The Virginia State Corporation Commission's Bureau of Insurance released a report on surveys of homeowners and passenger automobile insurers in 1999 that concluded:

> *In every case where insurers have proposed to use credit scoring as a rating factor and have been able to provide sufficient data to the Bureau's [Bureau of Insurance] actuaries, the use of credit scoring has been found to be statistically correlated to losses.*

The report also addressed the issue of discrimination and credit scoring and found that credit scoring was not inherently discriminatory:

The Bureau analyzed the relationship between credit scores and income as well as the relationship between credit scores and race. Nothing in this analysis leads the Bureau to the conclusion that income or race alone is a reliable predictor of credit scores thus making the use of credit scoring an ineffective tool for redlining.

At the same time, some consumer groups have expressed the concern that the use of credit scoring may serve as a barrier to access to insurance for some classes of people.

At the same time, some consumer groups have expressed the concern that the use of credit scoring may serve as a barrier to access to insurance for some classes of people. Research completed by the Federal Home Loan Mortgage Corporation indicates that minority borrowers are more likely to experience credit problems than white borrowers. This concern is among the reasons why many states prohibit the use of credit scores as the only reason for terminating a policy. West Virginia's Insurance Commission has implemented this restriction (see discussion below).

Recent Credit Scoring Bills Introduced In the West Virginia Legislature

Since the Legislative Session of 2000, the Legislature has considered several bills dealing with the use of credit scoring. The Legislature did not pass any of these bills.

Since the Legislative Session of 2000, the Legislature has considered several bills dealing with the use of credit scoring. The Legislature did not pass any of these bills. The most recent bill was House Bill 2863, introduced during the Legislative Session of 2005, which sought to prohibit the use of credit scoring for calculating premium rates for homeowners or automobile liability insurance. The Legislature considered similar bills during the Legislative Session of 2004, House Bill 545 and Senate Bill 4488, both of which sought to prohibit the use of credit scoring in determining casualty insurance premium rates. During the Legislative Session of 2000, the Legislature considered Senate Bill 576, which had the goal of prohibiting the declination of automobile liability or homeowners insurance solely on the basis of credit scoring data.

West Virginia's Insurance Commission Follows the NCOIL Model Law Regarding the Use of Credit Information

The National Association of Mutual Insurance Companies (NAMIC) analyzes state laws governing the use of insurance scoring. Part of its analysis has involved the identification of states that have enacted legislation based on the National Conference of Insurance Legislators (NCOIL) Model Act for credit scoring legislation. The NCOIL adopted the Model Act on November 22, 2002. The Act was intended to establish guidelines for the use of credit scoring for personal, but not commercial, insurance. It's objective was to provide protection to consumers regarding the use of credit information.

At the time of this report, the NAMIC reported:

> To date, *48 states have taken some form of legislative or regulatory action on this important issue, with Pennsylvania and Vermont the lone exceptions. The scope and regulatory provisions adopted in each state varies considerably.*

Appendix B summarizes the most recent information available regarding the states that have either approved legislation that includes at least one or all five major provisions of the NCOIL Model Act. These provisions include:

1. Prohibiting certain uses of credit history information (42 states);
2. Dispute resolution measures (36 states);
3. Requiring insurers to notify consumers that the insurer may obtain and utilize an applicant's credit history (35 states);
4. Requiring insurers to explain to consumers any adverse actions taken in accordance with the Federal Fair Credit Reporting Act (39 states); and
5. Requiring insurers to file insurance scoring methodologies with the state insurance department (35 states).

While West Virginia has not yet passed any legislation that bans or limits the use of credit scoring by insurance companies operating in the state, the Commission has developed a set of guidelines governing its use.

At the time of this report, the NAMIC listed West Virginia as one of twenty-seven (27) states who "*....have approved laws or regulations that either replicate the basic NCOIL model language for each of these five factors, or address the underlying issue in some way."* The NAMIC further stated that West Virginia is one of the twenty-four (24) states it considers as having based their regulation of credit scoring on the NCOIL Model Act.

While West Virginia has not yet passed any legislation that bans or limits the use of credit scoring by insurance companies operating in the state, the Commission has developed a set of guidelines governing its use. The Commission has released Informational Letter Number 142A in August 2003, which summarizes these guidelines (see Appendix C). The Commission drafted Informational Letter Number 142A following the model legislation prepared by the NCOIL. The letter contains sixteen (16) requirements for companies utilizing credit reports or scoring. Some of the major requirements include:

- ❏ Banning the use of data for the purpose of unfairly discriminating on the basis of "*age, race, socioeconomic class, occupation, nationality, religion, sex or handicap*".
- ❏ The algorithm must be "*an accurate and statistically credible predictor of loss*".

- ❑ The Commissioner may request and review a company's credit scoring algorithm and its underlying statistical data.
- ❑ Credit scoring will not be used to affect overall rates, which require a rate change request.
- ❑ Credit scoring cannot be the sole basis for declining to provide automobile or homeowner's insurance.
- ❑ Requiring a company to provide "*...copies of the company's applications for private passenger automobile and homeowner's coverage as well as any supplemental documents which disclose the fact that the company may obtain the applicant's credit information.*

The Insurance Commission Reviews Credit Scoring Models for All Insurance Companies With Major Market Shares in the State

The Insurance Commission requests credit scoring information from companies by completing an annual survey. Data gathered by the survey allows the Commission to evaluate compliance with Informational Letter Number 142A.

The Commission conducted a survey of twenty-six (26) insurance companies that utilize credit scoring during 2004. The survey included all insurance companies that wrote at least one percent (1%) of automobile or homeowners insurance in the state. The Commission also surveyed three additional companies with less than a 1% market share because the Commission knew that these companies utilized credit scoring.

The survey requested thirteen (13) items (see Appendix D). The Commission questions included Question Number 3, which stated:

> *Please identify and provide each credit score model(s) the Company used from January 1, 2001 through September 1, 2004, inclusive. Please identify effective dates each model was implemented by the Company and all criteria (data elements) used to develop a credit score.*

Other information requested by the survey included methods by which the companies tested to ensure that their calculation and uses of credit scores adhered to the policies set forth in Informational Letter Number 142A, forms used by each company and the impact of credit scoring on rates.

The Commission has not yet tabulated the survey's results, but since the survey included all companies with at least a 1% market share, it is evident that the companies that write the majority of policies in West Virginia use credit scoring.

The Commission has not yet tabulated the survey's results, but since the survey included all companies with at least a 1% market share, it is evident that the companies that write the majority of policies in West Virginia use credit scoring. The Insurance Commission clearly has sought to review and regulate the use credit scoring by companies operating in the state according to the principles set forth in the NCOIL's Model Act.

Conclusion

While the use of credit scoring by insurance companies operating in West Virginia appears to be widespread, the Insurance Commission has developed a model for regulating its use that adheres to the NCOIL's Model Act and, therefore, already considers the most important concerns that have been expressed regarding credit scoring. The requirements of Informational Letter Number 142A consider both the statistical reliability of credit scoring methods as well as the fair treatment of consumers.

WEST VIRGINIA LEGISLATURE

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John Sylvia
Director

May 2, 2005

Ms. Jane L. Cline, Insurance Commissioner
West Virginia Office Of The Insurance Commissioner
1124 Smith Street P.O. Box 50540
Charleston, WV 25305-0540

Dear Commissioner Cline:

This is to transmit a draft copy of the Preliminary Performance Review of the West Virginia Insurance Commission. This report is scheduled to be presented during the May 15-17, 2005 interim meeting of the Joint Committee on Government Operations. We will inform you of the exact time and location once the information becomes available. A representative from your agency should be present at the meeting to orally respond to the report and answer any questions the committee may have.

We would like to schedule an exit conference to discuss any concerns you may have with the report. We would prefer to meet Thursday May 5, 2005. We need your written response by noon on Monday, May 9, 2005 in order to include it in the final report. If your agency intends to distribute additional material to committee members at the meeting, please contact the House Government Organization staff at 340-3192 by Tuesday, May 10, 2005, to make arrangements. Thank you for your cooperation.

Sincerely,

John Sylvia

JS/bb

Enclosure

Appendix B: Summary of State NCOIL Model Law Provisions

States	Prohibited Uses	Dispute Resolution	Initial Notification	Adverse Action Notification	Filing Requirements
Alabama	X	X	X	X	X
Alaska	X	X	X	X	X
Arizona	X			X	
Arkansas	X	X	X	X	X
California					
Colorado	X	X	X	X	X
Connecticut	X	X		X	X
Delaware	X	X	X	X	X
Florida	X	X	X	X	X
Georgia	X	X	X	X	X
Hawaii					
Idaho	X				
Illinois	X	X	X	X	X
Indiana	X	X	X	X	X
Iowa	X	X	X	X	X
Kansas	X	X	X	X	X
Kentucky	X				
Louisiana	X	X	X	X	X
Maine	X	X	X	X	X
Maryland	X	X	X	X	X
Mass.		X		X	
Michigan		X	X	X	X
Minnesota	X		X		X
Miss.	X	X	X	X	X
Missouri	X	X	X	X	X
Montana	X			X	
Nebraska	X	X	X	X	X
Nevada	X	X	X	X	

States	Prohibited Uses	Dispute Resolution	Initial Notification	Adverse Action Notification	Filing Requirements
New Hampshire	X	X	X	X	X
New Jersey	X	X	X	X	X
New Mexico	X	X	X	X	X
New York	X	X	X	X	X
North Carolina	X	X		X	X
North Dakota	X	X	X	X	X
Ohio	X	X	X	X	
Oklahoma	X	X	X	X	X
Oregon	X	X	X	X	X
Rhode Island	X	X	X	X	X
South Carolina	X	X	X		X
South Dakota	X				
Tennessee	X	X	X	X	X
Texas	X	X	X	X	X
Utah	X	X	X	X	X
Virginia	X	X	X	X	X
Washington	X	X		X	X
West Virginia	X	X	X	X	X
Wisconsin	X	X	X	X	X
Wyoming					

** Source: National Association of Mutual Insurance Companies website.*
See explanation of categories on following page.

Appendix C: West Virginia Information Letter No. 142A

August 2003

West Virginia Informational Letter

No. 142A

To: All Insurance Companies Licensed To Do Business in the State of West Virginia, Insurance Trade Associations, Insurance Media Publications and All Other Interested Persons

Re: Credit Scoring for Personal Lines

The purpose of this letter is to replace Informational Letter 142, regarding the West Virginia Insurance Commissioner's policy on the use of credit scoring. We have developed an internal procedure, which can be modified as the need arises, for the review of filings which rely, in any way, upon the use of credit reports or credit scoring. All such filings are expected to meet the following guidelines:

1. The insurer, rating organization or model provider has tested and certified, and further retains documentary evidence available to the Department upon request, that such data are not used in an unfairly discriminatory manner based upon age, race, socioeconomic class, occupation, nationality, religion, sex, or handicap, either directly or indirectly.

2. The insurer, rating organization or model provider has tested and certified, and further retains documentary evidence available to the Department upon request, that the algorithm is an accurate and statistically credible predictor of loss.

3. That the insurer, rating organization or model provider maintains and uses, without exception, random testing procedures for auditing the accuracy of an insurance scored assignment. In the event an inaccuracy is discovered, affected scores will be re-run and the insurer will reevaluate those risks based on the corrected score, refunding any difference in premium overpayments.

4. The Commissioner may request that the model developer provide the actual credit scoring algorithm in use by the insurer together with all statistical data used to develop the algorithm. The Commissioner recognizes that such information may be proprietary trade secret and, if so designated by the insurer or model developer, the same shall be withheld from public disclosure, provided that the insurer or model developer files the same separately and clearly identifies the material as such.

5. Implementation of the use of credit reports or credit scoring for the first time will not have any overall rate impact. Any change which results in an overall rate change will be accompanied by a rate change request.

6. Credit scoring shall not be the sole basis for the declination of a request for personal lines automobile or homeowners insurance. Placement of insurance with an affiliate company shall not be considered a declination.

7. In the event of the absence of credit information or if an insurer is unable to obtain sufficient information to produce an accurate credit score, the insurer must do one of the following:

    1. Treat the consumer as otherwise approved by the Insurance Commissioner, if the insurer presents information that such an absence or inability relates to the risk for the insurer; or
    2. Treat the consumer as if the applicant or insured had neutral credit information; or
    3. Exclude the use of credit information and use only other underwriting criteria.

8. The methodology and logistics in obtaining the credit report are not in violation of the Fair Credit Reporting Act.

9. The insurer consistently uses the same source of credit reports and credit scores, as to all insureds, and will not change said source more than once per year.

10. The insurer consistently uses the same credit score model and methodology and will not change said model or methodology more than once per year. Any change in the way that credit scores are used as part of a rating plan must receive prior approval.

11a. The insurer shall disclose, either on the insurance application or at the time the insurance application is taken, that it may obtain credit information in connection with such application. Such disclosure shall also give notice that the policyholder may request a recalculation of credit score once in a 12-month period. See 13c. for language to be included in such notice.

11b. If an insurer takes an adverse action (as defined in the Fair Credit Reporting Act, 15 USC 1681a (k)) based upon credit information, the insurer shall provide notification to the consumer that an adverse action has been taken based upon credit information and shall further provide the insured with the name and address of the source from which the information was obtained.

12. The credit score model does not consider multiple inquiries from the insurance, mortgage lending, or auto finance industries within a 30 day period, i.e., shopping for insurance or credit rates does not adversely affect the credit score.

13a. If the insurance company uses credit information for tiering or rating, the insurance company shall recheck the credit scores of policyholders within 36 months of the last credit score calculated to determine if the policyholder's credit score has changed. The insurer shall have the discretion to obtain current credit information upon any renewal before the 36 months.

If there has been a change, the insurer shall re-underwrite and re-rate the policy based upon the current credit report or credit score at the next renewal. The insurance company is not required to recheck the credit scores of policyholders that are already receiving the best rate.

13b. Upon request of the insured, the insurer shall re-underwrite and re-rate the policy based upon a current credit report or credit score at renewal. An insurer need not recalculate the credit score or obtain the updated credit report at the request of the insured more frequently than once in a twelve-month period. If such request is made less than 45 days prior to the next renewal date, the insurer shall re-underwrite and re-rate the policy for the following renewal.

13c. The insurer shall give notice to existing policyholders within 12 months of the issuance of this Informational Letter of the option to have scores rechecked as stated in 13b. Such notice may be included with the policyholder's renewal notice. Such notice must be given at least once, must be 14 pt font size and stated as follows:

Your credit information is used by (company) to produce a credit score. This credit score has an effect on the premium that you pay for your insurance. (Company) is required by the Insurance Commissioner to recheck your credit information no less than once every 36 months for changes. You have the option to request that (company) recheck your credit score more frequently than once every 36 months, but you can only make this request once during any twelve-month period. If there has been a change in your credit score, (company) shall re-underwrite and re-rate the policy based upon the current credit report or credit score. The change in your credit score may result in an increase or a decrease in the premium that you pay for your insurance. Any changes in your premium will take place upon renewal if your request is made at least 45 days before your renewal. If the request is made less than 45 days before your renewal date, the insurer shall re-underwrite and re-rate the policy for the following renewal.

14. Insurers using credit scores for rating shall make a filing that includes actuarial justification for those factors when there is a change in rating factors, as this effectively constitutes a pricing revision.

15. The insurer does not use credit information to underwrite or rate a risk where such information has been identified on the records of the credit bureau as in dispute by the policyholder or applicant. (A) If a credit bureau determines that the credit report or credit score of an applicant is incorrect due to inaccurate or incomplete information contained in the credit report and if the insurer receives notice of this determination from the applicant or the credit bureau, the insurer shall, within 30 days after receiving the notice: (i) re-underwrite the applicant; (ii) re-rate the applicant; and (iii) adjust the premium as indicated in subsection (B). (B) If it is determined by the re-underwriting or re-rating in accordance with subsection (2) above that the applicant has overpaid the premium, the insurer shall refund to the applicant the amount of the overpayment of premium. Such payment shall be

calculated back to the shorter of: (1) the last 12 months of coverage; or (ii) the actual period of coverage.

16. This informational letter only applies to personal lines property and casualty insurance.

If you have any questions regarding the contents of this Informational Letter, you may contact the Rates and Forms Division at (304) 558-2094.

Jane L. Cline
INSURANCE
COMMISSIONER

Appendix D: Questionnaire Sent to Insurance Companies in WV

REQUESTS FOR INFORMATION AND DOCUMENTS

You are requested to answer the following requests for information separately and fully, in writing, under oath, and to serve your answers and produce the requested documents on the undersigned within seventy-five (75) days after mailing of these requests upon you. When producing the requested documents, please submit them in response to each specifically numbered request and label accordingly. The Company may produce the documents in an electronic format.

You are further requested to label or mark the specific portions of your answers or documents which yo deem trade-secret, proprietary or in any way exempt from the Freedom of Information Act (FOIA). When asserting a FOIA exemption, please include a detailed statement of the Company's justification.

You are further requested when preparing your answers to provide a full, accurate narrative response to the best of your knowledge in order that the Insurance Commission may understand the Company's position, practice and/or procedure.

Finally, if the company uses credit scoring/insurance scoring (hereinafter referred to as "credit scoring") in multiple types or lines of business (automobile, homeowners, umbrella, inland marine, commercial, etc.) we are requesting that the Company answer each question and produce the requested documents by individual type or line of business.

1. Please state whether the Company uses credit coring in any manner whatsoever. If the Company does use credit scoring, then please state by what type or line of business, whether it is used in underwriting, rating, or both and for each type or line of business provide a detailed description of the manner in which the Company utilizes credit scoring.

2. Please describe how the Company, rating organization or the model provider tested and certified credit scoring is not used in an unfairly discriminatory manner based upon age, race, socioeconomic class, occupation, nationality, religion, sex, or handicap, either directly or indirectly and provide any documents in your possession demonstrating the same.

3. Please identify and provide each credit scoring model(s) the Company used from January 1, 2001 through September 1, 2004, inclusive. Please identify effective dates each model was implemented by the Company and all criteria (data elements) used to develop a credit score.

4. Please describe how the Company, rating organization or model provider developed, tested and certified that the credit scoring algorithm was an accurate and statistically credible predictor of loss and provide any documents in your possession demonstrating the same.

5. Please describe any random testing procedure whose purpose is the testing of the accuracy of a credit scored assignment used by the Company, rating organization or model provider. In addition, please provide any documents in your possession detailing each time inaccuracy

may have been discovered, how the credit scores were re-run, the process for reevaluating those risks based on the corrected score, and documentation fo refunding any difference in premium overpayments.

6. Please provide copies of the Company's private passenger automobile and homeowners underwriting guidelines for West Virginia. Underwriting guidelines should specifically include acceptable risk criteria for each line as it pertains to credit scoring as well as minimum scoring levels for each tier. It is specifically requested that the Company identify how it treats those applicants who have a "no hit" or "no score".

7. Please provide or, in the event no documents exist that are responsive to this request, prepare a rate impact analysis or similar type of document demonstrating the effect credit scoring has or has had upon the rates the Company charges. If the Company uses credit scoring for underwriting purposes only (eligibility or tier placement) then it need not prepare an impact analysis. The term "impact analysis" as used in this question refers to any type of analysis, schedule or exhibit listing credits; debits; surcharges; or rating factors relied upon by the Company when calculating premium taking into consideration a credit score. Additionally, the impact analysis should demonstrate the distribution of the Company's book of business (policy count or policy distribution percentage) and the estimated or actual premium charge resulting from the inclusion of a credit scored credit, debit, surcharge or rating factor.

8. Please describe in detail the Company's methodology and logistics for obtaining a credit Report highlighting the Company's efforts to comply with the Fair Credit Reporting Act.

9. Please state the Company's data source for credit reports and/or credit scores and the dates when each source was used.

10. Please provide copies of the Company's applications for private passenger automobile and homeowner's coverage as well as any supplemental documents which disclose the fact that the Company may obtain the applicant's credit information.

11. Please state the number insureds having requested that the Company re-underwrite and/or re-rate their policies based upon a current credit report or credit score.

12. Please describe how the Company will use credit information to underwrite or rate a risk where such information has been identified on the records of the credit bureau as in dispute by the policyholder or applicant.

13. Please describe the method by which the Company compiled with paragraph 13c of Informational Letter No. 142A.

2004 CREDIT SCORING SURVEY RECIPIENTS

The following is a list of the insurance companies who received the 2004 Credit Scoring Survey. These companies were selected due to their market share in the State of West Virginia. Each of these companies write at least 1% or more of the automobile or homeowners insurance in our State, except the following: Progressive Paloverde (.87%); State Auto Property and Casualty (.79%); and Hartford Insurance Company (.51%). These three companies were included based upon the fact that the agency was aware that each used credit scoring to either underwrite or rate policies in West Virginia.

State Farm Fire and Casualty Company
Erie Insurance Property and Casualty Company
Nationwide Mutual Fire Insurance Company
Allstate Insurance Company
Farmers and Mechanics Mutual Insurance Company of WV
Municipal Mutual Insurance Company
West Virginia Insurance Company
Westfield Insurance Company
Glens Falls Insurance Company
Shelby Casualty Insurance Company
Ohio Farmers Insurance Company
Farmers Mutual Insurance Company
Foremost Insurance Company
Farm Family Casualty Insurance Company
LM Property and Casualty Insurance Company
Safeco Insurance Company of America
United Services Automobile Association
State Auto Property and Casualty Insurance Company
State Farm Mutual Automobile Insurance Company
Nationwide Mutual Insurance Company
Nationwide Assurance Company
Hartford Insurance Company of the Midwest
Nationwide Property and Casualty Insurance Company
Dairyland Insurance Company
Progressive Classic Insurance Company
American Home Assurance Company

Appendix E: Credit Scoring Bills Introduced in Other States

Recent Credit Scoring Bills Introduced In Other States			
State	**Bill #**	**Bill Description**	**Bill Status**
California	AB 800	Revises the process of investigating disputed information by requiring a furnisher to correct any inaccurate information to a consumer credit reporting agency within a specified time. Provides that confirming inaccurate information after an investigation is a violation of the act.	Bill passed both Assembly and Senate in 2003. Being held at Senate desk, January 12, 2004.
California	SB 1323	Prohibits using credit ratings, credit reports, credit scoring models, or credit information to underwrite, classify, or rate homeowners' insurance policies. Homeowners' insurers would also be prohibited from refusing to issue, or non renewing or cancelling, a homeowners' policy based upon these types of credit information.	Passed Senate on May 18, 2004. Do pass from House Assembly Committee on Appropriations on August 12, 2004.
Colorado	HB 1236	Establishes notification requirements where credit information is used during application process.	Law; effective January 1, 2005.

State	Bill #	Bill Description	Bill Status
Colorado	HB 1292	Prohibits use of credit scoring for the acceptance, denial, renewal or rating of a potential insured for insurance underwriting purposes in connection with homeowners insurance.	Law; effective August 4, 2004.
Colorado	SB 216	Prohibits certain uses of credit information in personal lines insurance rate making.	Law; effective January 1, 2005, with Section 2, repealing Section 2 of HB 1292, effective June 4, 2004.
Iowa	SB 2257	Adopts language similar to the NCOIL model relative to the use of credit information by property and casualty insurers for underwriting or rating purposes.	Law. Effective October 1, 2004. (per SB 2298)
Maryland	HB 504	Similar to SB 101	Vetoed; May 26, 2004.
Maryland	SB 101	Repeals a sunset provision in law allowing a discount of up to 40 percent, based on credit history, on a new motor vehicle policy.	Signed by Governor on April 27, 2004.
Massachusetts	HB 1049	Requires that a statement of how a credit score is computed be provided to the consumer about who the credit score relates whenever a credit score is requested.	Bill carried over from 2003 session.

State	Bill #	Bill Description	Bill Status
Massachusetts	HB 3112	Requires a consumer credit reporting agency to provide a notice to a consumer who requests their credit score.	Bill to become part of House study on consumer protections.
Massachusetts	SB 2093	Prohibit the use of credit rating in determining rates, premiums, or classifications of risks bu the Commissioner of Insurance. Rates could not be excessive, inadequate or unfairly discriminatory.	Read second time in Senate and ordered to a third reading on June 9, 2004.
Michigan	HB 5536	Prohibits use of collection accounts with a medical code as a negative factor in an insurance score.	Referred to House Insurance Committee on February 12, 2004.
Michigan	HB 5803	Prohibits making underwriting and rating decisions for personal lines policies solely on the basis of credit information.	Introduced and referred to House Committee on Insurance on April 22, 2004.
New York	AB 2661	Prohibits taking a person's credit history into account when calculating homeowners' rates. Homeowners' insurance can not be denied based on a person's credit history.	Referred to Insurance Committee on January 17, 2004.

State	Bill #	Bill Description	Bill Status
New York	SB 2728	Prohibits insurers from taking an adverse action against any consumer based on the consumer's credit history. An adverse action would be defined to include: (a) cancellation, denial, or nonrenewal of insurance coverage; and (b) imposition of a higher insurance rate or premium for insurance than would have been offered if a consumer's credit history, credit score, or insurance score had been more favorable.	Referred to Insurance Committee on January 7, 2004.
New York	SB 3186	Prohibits the refusal to issue or renew a motor vehicle insurance liability policy based on solely or in part on the applicant's credit history.	Referred to Insurance Committee on January 7, 2004.
New York	SB 5618	Enacts provisions relating to the use of credit information by personal lines insurers; defines terms; provides for certain notification, dispute resolutions and error correction procedures; requires filling by insurers of scoring models.	Passed Senate and passed Assembly June 22, 2004. Delivered to Governor on July 15, 2004.

State	Bill #	Bill Description	Bill Status
Ohio	SB 151	Prohibits disclosure of information relative to insurance coverage that was submitted in whole or in part with an individuals credit history or request for consumer report.	Law; effective September 23, 2004.
Pennsylvania	HB 2290	Amends the Unfair Insurance Practices Act to prohibit the sole use of credit information for the purposes of cancelling, denying or increasing the rate of motor vehicle insurance.	Referred to the House Committee on Insurance on January 6, 2004.
Pennsylvania	SB 942	Restricts the use of credit scoring in personal lines insurance.	Referred to the Senate Committee on Banking and Insurance October 23, 2003.
Tennessee	HB 2339 (Similar to SB 2259)	Imposes certain restrictions on insurers who use credit scoring.	Law; effective January 1, 2005.
Tennessee	SB 2259	Prohibits the use of credit report after 90 days from first policy date or renewal date; use inquiries requested by consumer or for consumer's own information; use of inquiries relating to insurance coverage, home mortgage industry, or multiple lender inquiries; deny cancel or nonrenew a policy on the sole basis of credit information; consider absence of credit information in underwriting.	Law; effective January 1, 2005.

State	Bill #	Bill Description	Bill Status
Washington	HB 2727	Requires all personal lines insurers that use credit history or insurance scores to determine personal insurance rates, premiums, or eligibility for coverage to file all rates and rating plans with the commissioner of insurance.	Law; effective April 12, 2004.
Source: National Association of Mutual Insurance Companies			

Appendix F: Agency Response

STATE OF WEST VIRGINIA

Offices of the Insurance Commissioner

JOE MANCHIN III
Governor

JANE L. CLINE
Insurance Commissioner

May 9, 2005

Mr. John Sylvia
West Virginia Legislature
Performance Evaluation and Research Division
Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0610

Dear Mr. Sylvia:

Thank you for providing a draft of the "Performance Review of the West Virginia Insurance Commission." We appreciate the efforts of the auditors and the courtesies extended to those involved in this process. This response will address all recommendations and issues contained in the report.

Issue 1: "*The Insurance Commission takes longer to resolve many consumer complaints than it's internal policy recommends, but has resolved a higher percentage of cases in a timely manner during recent years.*"

The internal goal of concluding complaints within 45 days was established in June of 2003 as part of an overall effort to improve the timeliness of complaint closures. Since the establishment of that goal the complaint resolution timeframe has improved. The goal does not apply to complaints against HMO companies which are not subject to the Unfair Trade Practices Act (UTPA) or to company sponsored health plans formed under the federal ERISA laws, which are not under the authority of the Insurance Commission. In an effort to assist consumers, complaints involving ERISA plans are accepted even though outside of our jurisdiction and, if resolved, often take considerable time. Obtaining the internal goal is further affected by the practice of not closing a resolved claim until all transactions have concluded. In terms of the 45 day goal, a complaint is deemed to be complete when all information is received and a decision made or agreement reached on the particular complaint. However, a review of the complaint files reveals that a complaint often remains open until all agreed transactions are completed and we are notified of the completion. This procedure will be reviewed and proper amendments made.

"The Commission has no documentation of having ever taken disciplinary action against an insurance company that violated the rule to provide information within 15 working days regarding a complaint…."

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Initially, it should be pointed out that the language of the UTPA, to which Series 14, Title 114 of the Code of State Rules relates, requires that the company's behavior constitute a general business practice before action can be taken against the company relating to claims handling issues. Because of this requirement, we would not have taken action against a company for a single violation of the rule provision requiring responses to this department within 15 business days. This will change on the effective date of S.B. 418, and the Commissioner will be allowed to penalize a company for one intentional violation even though a finding has not been made as to a general business practice.

The report states that the Commissioner has no documentation of having ever taken disciplinary action against an insurance company that violated the response time provision subsection 5.2 of Series 14. However, through market conduct the Commissioner has taken such action. A very effective tool for ensuring that our regulated entities conduct themselves properly in the marketplace is found in West Virginia Code Section 33-2-9, which is known as the "examination statute." This statute requires routine examinations of all regulated entities and gives the Commissioner discretion to examine a company more frequently if company conduct dictates. At the beginning of this administration, it was recognized that an in-house market conduct unit is needed to more thoroughly regulate company behavior and to be responsive to consumer issues. Our in-house market conduct unit became operational in late 2002 and has completed comprehensive examinations on seven domestic companies, five being non-HMO companies subject to the UTPA and related rules. As a result of those examinations, we have determined that one of those five companies has failed the standard relating to response time under 114-14-5.2. This particular company did not respond to our Consumer Services Division in 6 out of 58 files reported in the Insurance Commission's complaint log for the exam period. The company was ordered to comply with this rule provision and the company was assessed a general penalty for various code and rule violations found, including 114-14-5.2.

As we move forward, it has been our plan to call more "targeted" exams that relate to specific consumer issues, rather than the broad-based exams we've been conducting to date. Toward that end, in August of 2004 we updated our data base in the Consumer Services Division to require complaints examiners to enter a specific code section if the examiner believes that there has been a code violation. Regular reports are run by our market conduct examiner to determine what legal issues are appearing in the data base, which improves our market analysis capabilities and the surveillance of companies' compliance.

"Staffing needs are a concern to the Commission and should be addressed."

The Commissioner previously recognized the need to supplement the current staffing and has previously proposed the creation of a new job description allowing the addition of an attorney to the Consumer Services Section. Additionally, transition teams are currently reviewing the required staffing levels of each function being transferred to the Insurance Commission from the Workers Compensation Commission and the skills of the personnel scheduled to be transferred to determine the proper staffing levels. This review includes identifying those individuals that are qualified to join the present consumer services staff.

"The Legislative Auditor therefore recommends that the Insurance Commission seek to examine its complaints processing procedures and identify ways in which it can process complaint cases in a more expeditious manner…."

The Insurance Commission agrees with this recommendation and has previously recognized the need for further improvement. To that end, a rule change has been drafted and is currently under review shortening the time companies are allowed to respond to inquires from 15 working days to 10. Further, as stated above, S.B. 418 amends current law allowing the Commissioner to penalize a company for one intentional violation even though a finding has not been made as to a general business practice.

"The Insurance Commission should inform insurance companies of the 15-day time limit when responding to any information request related to complaint cases."

The Insurance Commissioner agrees with this recommendation and will notify companies on a more frequent basis than current practices. Currently initial correspondence regarding complaints remind companies of the requirement to respond within 15 working days. This reminder will be included in other correspondence.

Issue 2: "Although the West Virginia Legislature has not addressed credit scoring through legislation, the Insurance Commission has developed a set of guidelines governing its use."

The Insurance Commission agrees with the conclusion of the auditor's report.

Sincerely,

Bill Kenny
Deputy Commissioner
West Virginia Insurance Commission

BK/jz