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INSURANCE FRAUD IN AMERICA: CURRENT ISSUES FACING INDUSTRY AND CONSUMERS

HEARING

BEFORE THE

SUBCOMMITTEE ON CONSUMER PROTECTION, PRODUCT SAFETY, INSURANCE, AND DATA SECURITY

OF THE

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

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ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

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INSURANCE FRAUD IN AMERICA: CURRENT ISSUES FACING INDUSTRY AND CONSUMERS

THURSDAY, AUGUST 3, 2017

U.S. SENATE,
SUBCOMMITTEE ON CONSUMER PROTECTION, PRODUCT SAFETY, INSURANCE, AND DATA SECURITY
COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:49 a.m. in room SR–253, Russell Senate Office Building, Hon. Jerry Moran, Chairman of the Subcommittee, presiding.

Present: Senators Moran [presiding], Blumenthal, Nelson, Fischer, Klobuchar, Capito, Hassan, Cortez Masto, and Young.

OPENING STATEMENT OF HON. JERRY MORAN, U.S. SENATOR FROM KANSAS

Senator MORAN. Good morning, everyone. I call the hearing of this Subcommittee on Consumer Protection, Product Safety, Insurance, and Data Security to order. As our title suggests, this Subcommittee exercises wide jurisdiction over a diverse range of topics. And this will be our first hearing this Congress to examine matters related to insurance, specifically today, that of insurance fraud.

Thank you for our expert witnesses who have joined us.

Insurance fraud is a major concern not only for insurers—who bear the cost of fraudulent claim payouts—but also consumers, who see those costs passed on to them in the form of higher premiums. This hearing will examine the scope of insurance fraud at large in the United States and address nationwide fraud trends across a variety of insurance markets, including property and casualty, and life insurance. In addition, we'll discuss the tools available to states, insurers, and consumers to protect themselves against these crimes.

The insurance industry has an enormous presence in the United States. There are nearly 3,000 property and casualty insurance companies across the country, another 850 life and health insurance companies. Together, they generated over $1 trillion in premiums in 2015 alone.

The FBI reports that the sheer size of this industry makes it an attractive target for criminals by providing ample opportunities and bigger incentives for committing illegal activities, estimating the total cost of non-health insurance fraud in the United States at more than $40 billion annually. That level of insurance fraud, in turn, costs the average American family upwards of $700 per year in the form of increased premiums.

With examples of insurance consumer concerns as recent news reports indicate, Wells Fargo charged its automobile loan customers for collision insurance they did not need, this hearing is timely. As for oversight, my staff is already in communication with Wells Fargo regarding these concerns, and we plan to follow up accordingly to gather additional information on the circumstances and what should be done.

While insurance is largely regulated at the state level, insurance fraud schemes can and do lead to Federal criminal charges, and I believe the Federal Government must do what it can to protect consumers from bad actors who seek to defraud them.

As was a common theme among popular consumer scams discussed in this Subcommittee earlier this year, insurance fraud schemes are constantly evolving and growing in complexity over time. Technology must and will play a crucial role in catching sophisticated fraud activity. And I look forward to learning more from our distinguished witness panel about the use and efficacy of emerging technologies, data collection, and information-sharing practices to better detect and prevent insurance fraud.

Once again, thank you for being here. Thank you for generously delaying your August travel plans to be part of this important hearing.

[The prepared statement of Senator Moran follows:]

PREPARED STATEMENT OF HON. JERRY MORAN, U.S. SENATOR FROM KANSAS

Good morning, everyone. I call to order this hearing of the Senate Subcommittee on Consumer Protection, Product Safety, Insurance and Data Security.

As the title suggests, this Subcommittee exercises wide jurisdiction over a diverse range of topics. This will be our first hearing this Congress to examine matters pertaining to insurance—specifically, that of insurance fraud. Thank you to our expert witnesses who came here to join us today.

Insurance fraud is a major concern not only for insurers—who bear the costs of fraudulent claim payouts—but also consumers, who see these costs passed on to them in the form of higher premiums. This hearing will examine the scope of insurance fraud at-large in the United States and address nationwide fraud trends across a variety of insurance markets, including property and casualty, and life insurance. In addition, we'll discuss the tools available to states, insurers, and consumers to protect themselves against these crimes.

The insurance industry has an enormous presence in the United States. There are nearly 3,000 property and casualty insurance companies across the country, and another 850 life and health insurance companies. Together, they generated over 1 trillion dollars in premiums in the year 2015 alone.

The FBI reports that the sheer size of this industry makes it an attractive target for fraudsters by providing ample opportunities and bigger incentives for committing illegal activities, estimating the total cost of non-health insurance fraud in the U.S. to be more than 40 billion dollars annually. That level of insurance fraud, in turn, costs the average American family upwards of 700 dollars per year in the form of increased premiums.

With examples of insurance consumer concerns like recent news reports indicating Wells Fargo charged its automobile loan customers for collision insurance they did not need, this hearing is exceptionally timely. As for oversight, my staff is already in communication with Wells Fargo regarding these concerns, and I plan to follow up accordingly to gather additional information on the circumstances and what is being done to address these issues.

While insurance is largely regulated at the state level, insurance fraud schemes can and do lead to Federal criminal charges, and I believe the Federal government must do what it can to protect consumers from bad actors who seek to defraud them.

Raising consumer awareness is a significant component of helping consumers protect themselves, and to that end this hearing will highlight a number of current in-

surance fraud trends—including auto insurance fraud, workers' compensation fraud, fee churning schemes, and contractor fraud in the wake of natural disasters.

As was a common theme among popular consumer "scams" discussed in this Subcommittee earlier this year, insurance fraud schemes are constantly evolving and growing in complexity over time. Technology must and will play a crucial role in catching sophisticated fraud activity, and I look forward to learning more from our distinguished witness panel about the use and efficacy of emerging technologies, data collection, and information sharing practices to better detect and prevent insurance fraud.

Once again, thank you all for being here and generously delaying your August recess travel plans to be a part of this important hearing. With that I will now turn to the Ranking Member, Senator Blumenthal, for his opening remarks.

Senator MORAN. And I now turn to my Ranking Member, Senator Blumenthal, for his opening remarks.

STATEMENT OF HON. RICHARD BLUMENTHAL, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you, Mr. Chairman, and thank you so much for having this hearing.

Before I give some very, very brief opening remarks, I want to yield to the Ranking Member, my friend Senator Nelson, for some remarks because he has to leave to go to a classified intelligence briefing this morning.

STATEMENT OF HON. BILL NELSON, U.S. SENATOR FROM FLORIDA

Senator NELSON. Thank you for your courtesies, Mr. Chairman and Senator Blumenthal.

Years ago, I had the hardest job, Commissioner, that I've ever had in public service, that of the elected insurance commissioner of Florida. Not the least of one of the challenges was the fact that we inherited a mess in the aftermath of a monster hurricane.

In the course of all of those years of trying to be a proactive insurance commissioner, we would run into fraud quite a bit. And when I say "quite a bit," I mean a small percentage, just minimal percentage, of all the insurance that is bought and sold, but when you would find it, it would be despicable.

For example, we found insurance companies selling low-value burial policies that had done it for decades in the African American community for which they charged the African American community a higher rate than the same policies sold in the white community. Once we discovered that and busted it open, it quickly stopped. Some of those insurance companies have long since been sold to other insurance companies, and the practice involved some of the national insurance companies.

Individual states, not the Federal Government, continue to be the primary regulators of insurance. And, that fact is not lost on us, as we are now trying to fix the existing law on health insurance. As we're going forward, the insurance commissioners are going to have to be brought into the discussion to determine what will work in their states. As recently as last night, there were a group of 14 of us, interestingly, divided evenly between Rs and Ds, talking about the fixes that could be done primarily through Senator Alexander's Committee, once we get back here in September. And so it's important that we consider your ideas, Mr. Commissioner.

Insurance has been an issue in front of us so much because of the dominance of the debate of health care. We discussed, for example, one of the experiences that we had in Florida when I inherited a paralyzed marketplace in the state because insurance companies had fled Florida due to monster Hurricane Andrew.

By the way, there happened to be a lot of fraud committed in the course of all of that debacle. And one of the ways of getting insurance companies back into the state was to create a reinsurance fund against hurricane catastrophe. That fund exists today with huge reserves, the Florida Hurricane Catastrophe Fund.

As we look at the question of fraud, I am very, very appreciative of you, Mr. Chairman and Mr. Ranking Member, that you all would hold this hearing. All fraud does is it hurt insurance companies, hurt the people, and hurt the providers, and hurt the agents. It hurts everybody, and we ought to be ferreting it out.

Thank you for bringing forth this hearing. Thank you.

[The prepared statement of Senator Nelson follows:]

PREPARED STATEMENT OF HON. BILL NELSON, U.S. SENATOR FROM FLORIDA

Thank you for calling this hearing Mr. Chairman. As Florida's former insurance commissioner, I've seen firsthand how fraud impacts consumers and insurers.

Insurance fraud takes on many forms from sales abuses that target the elderly to "cash for crash" schemes where accidents are deliberately staged or caused for financial gain.

One of the most despicable cases I can recall was that of an insurer who took advantage of black policyholders for decades by overcharging them for burial policies.

Fortunately, we were able to put a stop to that practice.

While individual states, and not the Federal government, continue to be the primary regulators of insurance, I welcome hearing from our distinguished panel today regarding the trends they're seeing on the fraud front and whether there is a role the Federal government can play to help the states.

Meantime, since we are talking about insurance, I would also like to take this opportunity to share my thoughts on last week's health care vote and its aftermath.

As I have said throughout this process, we need to come together and seek bipartisan solutions to fix the Affordable Care Act and not undo all of the good things its done.

That is why I've been working with Senator Collins to find solutions that will provide immediate relief to families back home.

In fact, over the last week the two of us have joined a bipartisan group of other senators who share our desire to find a path forward.

We've discussed creating a permanent reinsurance fund to lower the financial risk of insurance companies and reduce premiums for American families.

I've seen this work before during my days as insurance commissioner following Hurricane Andrew, the second costliest hurricane in our Nation's history.

In Andrew's aftermath, Florida established a reinsurance fund to insure the insurance companies for their catastrophic losses.

The same thing can and should be done for health care.

I cosponsored a bill to create a permanent reinsurance program that would provide Federal funding to cover 80 percent of insurance claims falling between $50,000 and $500,000 over the next two years.

After that, Federal funding would cover 80 percent of insurance claims between $100,000 and $500,000.

One Florida insurer estimated the bill would reduce premiums for Floridians by up to 13 percent.

We can also work in a bipartisan manner to fund payments that lower Americans' out-of-pockets costs.

These are the same payments the administration is threatening to end that lower costs for millions of Americans.

If these payments are stopped, there will be real consequences.

Working families will face higher premiums and fewer insurance options. In Florida, premiums will increase by 25 percent if these payments are cancelled.

Higher costs mean fewer folks will be able to afford coverage.

Our colleagues on the HELP Committee, Chairman Alexander and Ranking Member Patty Murray, have the right idea.

They have committed to holding a series of hearings with the goal of stabilizing the ACA's insurance market.

That's a good start and one I hope we can all get behind because, in reality, it's going to take more than just a few of us to improve health care for families back home.

That said Mr. Chairman, I would welcome working with you or any of my colleagues here to find that path forward.

Senator MORAN. Senator Nelson, thank you for joining us. We appreciate you being here and understand there are other commitments.

And I again recognize the Senator from Connecticut, the Ranking Member.

Senator BLUMENTHAL. Thank you.

Senator Nelson is absolutely right. Insurance fraud hurts everyone, including the business people, who are charged higher premiums, as well as consumers, because insurance fraud is costly to those companies. And, of course, it hurts individual consumers who are misled or deceived when they believe they are owed money for legitimate claims and they find that somehow there is fine print in the policy, sometimes inserted or interpreted in ways they never thought possible. And that's why we're here today.

I hope that you will not take personally the anger and frustration that I and others may express today. Your willingness to be here I think is very important, and I want to thank each of you for being here to enlighten us and respond to our questions.

But what we've seen is, for example, in Connecticut, homeowners affected by a substance called pyrrhotite. Insurance companies have surreptitiously modified their homeowner policies without properly telling them to exclude damage to a home's foundation once the insurance companies learn that those foundations had a potential and naturally occurring flaw as a result of that substance, pyrrhotite. The insurance companies in effect changed the policies without properly notifying their consumers. And I'm going to be asking questions about that occurrence.

Insurance companies have stalled and delayed payment of claims citing obscure clauses in policies, forcing policyholders into protracted and expensive legal battles just to receive legitimate and rightful claims.

Insurance companies have used Social Security data to cut off annuity or retirement payments upon a policyholder's death, but they haven't stopped collecting premium payments in the meantime. And just last week, we learned about Wells Fargo forcing unwanted insurance on auto loan borrowers without their knowledge since at least 2012 through a process known as, "force-placed insurance."

I spent a couple of decades as Connecticut's Attorney General, and I saw all kinds of fraudulent schemes and the stories and testimonies about misleading and sneaky insurance companies from Americans across my state in Connecticut, ought to be of tremendous concern because at the end of the day, what insurance companies have that's most important to them is their credibility and their reputation for honesty. And these kinds of instances, even if they are a handful, cost literally millions, tens of millions, of dol-

lars to ordinary consumers, and they give the vast majority of insurance companies and brokers and agents a bad name.

And I want to hear today from industry and consumer advocates about how we can hold insurance companies accountable for any misleading or unfair action. I hope that today's hearing is the beginning, not the end, of this inquiry.

And again I thank the Chairman for having us all together today. And I will be—I've read your testimony. I'm going to be leaving for your testimony because I have a Judiciary Committee meeting, but I'll be back for the questions.

I apologize for my absence, Mr. Chairman.

Senator MORAN. Senator Blumenthal, thank you for your cooperation. We look forward to your return. I'll introduce the witnesses, and we'll take their testimony.

Our panel consists of the following: The Honorable John Doak, who is the Oklahoma Insurance Commissioner, and he is here testifying on behalf of the National Association of Insurance Commissioners; Mr. Dennis Jay, Executive Director, Coalition Against Insurance Fraud; Mr. Sean Kevelighan, Chief Executive Officer, Insurance Information Institute; Mr. Tim Lynch, Director of Government Affairs, National Insurance Crime Bureau; and Ms. Rachel Weintraub, General Counsel, Consumer Federation of America. Thank you all for being here today.

We'll begin with you, Commissioner Doak. Senator Inhofe intended to introduce you today. He is unable to be with us this morning. He had prepared some remarks of introduction, and I will make those a part of the record. We now turn to you for your testimony.

STATEMENT OF HON. JOHN D. DOAK, INSURANCE COMMISSIONER, STATE OF OKLAHOMA, ON BEHALF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mr. DOAK. Thank you very much.

Good morning, Chairman Moran, Ranking Member Blumenthal, and members of the Subcommittee. I appreciate the opportunity to testify to provide state insurance regulators' perspective on insurance fraud trends and our efforts to reduce and deter this activity.

Insurance is an attractive target for fraud because detection can be challenging. Unlike bank or credit card accounts, consumers do not frequently interact with insurance policies. Premiums are typically paid annually, and claims are filed only upon injury, death, or damage to one's property. With consumers and business spending over $2 trillion on insurance per year with infrequent interactions, tempting windows of opportunity are created for criminals. Some estimate insurance fraud costs between $80 billion to $100 billion annually across all lines of insurance. Ten percent or more of the property/casualty insurance claims may be fraudulent.

State insurance regulators are tracking several current trends in insurance fraud. For example, state insurance departments have seen contractor and adjustor fraud occurring after natural disasters. In these instances, contractors or insurance adjusters require advanced payment from consumers for services or advance assignment of insurance policy benefits and then disappear without ever doing the work. In cases where repairs were made, the contractor

does shoddy work using substandard materials. In Oklahoma, my department's Anti-fraud Unit deploys after disasters to assess damage and educate consumers about fraud prevention. Here's a photo of myself and Governor Fallin and state legislators with our anti-fraud unit after a recent tornado in Elk City, Oklahoma.

[Photo shown of Mr. Doak with Governor Fallin]

We've also seen a scam where strangers offer to replace vehicle windshields, claiming it's unsafe and the insurance will cover the cost. Even though the windshield is undamaged, the fraudster replaces it, files a claim on the individual's policy, and not only is the work unnecessary and the claim fraudulent, but the replacement windshield may not be installed correctly, leading to serious safety risk.

Last, state insurance regulators are seeing an increase in fraudulent activity in the health care sector, such as prescription drug and medical equipment scams, including unjustified claims and identity theft. These trends are deeply troubling, which is why fighting insurance fraud is one of the highest priorities of state insurance regulators. We initiate inquiries on suspected fraud acts, and we have the authority to conduct exams to investigate. Many of the state bureaus possess law enforcement powers and may have civil authority to impose fines.

State insurance regulators work with insurers and their special investigation units to address suspected fraud and ensure that they are complying with state fraud prevention statutes. As part of our anti-fraud efforts, state insurance regulators formed an Antifraud Task Force in the 1980s to coordinate this work. I serve as the current Chair. In this task force, the states review fraudulent insurance activities, discuss national trends, address concerns related to insurance agent fraud and unauthorized insurance sales. We also engage with consumers and insurers to address anti-fraud issues.

The NAIC created the Online Fraud Reporting System through which consumers and insurers can report suspected fraud to insurance departments. This provides consumers and insurers one central portal to report suspected fraud. A report made against an insurer or intermediary is delivered to all states in which they do business.

In addition, the Task Force is evaluating sources of anti-fraud data and looking at ways to improve the exchange of information among regulators, law enforcement, insurers, and anti-fraud organizations. The Task Force is developing uniform fraud referral requirements that would require companies to submit data relating to suspected fraud to insurance departments.

Finally, we engage in efforts to educate consumers regarding insurance fraud. The NAIC has consumer resources, including its "Fight Fake Insurance" program, which encourages, "Stop, Call, and Confirm," the insurance agent and the company to make sure the insurance agent and company are properly licensed before buying coverage.

In conclusion, as insurance fraud continues to develop, the state regulators will remain vigilant. We continue to adapt strategies that prevent and detect fraud in order to protect consumers and maintain insurers' financial health.

Thank you, sir, for the opportunity to be here. And we'd be pleased to take your questions at the appropriate time.

[The prepared statement of Mr. Doak follows:]

PREPARED STATEMENT OF JOHN D. DOAK, INSURANCE COMMISSIONER, STATE OF OKLAHOMA, ON BEHALF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Introduction

Chairman Moran, Ranking Member Blumenthal, and members of the Subcommittee, thank you for the invitation to testify today. My name is John Doak. I am the elected Insurance Commissioner for the state of Oklahoma and I present today's testimony on behalf of the National Association of Insurance Commissioners (NAIC).[1] I serve as the Chair of the NAIC's Antifraud Task Force as well as its Property and Casualty Committee. On behalf of my fellow state insurance regulators, I appreciate the opportunity to provide an overview of our efforts to detect, investigate, and prevent insurance fraud.

Insurance is an essential part of the financial services sector, a fundamental pillar of our economy and vital for the well-being of our citizens. It is a means of protection against damage to property or loss of life, and is at the core of the risk management strategies of consumers and businesses. Insurance can be an attractive target for fraud because detection can be a challenge. Unlike other financial products, particularly bank or credit card accounts, which consumers access weekly or even daily, consumers do not interact with their insurance policies with the same frequency—premiums are generally paid monthly or annually and claims are filed only upon the occurrence of an insured event such as injury, death, or damage to one's property. Consumers and businesses spend more than $2 trillion on insurance per year, and the relatively infrequent interactions between consumers and many of their policies creates tempting windows of opportunity for criminals. The prevalence of insurance fraud costs an estimated $80–100 billion dollars annually across all lines of insurance and industry estimates that 10 percent or more of property-casualty insurance claims alone may be fraudulent. Insurance fraud inflicts significant financial and personal damage on consumers and imposes additional costs on insurance companies that can be passed along to policyholders in the form of higher premiums.

Reducing and deterring fraud is a priority for state insurance regulators, whose antifraud activities aim to protect consumers and maintain insurers' financial health. The state insurance regulatory response to insurance fraud is multifaceted, involving consumer education and information, reporting and prevention, investigation, and corrective action.

State Insurance Regulators' Efforts to Fight Fraud

Fighting fraud is an important aspect of state insurance regulation. States combat insurance fraud through special fraud bureaus that are charged with identifying fraudulent acts, investigating cases, and preventing insurance scams. Thirty-one states and the District of Columbia have fraud bureaus housed in their insurance department[2] while eleven states have bureaus housed in their attorney general's office, law enforcement agencies, or another regulatory entity. Other states address insurance fraud through their market conduct, consumer affairs, or legal divisions. Many state fraud bureaus possess law enforcement powers and may also have civil authority to impose fines. State fraud bureaus initiate independent inquiries and conduct investigations on suspected fraudulent insurance acts. They also review reports or complaints of alleged fraudulent insurance activities from federal, state and local law enforcement and regulatory agencies, persons engaged in the business of insurance, and the public to determine whether the reports require further investigation and to conduct these investigations. State fraud bureaus regularly conduct independent examinations of alleged fraudulent insurance acts and undertake studies to determine the extent of these acts. States can also access the NAIC's Regu-

[1] The NAIC is the United States standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. Through the NAIC, we establish standards and best practices, conduct peer review, and coordinate our regulatory oversight. NAIC members, together with the central resources of the NAIC, form the national system of state -based insurance regulation in the U.S.

[2] California, Connecticut, Louisiana, Maryland, and Oklahoma also have fraud bureaus in their state attorney general's office. Louisiana also has a fraud bureau in their state law enforcement agency.

latory Information Retrieval System (RIRS), which contains all final adjudicated actions taken and submitted by state insurance departments. This information typically includes administrative complaints, cease and desist orders, settlement agreements and consent orders, and license suspensions or revocations. Since 2007, there have been more than 96,000 adjudicated actions submitted by the states into RIRS. States can receive alerts through this system.

State insurance regulators work with insurers and their special investigation units (SIUs) to address suspected fraud. The SIUs are divisions within insurers to investigate insurance fraud and usually consist of former law enforcement or claims employees turned investigators. Insurers' SIUs must comply with the *NAIC Insurance Fraud Prevention Model Act* (#680) or similar state fraud prevention statutes. This model act creates a framework to help state insurance regulators identify, investigate, and prevent insurance fraud and provides guidance on how to assist and receive assistance from other state, local and Federal law enforcement and regulatory agencies in enforcing laws prohibiting fraudulent insurance acts. Further, the *NAIC Antifraud Plan Guideline* (#1690) establishes standards for SIUs regarding the preparation of an antifraud plan to meet state insurance department requirements. By conducting an audit or inspection, or by reviewing an insurer's antifraud plan in conjunction with a market conduct examination, state insurance regulators help ensure an insurance company is following its submitted antifraud plan.

NAIC Antifraud Initiatives

As part of state insurance regulators' efforts to help fight the growing problem of insurance fraud, the NAIC formed an Antifraud Task Force in the 1980s. Through this task force, states coordinate efforts to review issues related to fraudulent insurance activities and schemes; address national concerns related to insurance agent fraud and unauthorized insurance sales; educate consumers about insurance fraud; maintain and improves electronic databases regarding fraudulent insurance activities; and disseminate research and analysis of insurance fraud trends to the insurance regulatory community. The Task Force also serves as a liaison between insurance regulators, law enforcement and other antifraud organizations, and coordinates with state and Federal securities regulators.

Data collection and information-sharing are critical to our antifraud efforts. Through the NAIC, state insurance regulators created the Online Fraud Reporting System (OFRS), through which consumers and insurers can electronically report suspected fraud to the appropriate insurance department. By using this system, consumers and insurers have one central, online portal to report suspected fraud to one or more states. A report made in OFRS against an insurer or intermediary is delivered to all states in which the insurer or intermediary does business. Since its inception in 2005, there have been more than 685,000 reports of suspected fraud received through OFRS.

In addition, the Task Force is undertaking an initiative to evaluate sources of antifraud data and propose methods for improving the exchange of information among insurance regulators, law enforcement officials, insurers SIUs, and other antifraud organizations. The Task Force is developing uniform insurance fraud referral requirements for insurers to submit suspected insurance fraud data to state insurance departments. We are collecting information from the states in order to develop these requirements. Task Force members also continue to develop new and update existing seminars, trainings and webinars for regulators regarding insurance fraud and relevant trends, and efforts to combat fraud.

The NAIC and state insurance regulators also play an important role in educating consumers. The NAIC has a robust communications effort in place through its consumer alerts and Insure U public education program to assist consumers with navigating the complexities of insurance. The NAIC website provides tools to help consumers avoid being scammed. The NAIC's "Fight Fake Insurance" program was developed to protect consumers from insurance fraud by encouraging them to "Stop, Call, Confirm" that the individual insurance agent and company are properly licensed by their state insurance department before buying coverage. In my home state of Oklahoma, my department leads a series of Senior Fraud Conferences throughout the year focused on educating and protecting seniors regarding Medicare fraud and other types of financial fraud. In 2017, we held seven conferences with approximately 500 attendees statewide.

Coordination with Federal Government and International Partners

In addition to our work with insurance consumers within our own states, state insurance regulators collaborate with our Federal and international colleagues to address insurance antifraud issues. State insurance regulators work with the U.S. Department of Treasury and other financial regulators on Anti-Money Laundering

(AML) initiatives as well as initiatives to combat the financing of terrorism (CFT), which can involve permanent life insurance, annuities, and other products with cash value or investment features. While the Treasury Department's Financial Crimes Enforcement Network (FinCen) has primary responsibility in this arena, state regulators coordinate with FinCen and monitor insurer activities to make sure they are not engaging in these activities and are not susceptible to those acts. To cooperate and facilitate the sharing of information, state insurance departments and FinCen have established Memorandums of Understanding and insurance regulators notify appropriate Federal regulators if an insurer is not in compliance with AML/CFT requirements.

With regard to health care, the NAIC and state insurance regulators participate in the Centers for Medicare and Medicaid Services' (CMS) Healthcare Fraud Prevention Partnership (HFPP), a voluntary public-private partnership between the Federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations. The HFPP aims to foster a proactive approach to detect and prevent healthcare fraud through data and information sharing.

On the international front, the NAIC actively participates in the International Association of Insurance Supervisors' (IAIS) Financial Crime Task Force to addresses supervisory practices and issues surrounding fraud, anti-money laundering/combatting the financing of terrorism, and cyber risks.

Current Insurance Fraud Trends

Through our interactions with our state and Federal regulatory and law enforcement counterparts, we are seeing some disturbing insurance fraud trends, including:

- *Contractor/adjuster fraud following natural disasters:* State insurance departments have seen a number of instances of contractor and adjuster fraud recently that have occurred immediately after floods, tornados, and other natural disasters. Contractors or insurance adjusters have required advance payments from consumers for services or advance assignment of insurance policy benefits. In these cases, the contractors sometimes disappear without ever doing the work. In other cases where repairs are made, the contractor engaging in this conduct does substandard work using substandard materials. In Oklahoma, my department's antifraud unit deploys to disaster areas to assess damage and to educate consumers about potential fraud and how to avoid it. They will place yard signs in affected areas with our consumer hotline so consumers know how to get help with insurance issues and go door to door to speak to impacted individuals.
- *Medical equipment scams on seniors and identity theft:* In this scam, seniors receive unsolicited calls from scammers who insist that the seniors have an urgent need for medical equipment and claim Medicare or Medicaid will pay for the equipment at no cost to them. The personal information provided by the victim is then used to file unjustified claims and for other fraud schemes, such as identity theft.
- *Opioid abuse/insurance scam:* As a result of the growing opioid epidemic, state insurance regulators are seeing an increase in fraudulent prescription scams to capitalize on this surge in addiction. Some corrupt medical professionals are unlawfully and overly prescribing opioids, while billing the costs to insurance companies. "Pill mill" doctors that overly prescribe pills without medical justification run clinics in which they give patients opioid prescriptions, typically for cash, with few questions asked. This scheme allows patients to easily obtain opioids in order to sell or misuse them.
- *Automotive windshield replacement scams:* State insurance departments are seeing a rise in a scam whereby a stranger at a car wash, a parking lot attendant, or valet parking service offers to repair or replace a vehicle owner's windshield. The fraudster claims the windshield is unsafe and says that insurance will take care of the entire cost. Even though the windshield is perfectly fine, the fraudster replaces the windshield and files a claim on the individual's policy. Not only is the work unnecessary and the claim fraudulent, the replacement windshield may itself be defective, may not be a correct fit or may not be installed correctly, which can then lead to serious safety risks.
- *Life insurance fraud:* State insurance departments are also seeing a rise in the tragic case of parents or guardians taking out a life insurance policy on their child and then murdering them for the payout. State insurance departments are currently working diligently on ways to tighten insurers' underwriting procedures and assist local law enforcement by closely monitoring and possibly preventing the sale and issuance of such policies.

These examples are a few of the recent trends that we have observed, but other fraudulent scams have been around for some time, such as staged auto accidents with the resulting fraudulent automotive and medical claims, faked workers compensation claims, and arson by homeowners.

Conclusion

As insurance fraud continues to evolve, state insurance regulators remain vigilant in our efforts to combat fraud and work with relevant stakeholders to address critical concerns. Our fight against insurance fraud never stops and state insurance regulators continue to adapt our strategies to prevent, detect, and investigate such schemes to protect consumers and support insurers' financial health. We appreciate the subcommittee's focus on this important issue and the opportunity to be here on behalf of the NAIC, and I look forward to your questions.

Senator MORAN. Thank you very much for your testimony.

Now, Mr. Jay.

STATEMENT OF DENNIS JAY, EXECUTIVE DIRECTOR, COALITION AGAINST INSURANCE FRAUD

Mr. JAY. Chairman Moran, members of the Committee, thank you for holding this hearing on an important issue that virtually affects every consumer and business in America. My name is Dennis Jay, and I am Executive Director of the Coalition Against Insurance Fraud. We were founded 24 years ago as a national broad-based alliance of the major stakeholders in the fight against fraud, and that includes consumers, government agencies, and insurance companies. And, in fact, the four organizations represented at the table today all had a hand in founding our organization, particularly so with Consumer Federation of America.

Our mission is to unite the forces in combating insurance fraud, while we also are involved in legislative advocacy on the state level, empowering consumers to help fight fraud, as well as conducting meaningful research.

Mr. Chairman, as you said in your opening remarks, overall, insurance fraud in property/casualty specifically, continues to be a drain on consumers and businesses in this country to the tune of tens of billions of dollars each year. And it's committed by organized rings, by professionals, such as medical providers and lawyers, insurance agents, by home contractors, by body shops, as well as everyday Americans, our friends, coworkers, and neighbors.

The schemes go beyond just inflating insurance claims. Some of them can leave businesses and consumers in financial ruin, some can injure and even kill innocent consumers. Our submitted statement includes a comprehensive list of these scams and some of the ways that the fraud-fighting community is looking to counter them.

During the last 20 years, property/casualty insurers have helped counter the growing threat by establishing investigation units within their company and investing heavily in training and in technology. And on that last point, the sharing of claims data by these insurance companies has been absolutely essential in helping to detect fraud, especially some of the schemes by these organized criminal enterprises that are defrauding billions of dollars.

I would also like to mention that the property/ casualty industry also participates in the successful Healthcare Fraud Prevention Partnership. This is a collaborative effort in which Medicare, Medicaid, TRICARE, the VA, private health plans, and others share data and intelligence on crooked medical providers. And to date,

this effort, this public-private partnership, has saved over $300 million. And we just will continue to see good things from them in the future.

However, the property/casualty insurers are not allowed to access or to contribute to the data in this rich pool of anti-fraud information because of restrictions in HIPAA, and that's a shame because we know that some of the fraudsters that are ripping off property/casualty insurers are also defrauding Medicare and Medicaid, and vice versa. And I know it's beyond the jurisdiction of this Committee, but at some point, I hope Congress will take a look at that, and maybe we can resolve it at some point.

On the state level, following up on Commissioner Doak, state legislatures really have come to the table and have enacted some very responsible anti-fraud initiatives. To date, all states but two have enacted specific fraud statutes to define insurance fraud and set penalties.

Thirty-eight states have established anti-fraud units that investigate and prosecute insurance fraud. Many of them have police powers. And some of them have prosecutors within their departments that specifically only do insurance fraud, and that has really done a lot to help over the last few years.

There is a high level of collaboration between these state agencies and insurance companies in fighting fraud, and that in part is spurred because most states do require insurance companies to report fraud and to sponsor active anti-fraud programs within the companies.

However, after 20 years of increasing efforts to combat fraud, we're convinced that we're never going to arrest or convict our way out of this problem. More focus has to be on prevention and deterrence of insurance fraud. And public outreach programs, again like the Commissioner mentioned, have been vital in helping to alert consumers about some of the scams that can impact them, and also help otherwise honest people understand that there's a high price to pay for committing insurance fraud. And the research that we've done and others have done demonstrates that these programs are powerful in helping to stop fraud, and we need many more of them.

We use social media to try to engage consumers directly and, again, help to educate them about some of the scams, but also we see on social media that people brag about committing insurance fraud. Some actually use social media, Facebook, and Twitter, to solicit others to help them execute scams. We communicate with them, too, and hopefully we'll have an impact on that.

So at a time when the acceptance of unethical behavior seems to be increasing across the country, it's important that we have strategies that help to counter some of these trends.

So in conclusion, while I think we've come a long way in recent years, insurers, state governments, even the Federal Government, in combating fraud, and we need to be proud of that, we need to understand we're still a long ways away of turning the corner on insurance fraud. But we feel through continued collaboration and perhaps some of these prevention and deterrence efforts, we'll continue down the path of curbing insurance fraud and the associated costs to help save all Americans some money.

Thank you.

[The prepared statement of Mr. Jay follows:]

PREPARED STATEMENT OF DENNIS JAY, EXECUTIVE DIRECTOR, COALITION AGAINST INSURANCE FRAUD

Mr. Chairman, members of the Committee. My name is Dennis Jay and I am Executive Director of the Coalition Against Insurance Fraud. I commend you for holding this hearing and shedding light on an issue that affects virtually every consumer and every business in the United States.

The Coalition Against Insurance Fraud was founded 24 years ago as a national, broad-based alliance of major stakeholders in the fight against fraud—specifically consumers, government agencies and insurance companies. More than 150 mostly national organizations belong to our coalition.

Our mission is to help unite the forces working to combat fraud while focusing on legislative advocacy in the states, empowering consumers and conducting meaningful and useful research. The Coalition seeks to curb fraud in all lines of insurance no matter who may be a victim or a perpetrator.

We have successfully helped enact anti-fraud legislation in more than 20 states with what we call "balanced bills." This means they not only include criminal and civil penalties for defrauding insurers, but also include sanctions against people in the insurance industry who defraud consumers.

Fraud is committed by organized fraud rings, by professionals such as medical providers, lawyers and insurance agents, by home contractors and auto body shops as well as everyday Americans—our neighbors, friends and co-workers. Our research suggests this is an equal-opportunity crime committed by people of all ages, income levels, races, gender sand education levels. Most Americans admit to knowing someone who has committed insurance fraud.

Today, we would like to provide background on the impact and cost of insurance fraud in the United States and give you an update of the state of the fraud fight in property/casualty insurance.

Fraud involving automobile insurance, homeowners coverage and commercial insurance continues to be a drain on consumers, businesses and society in general. No one knows the total cost of insurance fraud because of the hidden nature of the crime. The data the Coalition analyzes from insurers, government agencies and others suggest insurance fraud costs tens of billions of dollars each year. This expense creates

hardships for low and middle-income consumers who are forced to pay an annual "fraud tax" on premiums for car and home insurance—as well as a built-in cost on every good and service.

Additionally, some scams injure and even kill innocent consumers. Businesses also suffer when they can ill-afford workers compensation insurance because of rising premiums due to fraud. Left unchecked, this can also cause an ever-increasing spiral as others become more tempted to commit insurance fraud as premiums continue to climb.

Types of insurance fraud.

Insurance fraud is one of the most eclectic crimes in America. Types of fraud include:

Automobile—staged crashes. Perpetrators can include runners, who coordinate the scams, drivers, passengers, lawyers and medical providers. Scammers intentionally cause cars to collide—sometimes with innocent motorists—to file fake damage and medical claims. This type of fraud is most severe in states that have no-fault automobile insurance. Lives are jeopardized when innocent motorists are maneuvered into car crashes staged by crime rings to collect large injury payouts from auto insurers. A family of three burned to death when a setup crash went awry after their car was hit by two large trucks on a California freeway. A grandmother in Queens, N.Y. died when her car went out of control after she was maneuvered into a staged crash. One organized ring in New York City collected more than $279 million in false claims through a network of chiropractors, lawyers and staged crash coordinators.[1]

In many cases, medical clinics in these scams are secretly owned by organized rings, employ a licensed physician to front for them and offer no real medical services. The tactics by many of these organized fraud rings can change quickly as insurers and government investigators focus on their scams. One day they may be in-

[1] *"Colossal crash ring in permanent reverse," http://www.insurancefraud.org/article.htm ?RecID=3453,* December 23, 2015

volved in bogus chiropractic care; and the next they are billing for questionable medical procedures or useless nerve testing.[2] Additionally, motorists with real injuries may be subject to useless template treatment that does nothing to alleviate their injuries, and may enhance their injury.

Automobile—padding/false claim. This usually occurs by a consumer, a body shop or glass-repairs facility that pads damage on an existing automobile claim, or submits a bill for unnecessary work or work not done in connection with an auto accident. In some cases, body shops will intentionally inflict more damage after the vehicle has been towed to their facility in order to increase their profits. Repairs may be substandard or haphazard, placing unsafe vehicles back on the road.

Automobile—give-up. Give-ups involve falsely reporting a vehicle stolen when it actually is hidden, shipped overseas, repossessed, dumped in a body of water, buried or burned. Perpetrators can include car owners and the people they hire to get rid of their vehicles. This crime is more severe during economic downturns when people feel they can no longer afford monthly auto payments or they are "underwater" on their loans. One factor that seems to encourage this fraud is longer loan terms (five and six years), when the loan balance is greater than the value of the vehicle. High gas prices also are a factor, especially of gas guzzlers, such as SUVs. Give-ups and can include motorcycles, recreational vehicles, boats and even farm equipment.

Automobile—underwriting. Underwriting fraud in auto insurance includes lying on an application to reduce premium or gain coverage that one wouldn't otherwise be qualified to obtain. Deceptions can include untruths about driving record, miles driven, where the car is garaged, and number and age of drivers in household. Auto underwriting fraud is also called rate evasion. This type of fraud causes the insurance rates of honest people to increase in order to subsidize either the increased risk presented or the accidents of the people who cheat.

Rate evasion has increased in recent years as more people purchase insurance online rather than by telephone or in person through an insurance agent. One version of this scam is the "crash and buy" scheme. Motorists who fail to purchase auto insurance get in accidents and then buy coverage and lie, claiming the accident occurred post-purchase.

Business—arson. Owners or operators who burn down or hire someone to torch a business, which is usually failing, for profit. Arson is more frequent during economic downturns. Cases have included building owners of occupied houses and apartments. In some cases, fire has spread to adjacent businesses and homes that also destroy these structures, placing lives and jobs at risk. This type of insurance fraud spans all socio-economic levels. Sadly, every year first-responders such as fire fighters die from battling intentionally-set fires.

Business—padding/faking. This type of fraud includes inflating a legitimate claim, or faking a theft or damage claim on a business. A classic case is inflating the value of inventory after a fire or flood.

Contractor fraud. Home contractors can defraud both insurers and consumers, from doing shoddy work to stealing claims payments. During natural disasters, unlicensed contractors from out of state are especially prone to committing fraud. Documented cases include contractors causing added damage to roofs and siding to billing the insurer for repair work.

Drug diversion. The opioid crisis affects property/casualty insurance as well as health insurers. Drug diversion includes the prescribing, distribution, selling, acquiring or using legal prescription drugs for illegal or illicit purposes. It is committed when patients addicted to painkillers and other prescription drugs illegally receive drugs from doctors, pharmacists, and street dealers. Physicians and pharmacists commit drug diversion when they knowingly prescribe and dispense painkilling drugs for no legitimate medical reason. Property/casualty insurers face these scams when they reimburse claimants and medical providers who treat auto accident victims, premises liability and workplace injuries.

Homeowners—arson. This includes burning a home that is either owned or rented to profit from claimed payments. Perpetrators can include home and business owners and the people they hire to commit the arson. Organized rings in major urban centers also have bought run-down homes, over-insured them and then set them on fire. One ring in South Florida was caught after photos of the same singed furniture kept showing up in claims for different house fires.[3]

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[2] *Scammers evolve tactics for medical equipment, sham clinics, nerve tests,* Robert A. Stern and James A. McKenney, *Journal of Insurance Fraud in America,* April 2017.

[3] *"Smoking Out Insurance-Arson Rings Earns Laura Uriarte Prosecutor Of Year Award,"* news release, January 12, 2017.

Homeowners—padding/faking. This includes inflating a legitimate theft or damage claim on a home or apartment. Sometimes fake receipts are used to inflate claims. Another common scheme is reporting a false burglary claim.

Fraud by insurance agents. Dishonest insurance agents and brokers defraud consumers by failing to remit their premiums to insurers, and sometimes by selling fake policies backed by no insurer. This type of fraud can leave consumers in financial ruin if they experience a major loss, such as a home or business fire or a large liability lawsuit.

Fraud by insurance company employees. Most criminal cases include claims-check diversion by claims adjusters who collude with a legitimate or fake claimant. Company employees also manufacture claims, manipulating the claims system. There also have been rare cases of insurance executives who loot companies and jeopardize the ability to pay claims. Some fake companies also have sold bogus coverage and have no wherewithal to pay claims. Often these criminals use the names of legitimate insurers to fool insurance buyers.

Liability—false claim. Grocery stores, restaurants, other businesses and homeowners face false claims by people who fake injury on their property. "Slip and falls" can result in large payouts to injured victims and their lawyers. In some cases, people have falsely claimed they found rodents, glass and severed fingers in food ordered in restaurants.

Fraud by public adjusters. Unlike adjusters who work for insurance companies, public adjusters are allowed to represent claimants in many states. They are paid a percentage of the final claims payment. Thus they have an incentive to illegally inflate the claims payment as high as possible, sometimes illegally by manufacturing losses. Crooked public adjusters can collude with attorneys and contractors to increase losses cause by water damage, fire and other perils.

Workers compensation fraud by workers. This fraud includes workers who fake injuries, refuse to go back to work after they heal, or have a side job while still collecting benefits. It is often encouraged by lawyers and medical providers who profit the more severe the injury and the longer the employee is off the job. During the 2008–2010 recession, solicitors were stationed outside of unemployment offices to encourage recently laid-off workers to file false injury claims.

Workers compensation fraud by employers. These scams occur when a business lies about how many employees it has, the types of jobs workers do, and their overall workers compensation claims experience. It is especially prevalent in the construction industry, where builders may employ undocumented workers off the books. Large businesses can saves hundreds of thousands of dollars in annual workers compensation premiums by committing underwriting fraud. The money they save can be used to underbid their honest competitors on construction bids. Organized rings also help businesses commit fraud by "renting" them shell corporations to use to buy coverage and fool insurers.[4] Employee leasing schemes and the practice of declaring employees as independent contractors both are prevalent in workers compensation rate-evasion fraud.

Workers compensation fraud by medical providers. The no-fault system of treating and compensating injured workers has generally worked well since its creation in the early 20th century. However, the no-fault aspect of the system appears to be an open invitation for dishonest medical providers to exploit injured workers and plunder the system. Schemes includes billing for services not rendered or needed, including chiropractic care, diagnostic tests and prescription drugs. In California alone, medical fraud in the workers compensation system costs multiple billions of dollars each year.

Anti-fraud efforts by industry

During the last 20 years, property/casualty insurers have helped counter the growing fraud threat by establishing investigation units, and investing in training and technology. In 2016, nearly three-quarters of insurers were deemed to be fully engaged in using anti-fraud technology to better and more quickly detect fraud.[5] Property/casualty insurers also support organizations that provide training and credentialing programs for investigators and claims personnel.

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[4] *"Shell games: How construction cons steal workers-comp premiums,"* by David M. Borum and Geoffrey R. Branch, *Journal of Insurance Fraud in America,* February 2017

[5] *"The State of Insurance Fraud Technology,"* Coalition Against Insurance Fraud, November, 2016.

Increasingly, insurers have resorted to civil lawsuits against medical providers to return payments from fraudulent claims, and to send a message that fraud won't be tolerated.[6]

The sharing of claims data among property/casualty insurers has proven to be instrumental in detecting suspected fraud, especially by organized rings. Property/casualty insurers also participate in the successful Healthcare Fraud Prevention Partnership (HFPP).[7] This collaborative effort is a forum for Medicare, Medicaid, Tricare, private health plans and others to share intelligence about schemes by medical providers who cost taxpayers and insurance buyers tens of billions of dollars each year. Government health programs and private health plans are allowed to pool and access data on suspect medical providers. This effort has uncovered dozens of schemes, and has so far saved nearly $300 million.

However, property/casualty insurers are not allowed to share or access HFPP data because of restrictions of the Health Insurance Portability and Accountability Act (HIPAA). The Coalition views this restriction as a lost opportunity: Research shows that many medical providers who defraud property/casualty insurers also file false claims against government programs, and vice versa.

Anti-fraud efforts of government

During the last 20 years, state governments have responded positively to what they see as the growing threat of insurance fraud. All states but two (Oregon and Virginia[8]) have enacted specific insurance fraud statutes to define fraudulent acts and set penalties. Additionally, 38 states and the District of Columbia have established specific agencies to investigate and prosecute insurance fraud. Most of these state agencies have police powers, and several employ prosecutors to exclusively deal with insurance fraud cases.

In many states, such as California, Florida, New Jersey and New York, insurance fraud bureaus are full law-enforcement agencies with hundreds of investigators employed in their units.

Together, state insurance fraud bureaus receive some 150,000 referrals each year about incidents of insurance fraud. Referrals are received from insurers, consumers and other law-enforcement agencies.

There is a high level of collaboration and cooperation among these state agencies and insurers in investigating and prosecuting fraud. A total of 43 states require insurers to report cases of suspected fraud. Several also require insurers to sponsor internal investigation units and provide training.

At least a half-dozen fraud bureaus also sponsor advisory committees to gain feedback and intelligence from stakeholders in the state, and to discuss ongoing anti-fraud efforts. The Coalition Against Insurance Fraud currently serves on five of those advisory panels.

In addition to referring cases for criminal prosecution, several fraud bureaus also have authority to take lower-level cases on an administrative and civil basis.[9]

Other efforts to counter fraud

Efforts by insurers and government agencies to detect, investigate and prosecute insurance fraud is vital to curbing these costly crimes. However, after more than 20 years of increasing efforts to combat fraud, it's clear our Nation will never arrest or convict its way out of insurance fraud.

No one knows what percentage of insurance fraud is detected. Informal surveys of insurers suggest it may be anywhere from 20 to 50 percent. Only a small percentage of those cases is ever opened for investigation by law enforcement agencies, and even a smaller percentage is ever adjudicated.

In recent years, more efforts have focused on prevention and deterrence. Public outreach messages help convince otherwise honest consumers that they will a high price for cheating on insurance.[10]

Research by the Coalition Against Insurance Fraud and others suggests that this strategy is helping to reduce fraudulent claims and encourage consumers to report fraud. The Coalition also has adopted a strategy of communicating directly with con-

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[6] *Insurer success in suing fraudsters expected to increase civil actions,"* Duane Morris Health Law, February 17, 2015

[7] Healthcare Fraud Prevention Partnership website, *https://hfpp.cms.gov/*

[8] While Virginia does not have a specific insurance fraud statute, it does have an insurance fraud bureau housed within the state police.

[9] *"Un-civil civil penalties can thwart fraudsters,"* by Howard Goldblatt, April 20, 2017, *https://www.insurancefraud.org/blog/apr-2017/un-civil-civil-penalties-can-thwart*

[10] *Social-marketing campaigns taking on small-time crimes,* by Virginia Roth and Bernard Host, *Journal of Insurance Fraud in America,* January 2016. *https://www.insurancefraud.org/jifa/jan-2016/social-marketing-campaigns-taking-o*

sumers through social media about insurance fraud issues, especially about schemes that target consumers, such as staged accidents, fake airbags, contractor fraud, dishonest insurance agents and medical ID theft. The use of Facebook,[11] Twitter[12] and other social-media outlets helps educate consumers about fraud, empowers them to avoid being scammed, and reduces their tolerance of this crime. Users of social media sometimes brag about the fraud they have committed and solicit others for help in executing scams.

At a time when the acceptance of unethical behavior seems to be increasing in our nation, it is important to have strategies in place that will counter this negative trend.

In conclusion

Insurers, state governments and the Federal government are light years away from where they were just twenty years ago in seeking to curb insurance fraud in the U.S. However, we still have a long way to go before we turn the corner on this crime. The Coalition Against Insurance Fraud is confident, however, that through continued collaboration, and though efforts to deter and encourage vigilance by all stakeholders, we will continue down the path of reducing the high costs of insurance fraud.

Senator MORAN. Mr. Jay, thank you very much.

Now, Mr. Kevelighan.

STATEMENT OF SEAN KEVELIGHAN, CHIEF EXECUTIVE OFFICER, INSURANCE INFORMATION INSTITUTE

Mr. KEVELIGHAN. Thank you very much, Chairman Moran, Ranking Member Blumenthal, and Committee members. I appreciate the opportunity to address you here today about current issues facing the insurance industry and consumers when it comes to insurance fraud in America.

My name is Sean Kevelighan. I'm Chief Executive Officer of the Insurance Information Institute. We are an industry-funded organization that has been at work for over 50 years. Our job is to, and our mission is to, explain what insurance does and how it works to consumers, public policy members, and members of the media as well.

Our members are primarily property and casualty, P&C, insurers, although 70 percent of our members also offer life insurance solutions.

Today, I will focus on fraud trends P&C insurers are seeing and how insurers and consumers can protect themselves against these crimes.

As economic first responders, P&C insurers paid out more than $327 billion in 2015 to settle claims. Many of these were to auto repair companies as well as building contractors, and this will undoubtedly be the case in 2017.

Insurance companies recognize the overwhelming majority of claims they receive are legitimate, and in those cases, the claims are paid out promptly. In fact, in the U.S., the consumers are recognizing them. Home insurers this year, from J.D. Power, received their highest rankings ever.

The relationship between insurers and consumers is one of trust. Consumers trust that insurance will help rebuild after catastrophes happen. While the insurer trusts that the reported information provided by the consumer is accurate and honest, unfortunately, whenever there is an incident of fraud, it has damaging con-

[11] *https://www.facebook.com/insurancefraud*
[12] *https://twitter.com/insurance_fraud*

sequences for the consumer and the insurance company. In fact, Deloitte estimated in 2012 that P&C insurers paid out as much as $30 billion, nearly 10 percent of all claims, for fraud.

Such claims create an additional cost, which insurers must factor into their underwriting and administration, resulting in all consumers having to pay higher premiums. This, in essence, puts a strain on the trust in the relationship. And for this reason, the insurance industry is dedicated to doing whatever it can to prevent fraud.

Five years ago—since the 5 years that Deloitte released its fraud study, insurers and the state regulatory departments have dramatically improved their fighting efforts, and we're hearing that today. Insurers have allocated additional resources, whether in their special investigation units or extra training, while today, nearly every state department, as we heard from Oklahoma, has in-house fraud bureaus, and they are getting results.

Aside from what we heard here today from California, if you look at the State of California, Commissioner Dave Jones has issued nearly a dozen news releases about insurance fraud cases in his department as either uncovered or worked on. The California cases included fraudulent claims for auto collisions that were either staged or never happened, or dealt with worker compensation claims where the number of employees was misrepresented or that the jobs that they undertook was misrepresented. These frauds drive up the costs.

One of the things that is interesting that P&C insurers are now seeing is how all of these are evolving, and as technology improves, so are the fraudsters improving the ways that they get more sophisticated and commit these crimes. And at the same time, consumers are increasingly wanting to buy their insurance policies from their mobile phones, they want to file a claim through their smartphone via photo. And the question is, How can they verify all this?

Fortunately, this is where the industry is beginning to embrace new technological innovations stemming from big data and artificial intelligence that will help improve delivery of their services to the U.S. consumer and reduce costs.

As we are seeing in so much of our lives, technology and digitalization can help bring benefits to society, in this case, by rooting out unwanted fraud. A report released last month by Boston-based Aite outlined the fact that insurers are recognizing their fraud-fighting efforts must adapt to the criminals and are finding that these efforts are actually creating quite optimistic results, whether through data aggregation, verification, or analyzing the data, and also using artificial intelligence and predictive analytics. The result, insurers are equipping themselves with technology tools they need to neutralize high-tech criminals.

As much as these emerging technologies make a positive impact, there will always be a human element to combating fraud, and that is where the I.I.I. plays a role. Consumers must have the information they need to make prudent financial decisions and to protect themselves from fraudulent activities. The I.I.I. is proud of the role it plays in keeping consumers informed.

Thank you again for the opportunity to speak before you today.

[The prepared statement of Mr. Kevelighan follows:]

PREPARED STATEMENT OF SEAN KEVELIGHAN, CHIEF EXECUTIVE OFFICER, INSURANCE INFORMATION INSTITUTE

Chairman Moran, Ranking Member Blumenthal, and committee members. I appreciate the opportunity to address you today about the current issues facing the insurance industry and consumers when it comes to insurance fraud in America.

My name is Sean Kevelighan and I am the Chief Executive Officer of the Insurance Information Institute (I.I.I.). The Institute is an industry-funded consumer education organization. We explain what insurance does, and how it works, to consumers, the media, and public policymakers.

The I.I.I.'s members include the Nation's largest auto, home, and business insurers. While much of our work focuses on property/casualty "(P/C)" insurers, nearly 70 percent of our members also offer life insurance solutions. Today I will focus on the insurance fraud trends P/C insurers are seeing, and how insurers and consumers can protect themselves against these crimes.

In its role as the U.S.'s economic first-responders, P/C insurers paid out more than $327 billion in 2015 to settle claims. Two years ago, many of these claim payout dollars went to auto repair companies and building contractors. This will undoubtedly be the case in 2017 as well. Insurers provide the capital infusion that allows consumers to recover after an accident, a fire, a windstorm, or another incident that causes either property damage or an injury.

Insurance companies recognize the overwhelming majority of claims they receive are legitimate, and these claims are paid promptly. U.S. consumers also recognize this fact. Indeed, in 2016 U.S. home insurers scored their highest-ever satisfaction rating among consumers who filed a claim, according to a J.D. Power survey. Insurers were given a score of 859 on a 1,000-point scale.

The relationship between insurers and consumers is one of trust. Consumers trust that insurers will help them re-build when catastrophe strikes, while the insurer trusts that the reported information provided by the consumer is honest. Unfortunately, whenever there is an incident of fraud it has damaging consequences for the consumer and insurance company alike. In fact, Deloitte estimated in a 2012 report that P/C insurers paid around $30 billion annually—nearly 10 percent of their total claim payouts—in fraudulent auto, home, and business insurance claims. Such claims create additional costs, which insurers must factor into underwriting and administration—resulting in all consumers having to pay more in premium. This, in essence, puts a strain on the trust relationship. And for this reason, the insurance industry works tirelessly to prevent fraud.

In the five years since Deloitte released its insurance fraud study, insurers and the state insurance departments that regulate them have dramatically improved their fraud-fighting efforts. Insurers have allocated additional resources to their internal Special Investigations Units (SIUs) and expanded their training of claims adjusters to detect fraudulent activity. Moreover, nearly every state insurance department has an in-house fraud bureau. And they are getting results.

For example, California Insurance Commissioner Dave Jones has issued this year alone nearly a dozen news releases on insurance fraud cases his Department either uncovered or worked on. The California cases involved the filing of fraudulent claims for auto collisions that were either staged or never occurred. Others dealt with workers' compensation insurance fraud, such as instances in which employers either misrepresented the number of employees who worked for them or misclassified the jobs the employees undertook. This type of fraud drives up the cost of doing business for a state's employers.

Insurance fraud schemes are, however, always evolving and getting more sophisticated, especially as insurance transactions are increasingly conducted online. Consumers increasingly want to buy insurance policies from their mobile devices, and have their insurance claims paid solely on the basis of the photo they send electronically to their insurer.

But how can insurers verify the identity of the mobile-device user, or the legitimacy of a property damage claim, without having the subject of the claim inspected personally by a claims representative?

This is where the insurance industry's embrace of new technological innovations stemming from big data and artificial intelligence will help improve delivery of their services to the consumer and reduce costs. As we are seeing in so much of our lives, technology and digitalization in insurance can help bring benefits to society; in this case by rooting out unwanted fraud.

In a report released last month, the Boston-based Aite (EYE–TAY) Group outlined the fact that insurers are recognizing their fraud-fighting efforts must adapt to this new era, and found reason for optimism. The Aite Group reports insurers are retaining state-of-the-art vendors, like data aggregators, producers, and receivers and then analyzing this data through the use of artificial intelligence and predictive analytics. The result? Insurance companies are equipping themselves with the high-tech tools they need to assess a prospective customer, verify a claim, and identify suspicious activity.

As much as these emerging technologies make a positive impact, there will always be a human element to combatting fraud, and that is where the I.I.I. plays a role. Consumer education is at the core of what we do, whether it be through our website content, media relations efforts, or public speaking engagements.

Like insurers, consumers must have the information needed to make prudent financial decisions and to protect themselves from fraudulent activities. The I.I.I. is proud of the role it has played in keeping consumers informed and vigilant about rogue contractors, staged auto accidents, and the criminals who want either to steal their insurance proceeds—or even their identity.

Thank you again for the opportunity to speak before you today.

Senator MORAN. Mr. Kevelighan, thank you very much.

Now, Mr. Lynch.

STATEMENT OF TIMOTHY J. LYNCH, DIRECTOR, GOVERNMENT AFFAIRS, NATIONAL INSURANCE CRIME BUREAU

Mr. LYNCH. Good morning, Mr. Chairman and members of the Committee. My name is Tim Lynch. I'm the Director of Government Affairs at the National Insurance Crime Bureau, based in Des Plaines, Illinois. The NICB is a national not-for-profit organization supported by 1,100 insurance companies who collectively write about 80 percent of the Nation's property and casualty insurance premiums. We are led by President and Chief Executive Officer Joe Wehrle, who is also a retired lieutenant general in the U.S. Air Force.

Working with our member companies, legislators, regulators, and law enforcement, we investigate organized criminal groups that commit insurance fraud and vehicle crime. We have a 105-year history of established cooperation with Federal, state, and local law enforcement to fight insurance fraud and help protect the American people from organized criminal rings.

Our investigative efforts are focused on external claims fraud, that is, multi-claim, multi-carrier scams perpetrated by organized criminal groups. Through a collective means of investigation, data analysis, legislative advocacy, training, and public awareness, NICB targets the most egregious forms of insurance fraud and vehicle crime. Some of the schemes we see are staged auto accidents, cargo theft, vehicle crime, and medical fraud abuses, just to name a few.

I'll focus briefly today on three areas: medical fraud, vehicle crime, and contractor fraud, as alluded to by Commissioner Doak and Mr. Jay.

Several years ago, NICB made an adjustment to devote more resources to fighting medical-related fraud based on a surge of inflated medical billing and collusion between disreputable doctors and other health care providers. To address this surge, since 2002, NICB has opened eight Major Medical Fraud Task Forces across the country in areas such as Chicago, Houston, New York, and just down the road from here in Fairfax, Virginia.

In 2012, based on our national reach and credibility on the topic of medical fraud, NICB was asked to serve on the Executive Board of the Healthcare Fraud Prevention Partnership under the U.S. Department of Health and Human Services. We know from experience that there is a significant amount of crossover between the fraud that impacts property and casualty insurers and the fraud that impacts Medicare, Medicaid, and private health insurance.

Building on the NICB model, the HFPP is working to share data and investigations across all lines of insurance to better detect fraud and assist law enforcement to root out potential criminal activity. For example, in 2014, our data analytics team compared over $900 million of health care claims data to NICB data resulting in the identification of over 100 schemes with health care and property/casualty fraud exposure. In other words, these folks, these organized rings, they don't discriminate, they'll rip off anyone.

In terms of vehicle-related crime, NICB's experience with this issue dates back to our founding in 1912. Stolen vehicles are profitable, whether intact, parted out, or illegally exported. Regardless if these vehicles are shipped overseas or sold here in the U.S., buyers of these vehicles often do not know these vehicles might be stolen. The essential, but missing, piece that enables this kind of black market enterprise is information.

Congress itself recognized this deficiency and, in 1992, passed legislation that created the National Motor Vehicle Title Information System, known as NMVTIS. Its purpose is to help protect consumers from unsafe vehicles and to keep stolen vehicles from being resold. We have served on the advisory board for NMVTIS since 2010.

This program, which is administered by the U.S. Department of Justice, protects states and consumers from fraud, reduces the use of stolen vehicles for illicit purposes, and provides consumers protection from unsafe vehicles. NMVTIS is intended to ensure key vehicle history information is available to consumers so they may make well-informed decisions.

Finally, as mentioned by Commissioner Doak and Mr. Jay, another issue where we've seen many abuses is in the area of roofer and contractor fraud. We've been very active on this matter from a legislative and public awareness standpoint, and we see numerous cases of exploitation from our team of investigators.

In short, this issue is pretty simple. In areas impacted by a severe weather event and there is serious damage to homes, dishonest repair contractors descend on these scenes, oftentimes within a day or two, and entice consumers into scams involving phony contracts, offers of free repairs, and filing bogus claims. Examples of inflating roof damage, as Commissioner Doak mentioned, are also prevalent, as well as these folks collecting a down payment from people to do no work and then to leave town. Several states have taken action to crack down on this, as Mr. Jay mentioned, including Oklahoma, Texas, and others.

We have worked with state departments of insurance and are willing to work with others, and we've worked with Commissioner Doak, on increasing public awareness of this issue using billboards, social media, and public service announcements.

In closing, Mr. Chairman, thank you for the opportunity to be here. I'm pleased to answer any questions at the appropriate time. Thank you.

[The prepared statement of Mr. Lynch follows:]

PREPARED STATEMENT OF TIMOTHY J. LYNCH, DIRECTOR, GOVERNMENT AFFAIRS, NATIONAL INSURANCE CRIME BUREAU

Good Morning Mr. Chairman and Members of the Committee, my name is Tim Lynch, Director of Government Affairs at the National Insurance Crime Bureau (NICB), based in Des Plaines, Illinois. The NICB is a national, not-for-profit organization supported by approximately 1,100 insurance companies that collectively write nearly 80 percent of the Nation's total property/casualty insurance premium. NICB is led by President and Chief Executive Officer Joe Wehrle. Mr. Wehrle is a retired Lieutenant General in the United States Air Force.

Working with our member companies, legislators, regulators and law enforcement, we investigate organized criminal groups that commit insurance fraud and vehicle crimes. We have a 105-year history of established cooperation with federal, state and local law enforcement agencies to fight insurance fraud and help protect the American people from criminal enterprises.

NICB's investigative efforts are mainly focused on external claims fraud—multi-claim, multi-carrier scams perpetrated by organized criminal groups. Through a collective means of investigation, data analysis, training, public awareness and legislative advocacy, NICB targets the most egregious forms of insurance fraud and vehicle crimes. Some of the fraud schemes we are involved with are staged auto accidents, cargo theft and medical fraud abuses.

I will focus my remarks today on 3 key areas: medical fraud, vehicle crime, and some recent state legislative activity on roofer/contractor fraud.

Several years ago, NICB made a strategic adjustment to devote more resources to fighting medical-related fraud based on a surge of inflated medical billing, collusion between disreputable doctors and other healthcare providers. To address this surge, since 2002, NICB has opened eight Major Medical Fraud Task Forces in major population centers such as Chicago, Houston, New York and not far from here in Fairfax, Virginia.

In 2012, based on our national reach and credibility on the topic of medical fraud, NICB was asked to serve on the executive board of the Healthcare Fraud Prevention Partnership (HFPP) under the U.S. Department of Health and Human Services. We know from experience that there is a significant amount of crossover between fraud impacting property/casualty insurers and fraud impacting Medicare, Medicaid and private health insurance.

Building on the NICB model, the HFPP is working to share data and investigations across all lines of insurance to better detect fraud and assist law enforcement to root out potential criminal activity. For example, in 2014, our data analytics team compared over $900 million of healthcare claims data to NICB data resulting in the identification of over 100 schemes with health care and property/casualty fraud exposure.

In terms of vehicle related crime, NICB's experience with this issue begins over 100 years to our founding in 1912. One of the most common reasons for vehicle theft is the ability to generate profit from organized vehicle theft activities. Stolen vehicles are profitable, either intact, parted out or illegally exported. Regardless if these vehicles are shipped overseas or sold right here in the United States, buyers of these vehicles often do not know the vehicles are stolen. The essential—but missing—piece that enables this kind of black market enterprise is information.

Congress recognized this deficiency and, in 1992, passed legislation that created the National Motor Vehicle Title Information System (NMVTIS). Its purpose is to help protect consumers from fraud and unsafe vehicles, and to keep stolen vehicles from being resold. NICB has served on the advisory board for NMVTIS since 2010.

NMVTIS, which is administered by the U.S. Department of Justice, protects states and consumers from fraud; reduces the use of stolen vehicles for illicit purposes; and provides consumers protection from unsafe vehicles. NMVTIS is intended to ensure key vehicle history information is available and affordable to consumers, so consumers may make well-informed decisions about used vehicle purposes and to avoid purchasing potentially unsafe vehicles or paying more than fair market value for a vehicle.

As mentioned by Oklahoma Commissioner Doak, another issue where we have seen egregious abuses is the area of roofer/contractor fraud. NICB has been very ac-

tive in this matter from a legislative and public awareness standpoint, and we see numerous cases of exploitation from our team of investigators.

In short, this issue is fairly simple. An area is impacted by a severe weather event, such as a tornado, and there is serious damage to residential communities. Dishonest repair contractors descend on these scenes—often times within days—and entice consumers into scams involving phony contracts, offers of "free repairs" and filing bogus claims. Instances of these individuals inflating roof damage is also prevalent, as well as collecting a sizable down payment to perform services only to skip town.

Several states have taken action to tighten up consumer protections against these abuses, such as Colorado, Kentucky, Illinois, Indiana, Minnesota, Nebraska, Oklahoma, Texas and others.

Since our industry is regulated at the state level, we have also worked with state departments of insurance—including Commissioner Doak on increasing public awareness of this issue using billboards, public service announcements and social media.

We would encourage the committee members—especially those who represent areas prone to severe weather—to communicate to your constituents that they exercise caution after severe weather events, and be sure to contact their insurance company before signing any repair contracts or providing up-front cash for materials—especially if it is from a contractor who just appears, unsolicited, at their door.

In closing, we would like to thank Chairman Moran and the Committee members for their interest in insurance fraud. We ask that you keep these three issues in mind—medical fraud, vehicle crime and property fraud—as you communicate with your state departments of insurance to help protect the citizens of your state from insurance fraud.

Thank you for inviting us to testify and I'd be happy to answer any questions.

Senator MORAN. Mr. Lynch, thank you very much.

Welcome back, Ms. Weintraub.

STATEMENT OF RACHEL WEINTRAUB, LEGISLATIVE DIRECTOR AND GENERAL COUNSEL, CONSUMER FEDERATION OF AMERICA

Ms. WEINTRAUB. Thank you, Chairman Moran and Ranking Member Blumenthal. I appreciate the opportunity to provide testimony on Consumer Federation of America's perspectives on insurance fraud in America. I am Rachel Weintraub, Legislative Director and General Counsel at CFA, a nonprofit association of approximately 280 pro-consumer groups that was founded in 1968 to advance the consumer interest through advocacy and education.

CFA is concerned about fraud by the insurance industry against consumers, and fraud by consumers against the industry. Both cost consumers dearly. Although most insurance companies and agent/brokers are honest and ethical, fraud by the insurance industry against consumers is a serious problem. It costs consumers when they pay premiums for unnecessary coverage, when they pay excessive rates for required coverage, when they buy insurance priced in an unfairly discriminatory manner, and it costs them when they are presented with misleading policy language that is constructed to make them believe they are purchasing protection they will never in fact receive.

Fraud by insurers also costs consumers who face unfairly denied claims, underpaid claims, and claims that take too long to be paid. Examples abound, and here are just a few. Insurers have used fake engineering reports to deny flood insurance claims after Superstorm Sandy. Insurers have participated in the sale of unnecessary policies, such as the placing of unnecessary auto insurance onto the auto loan payments of borrowers who were not advised of such action by Wells Fargo, as we just learned last week. A Medi-

care Advantage insurer settled a whistleblower case for $32 million in a case where the insurer exaggerated how sick patients were.

CFA has undertaken a series of reports on the plight of good-driving, lower income Americans. These consumers are unable to afford state-required auto insurance due to the use of unfair rating factors related to income. Our research has identified that good-driving, low-income people often pay more for auto insurance than wealthier people with accidents and tickets. It is unquestionably a defrauding of American consumers when insurers charge safe drivers more than unsafe drivers for the same coverage.

Fraud against the insurance industry by consumers is a serious issue. There are two types of such insurance fraud: hard fraud and soft fraud.

Hard fraud entails somewhat deliberate—someone deliberately planning or inventing a loss, such as a collision, auto theft, or fire that is covered by their insurance policy in order to receive a claim payment. Criminal rings are sometimes involved in hard fraud schemes and can steal millions of dollars. The data on hard fraud are fairly reliable since such data can be collected from criminal case records.

Soft fraud consists of policyholders exaggerating otherwise legitimate claims. For example, when involved in an automotive collision, an insured person might claim more damage than actually occurred. The statistics on the extent of such soft fraud are unclear, and there are some incentives to overreport it. Congress should be cautious about claims of soft fraud exceeding more than a few percent of premium dollars.

A specific consumer's likelihood to commit soft fraud appears to be impacted by how the consumer sees the insurance industry's treatment of them to be. The public's perception of insurers is very negative. If the industry can repair its image, that could positively impact the degree of fraud against it.

CFA supports insurer attempts to control fraud, including the creation of special investigative units to look into suspicious claims. However, SIUs and other attempts to control fraud must be reasonable. Such investigations should not go on for extensive periods while people are not able to return to their home, for example.

In conclusion, CFA is concerned about insurance fraud. We are aware of numerous types of fraudulent activity by a few insurers and by a few consumers using the insurance market, both of which harm the vast majority of consumers, who are honest and ethical. Congressional efforts should consider the whole range of frauds being committed in the insurance market, and the prospect of fraud should not be used to justify an unscrupulous attack on innocent consumers seeking claims payments.

Thank you.

[The prepared statement of Ms. Weintraub follows:]

PREPARED STATEMENT OF RACHEL WEINTRAUB, LEGISLATIVE DIRECTOR AND GENERAL COUNSEL, CONSUMER FEDERATION OF AMERICA

Chairman Moran, Ranking Member Blumenthal and other members of the Consumer Protection, Product Safety, Insurance, and Data Security Subcommittee. I appreciate the opportunity to provide testimony on Consumer Federation of America's (CFA) perspectives on Insurance Fraud in America. I am Rachel Weintraub, Legislative Director and General Counsel at CFA. CFA is a non-profit association of ap-

proximately 280 pro-consumer groups that was founded in 1968 to advance the consumer interest through advocacy and education.

CFA is concerned about insurance fraud and is working to contain it as well as document and identify it. We were a founding member of the Coalition Against Insurance Fraud and continue even today to serve on its Board of Directors and we conduct research to document inequality in the insurance market, especially the auto insurance market.

CFA is concerned about both kinds of fraud: that is, fraud by the insurance industry against consumers and fraud by consumers against the industry. Both cost consumers dearly.

Fraud by the Insurance Industry Against Consumers

I will first focus on fraud by the insurance industry against consumers. Although most insurance companies and agents/brokers are honest and ethical, fraud by the insurance industry against consumers is a serious problem. It costs consumers when they pay premiums for coverage they do not need; when they pay excessive and actuarially unjustifiable rates for coverages they are required to buy; when they buy insurance priced in an unfairly discriminatory manner; and it costs them when they are presented with inadequate and misleading policy language that is constructed to make them believe they are purchasing protection they will never, in fact, receive. And, of course, fraud by insurers also costs consumers who face unfairly denied claims, underpaid claims and claims that take far too long to be paid.

Examples abound, and here are just a few of many:

- Insurers, as Congress knows, have used faked engineering reports to deny flood insurance claims after Superstorm Sandy. This was documented by *60 Minutes* in "The Storm After the Storm." [1]
- At times insurers participate in the sale of unnecessary policies. A recent example is the placing of unnecessary auto insurance onto the auto loan payments of borrowers who were not advised of such action by Wells Fargo. This was documented just last week by numerous news outlets.[2]
- A Medicare Advantage Insurer settled a whistleblower case for $32 million, in a case where the insurer exaggerated how sick patients were.[3]
- Two top executives of AIG settled an accounting fraud case, agreeing to return almost $10 million in salary.[4]
- In just the last few years, insurers have begun to raise rates on people who do not shop around, a process called "price optimization." In this scam, insurers use information from non-driving related sources such as third-party consumer databases, grocery store shopping records, and social media analysis to determine if a person does or does not shop when prices go up. They use this information to raise the rate above the actuarially sound price on the non-shopping consumer. This is illegal in every state, since state laws require prices to be based on driving risk, not shopping tendency. Since CFA raised the issue three years ago, 20 states have banned the practice, but we believe this fraudulent pricing system is still being deployed or introduced in several states.

A quick search over the last month or so of headlines from *Insurance Business Magazine* identifies some other examples of the consistent drumbeat of insurer/agent fraud against consumers:

- A San Diego insurance agent was charged in connection with allegedly scamming five people—three of them seniors—out of a total of more than $1.1 million.[5] (July 24, 2017)
- A Connecticut man presented himself as an insurance agent after the state pulled his license and is headed to prison for nearly four years. The insurance

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[1] *https://www.youtube.com/watch?v=11VjWZvA0Ig*

[2] *https://www.nytimes.com/2017/07/27/business/wells-fargo-unwanted-auto-insurance.html; https://www.reuters.com/article/us-wells-fargo-insurance-idUSKBN1AG20Q; https://www.washingtonpost.com/news/business/wp/2017/07/28/wells-fargo-charged-570000-customers-for-auto-insurance-they-didnt-need-potentially-forced-some-to-have-cars-repossessed/?utm_term=.9073ef7bfeff*

[3] *http://www.npr.org/sections/health-shots/2017/05/31/530868367/medicare-advantage-insurers-settle-whistleblower-suit-for-32-million*

[4] *https://www.nytimes.com/2017/02/10/business/dealbook/former-aig-executives-reach-settlement-in-accounting-fraud-case.html?_r=0*

[5] *http://www.insurancebusinessmag.com/us/news/breaking-news/insurance-agent-charged-in-1–1-million-scam-73861.aspx*

agent pleaded guilty to wire fraud, according to the *San Francisco Chronicle.* Prosecutors say he scammed people out of more than $874,000.[6] (July 21, 2017)

- Farmers Insurance Exchange will refund $315,000 to more than 1,600 Minnesota drivers, after authorities found that the firm wrongfully charged the drivers with higher auto insurance rates. The state's Commerce Department said the insurer charged drivers with higher rates solely because they were home renters rather than homeowners. Minnesota law prohibits firms from setting auto insurance rates or benefits, or denying coverage, based on a driver's status as a residential tenant.[7] (July 19, 2017)
- A U.S. District Court has approved the $32.5 million settlement of a racial discrimination case against MetLife filed by a class of African-American former MetLife financial services representatives. The former employees filed the case against the insurer in 2015. They accused the firm of maintaining "a racially biased corporate culture and stereotypical views about the skills, abilities, and potential of African-Americans that affect personnel," a court docket said.[8] (July 12, 2017)
- A health care system suing Chubb paid itself "excessive" amounts from employee retirement programs and "unjustly enriched itself," the insurer claims.[9] (July 7, 2017)
- A Colorado insurance broker was sentenced to 12 years in state prison on Monday after he pleaded guilty to several counts of forgery, insurance fraud, and theft. The insurance broker pocketed some $130,000 in workers' compensation premiums that he wrote while his license was revoked. Previously, this broker had been sentenced to two years of probation and had his license revoked in 2014 after pleading guilty to forgery in what was described as a similar case.[10] (June 28, 2017)
- A recommended Federal class-action lawsuit against Allstate has been approved by the Pennsylvania Supreme Court. The class-action is in relation to Allstate's policy that mandates claimants undergo medical exams by a doctor of the carrier's preference before they can receive benefits.[11] (June 21, 2017)
- The owners of a California insurance agency have been indicted by a Federal grand jury for allegedly sending more than a million pieces of mail without paying the postage.[12] (June 13, 2017)

A. Auto Insurance Pricing

CFA has undertaken a series of reports on the plight of good-driving, lower-income Americans. These consumers are unable to afford state-required auto insurance due to the use of unfair rating factors related to income. Our research has identified that good-driving low-income people often pay more for auto insurance than wealthier people with accidents and tickets. It is, unquestionably, a defrauding of American consumers when insurers charge safe drivers more than unsafe drivers for the same coverage.

CFA's research addresses several different aspects of auto insurance rates, premiums and the market, but all point to a few key findings:

- The cost of state-mandated basic liability insurance is higher than many lower-income Americans can afford and the number of uninsured citizens in this category is higher than the national average as a result;
- Insurers use a variety of socio-economic rating factors unrelated to driving that push auto premiums up for lower-income Americans despite good driving records; and
- Stronger state consumer protections related to auto insurance rate setting leads to greater access to and more stability in auto insurance markets.

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[6] *http://www.insurancebusinessmag.com/us/news/breaking-news/fake-insurance-agent-gets-nearly-four-years-73739.aspx*

[7] *http://www.insurancebusinessmag.com/us/news/breaking-news/farmers-insurance-exchange-must-make-refunds-to-1600-drivers-73452.aspx*

[8] *http://www.insurancebusinessmag.com/us/news/breaking-news/judge-approves-metlifes-32–5-million-race-bias-class-action-settlement-72878.aspx*

[9] *http://www.insurancebusinessmag.com/us/news/breaking-news/insurer-claims-health-system-unjustly-enriched-itself-72483.aspx*

[10] *http://www.insurancebusinessmag.com/us/news/workers-comp/insurance-broker-gets-long-custodial-sentence-after-fraud-71698.aspx*

[11] (*http://www.insurancebusinessmag.com/us/news/breaking-news/allstate-hit-by-another-potential-class-action-71111.aspx*

[12] *http://www.insurancebusinessmag.com/us/news/breaking-news/insurance-agents-indicted-for-300000-mail-fraud-70249.aspx*

A description of each of the reports that CFA has issued since 2012 is available in the attached appendix. This is followed by a summary of the key recommendations from the reports. Our research documents that states require good-driving, lower-income Americans to purchase auto insurance to drive and harshly penalize them for driving without that insurance. But most states do not regulate the use of factors that raise rates on widows, renters, low-wage workers, people with less education and other factors that adversely discriminate against the poor.

B. Actions Against Insurers for Bad Faith

There are hundreds of legal actions against insurers for bad faith. Consumers pay money for premiums, often for many years, prior to an event occurring or a claim being filed. Consumers believe that insurers will do right by them if they file a claim. Once a claim is filed, the insurer owes the consumer a duty of utmost good faith in handling the claim. If the insurer improperly denies or delays payment of the claim, it is possible that the insurer has not acted in good faith. It is likely that the number of times consumers are defrauded by insurer bad faith is orders of magnitude larger than the number of times insurers are sued for this kind of fraud. For many consumers, this fraud comes in the form of an insurer's low-ball offer—on a total loss claim on a car insurance policy, for example—that may short the consumer by $1,500, which is devastating to a consumer but not a viable legal action against the insurance company either because the cost of litigation is too high or because many states prohibit such suits.

C. Fraud Against Consumers by Other Entities Involved in the Insurance Market

1. Storm Chasers

CFA warns consumers about "storm chasers," which are repair firms that come in after a storm and offer to repair structures. Often, they have no local connections, may not have proper insurance for their workers, and do subpar repairs. They have opportunities to do work, particularly after catastrophic weather events, because there are so many repairs that need to be done in a relatively short time. Insurers want to settle claims from storms as quickly as possible. However, insurers should work with reliable contractors to make sure that there are sufficient workers and supplies in the catastrophe area as repairs must be done in a timely way. State government action could assist in making sure that there are sufficient resources available to complete repairs promptly.

As bad as storm chasers can be, those that do acceptable work do help to get necessary work completed. The market demands an increase of contractors after a storm, and there would be value in helping communities identify those who will not cut corners in the repairs and can meet standards of quality that will equal the promises contained in the insurance contract. Consumers would be served by better tools to help distinguish between the fraudulent storm chasers and those contractors who arrive in the wake of a catastrophe not just looking for a quick buck but to provide a quality service.

Regardless of what additional resources might be made available in the future, CFA always advises consumers to make sure that the people they contract with for repairs after a storm are (1) capable of doing the work well, (2) properly credentialed, and (3) have references. We urge consumers to check with their insurance company if they have questions about a contractor who approaches them.

2. Opioids

Insurers have the data to monitor opioid prescription levels and should be a force for good in finding ways to tackle this mounting problem. We encourage insurers' full cooperation in working with government and others seeking solutions. However, insurers can also be part of the problem in a number of ways. First and most importantly, some insurers will not pay for alternatives to opioids such as steroid injections, physical therapy and nerve blocks.[13] Second, insurers try to do the right thing by limiting the amount of opioids to a person but sometimes are not sophisticated in doing so, since some patients have been on the specific drug for a long time and need more of the drug to get the necessary relief. In these cases, the patients often turn to street drugs, exacerbating the problem.

We could list many other examples of frauds against consumers by insurers. The point that CFA wants to make clear is that fraud against consumers by insurers needs Congressional attention.

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[13] *http://addictionblog.org/treatment/health-insurance-and-its-influence-on-the-opioid-epidemic/*

II. Fraud Against the Insurance Industry by Consumers

Fraud against the insurance industry by consumers is a serious issue. There are two types of such insurance fraud: hard fraud and soft fraud.

Hard fraud entails someone deliberately planning or inventing a loss, such as a collision, auto theft, or fire that is covered by their insurance policy in order to receive a claim payment. Criminal rings are sometimes involved in hard fraud schemes that can steal millions of dollars. The data on hard fraud are fairly reliable, since such data can be collected from criminal case records.[14]

Soft fraud consists of policyholders exaggerating otherwise legitimate claims. For example, when involved in an automotive collision an insured person might claim more damage than actually occurred.

The statistics on the extent of such soft fraud are very squishy and the insurers seem to have some incentives to over-report it. Congress should be very cautious about claims of soft fraud exceeding more than a few percent of premium dollars.

Some consumers believe that it is acceptable to increase insurance claims to make up for deductibles or because they believe their insurer has been unfair to them in some way. The Coalition Against Insurance Fraud found these disturbing attitudes among consumers;[15]

- 24 percent say it's acceptable to pad an insurance claim to make up for the deductible—that's a drop since 33 percent said it was acceptable in 2002;
- 18 percent believe it's acceptable to pad a claim to make up for premiums paid in the past;
- Younger males were much more likely to condone claim padding, and 23 percent of 18 to 34-year-old males say it's alright to increase claims to make up for earlier premiums. This compares with 5 percent of older males and 8 percent of females of the same age;
- More than half (55 percent) of U.S. consumers say poor service from an insurance company is more likely to cause a person to defraud that insurer;
- More than three-quarters (76 percent) say they're more likely commit insurance fraud during an economic downturn than during normal times (up from 66 percent in 2003)

A specific consumer's likelihood to commit soft fraud appears to be impacted by how the consumer sees the insurance industry's treatment of them to be. The public's perception of insurers is very negative. The 2015 Harris Poll on consumer attitudes towards various industries rates Insurance as 35 percent positive (only Financial Services, Tobacco and Government rank lower).[16] If the industry can repair its image, that could positively impact the degree of fraud against it.

CFA supports insurer attempts to control fraud, including the creation of Special Investigative Units (SIUs) to look into suspicious claims. However, SIUs and other attempts to control fraud must be reasonable. There are examples of such investigations going on for extensive periods of time while, for example, people are not able to return to their home because of the investigation into alleged arson until the damage is repaired. Frequently, these delays go on for an excessive period only to conclude with the finding that there was no fraud. Steps must be taken to assure that insurer fraud investigations are completed in a timely way so innocent people are not left hanging, for example, without a place to live for month after month.

III. Conclusion

In conclusion, CFA is concerned about insurance fraud; we are aware of numerous types of fraudulent activity by a few insurers and by a few consumers using the insurance market, both of which harm the vast majority of consumers who are honest and ethical. We would welcome Congress undertaking research to document and to minimize these types of harmful actions that put consumers at great economic disadvantage, so long as the effort is deployed in such a way that considers the whole range of frauds being committed in the insurance market, as we have outlined here. We support efforts to control these types of fraud, with the important warning that the prospect of fraud should not be used as a device to justify an unscrupulous attack on innocent consumers seeking claims payments.

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[14] *http://www.insurance.ca.gov/0400-news/0200-studies-reports/0700-commissioner-report/upload/AnnualReport2013.pdf,* at page 39.

[15] *http://www.insurancefraud.org/statistics.htm*

[16] *https://skift.com/wp-content/uploads/2015/02/2015–RQ-Media-Release-Report_020415.pdf* at page 13.

APPENDIX

CONSUMER FEDERATION OF AMERICA AUTO INSURANCE RESEARCH

3 Major Auto Insurers Usually Charge Higher Prices to Good Drivers Previously Insured by Non-Standard Insurers *Consumer Federation of America (2017)*

Auto insurance giants Allstate, Farmers, and American Family often charge nine to fifteen percent higher premiums to good drivers previously insured by smaller, "non -standard" insurers than those who had coverage from State Farm or other primary competitors. Allstate charged 15 percent ($235) more on average to good drivers previously covered by non-standard auto insurers such as Safe Auto Insurance and Equity Insurance Co. than if the y had been previously insured by State Farm. Farmers charged nine percent ($260) more on average to customers coming from non-standard companies, including Titan Insurance and Access Insurance Company, than those hailing from State Farm policies. American Family Insurance, the Nation's ninth largest auto insurer, charged nine percent ($166) more on average to customers previously with non-standard carriers, such as Direct General and Safeway Insurance.

Major Insurance Companies Raise Premiums After Not-At-Fault Accidents *Consumer Federation of America (2017)*

Safe drivers who are in accidents caused by others often see auto insurance rate hikes. The research analyzed premium quotes in 10 cities from five of the Nation's largest auto insurers. Among the cities tested, drivers in New York City and Baltimore pay out the most for an accident where the driver did nothing wrong, and customers in Chicago and Kansas City also face average increases of 10 percent or more when another driver crashes into them. CFA's research over recent years has consistently found that good drivers with certain socio—economic characteristics that suggest lower incomes generally pay more for auto insurance than higher-income drivers with the same driving record. This pattern holds when it comes to penalizing drivers for accidents in which they were not at fault. Higher-income drivers paid $78 more on average after a not-at-fault accident, while moderate-income drivers paid $208 more on average after a not-at-fault accident.

Major Insurers Charge Moderate-Income Customers With Perfect Driving Records More Than High-Income Customers With Recent Accidents *Consumer Federation of America (2016)*

Auto insurance prices are often more closely aligned with personal economic characteristics than with drivers' accident and ticket history. Testing premiums offered by the Nation's five largest insurers in ten U.S. cities for drivers with different socio-economic characteristics and different driving records, CFA found surprising results, including: upper-income drivers with DUIs often pay less than good drivers of modest means with no accidents or tickets on their driving record; moderate-income drivers with perfect records pay more than upper-income drivers who caused an accident in which someone was injured; progressive and GEICO consistently charge upper-income bad drivers less than moderate-income good drivers; moderate-income good drivers often pay more than upper-income drivers with multiple points on their record.

Major Auto Insurers Raise Rates Based on Economic Factors *Consumer Federation of America (2016)*

In most states auto insurance premiums are driven in large measure by economic factors that are unrelated to driving safety, a practice that most Americans consider unfair. Among the most common of the individual economic and socio-economic characteristics used by auto insurers are motorists' level of education, occupation, homeownership status, prior purchase of insurance, and marital status. Because each of these factors are associated with an individual's economic status and because insurers consistently use each factor to push premiums up for drivers of lesser economic means, the combined effect of insurers' use of these factors can result in considerably higher prices for low—and moderate-income Americans, leaving many overburdened by unfairly high premiums and others unable to afford insurance at all.

Good Drivers Pay More for Basic Auto Insurance If They Rent Rather Than Own Their Home *Consumer Federation of America (2016)*

Several major auto insurance carriers hike rates on good drivers who rent their home rather than own it. CFA tested the premiums charged by seven large insurers to a good driver in ten cities. For each test we only changed the driver's homeownership status and found that renters were charged seven percent more on average—

$112 per year—for a minimum limits policy than insurers charged drivers who own their homes, everything else being equal.

Price of Mandatory Auto Insurance in Predominantly African-American Communities *Consumer Federation of America (2015)*

CFA released research comparing auto insurance prices in predominantly African-American Communities with prices paid in predominantly white communities. Nationwide, in communities where more than three quarters of the residents are African American, premiums average 71 percent higher than in those with populations that are less than one quarter African American after adjusting for density and income. In Baltimore, New York, DC, Detroit, Boston and other cities, the disparity of premiums is more than 50 percent between predominantly African American and predominantly white ZIP codes.

New Research Shows That Most Major Auto Insurers Vary Prices Considerably Depending on Marital Status *Consumer Federation of America (2015)*

CFA released research on how insurers utilize marital status in their pricing of auto insurance policies. CFA questions the fairness and relation to risk of this pricing by most major insurers, particularly their practice of hiking rates on women whose husbands die by 20 percent on average, the "widow penalty."

Auto Insurers Fail to Reward Low Mileage Drivers *Consumer Federation of America (2015)*

CFA released research showing that large auto insurers frequently fail to reward drivers with low mileage despite a strong relationship between this mileage and insurance claims. The study found that three of the five largest insurers often give low-mileage drivers no break at all. In a 2012 nationwide survey conducted by ORC International for CFA, 61 percent of respondents said that it was fair for auto insurers to use mileage in pricing auto insurance.

Large Auto Insurers Charge High Prices, to a Typical Lower-Income Safe Driver with Car Financing, for Minimal Coverage *Consumer Federation of America (2014)*

CFA found that annual auto insurance premiums are especially high for the estimated eight million low-and moderate-income drivers who finance their car purchases. These drivers must purchase the comprehensive and collision coverage required by auto lenders in addition to the liability coverage required by states. In the 15 cities CFA surveyed, annual premium quotes were almost always more than $900 and were usually more than $1,500. In a related national opinion survey undertaken by ORC International for CFA, nearly four—fifths of respondents (79 percent) said that a fair annual cost for this auto insurance coverage was less than $750. One-half (50 percent) said that a fair annual cost was less than $500. Respondents were asked what they thought was a reasonable annual cost for a "30-year old woman with a modest income and ten years driving experience with no accidents or moving violations" for required liability, collision, and comprehensive insurance coverage.

High Price of Mandatory Auto Insurance for Lower Income Households *Consumer Federation of America (2014)*

The country's five largest auto insurance companies do not make a basic auto insurance policy available to typical safe drivers for less than $500 per year in over 2,300 urban and suburban ZIP codes including 484, or more than a third, of the Nation's lowest-income ZIP codes. In the report, CFA analyzed 81,000 premium quotes for State Farm, Allstate, Farmers, Progressive, GEICO and each of their affiliates in all ZIP codes in 50 large urban regions, which include urban, suburban and adjacent rural communities. CFA also reviewed the premium quotes from an additional 58 insurance companies—comprising a total of 207 insurance affiliates including those of the five largest insurers—which produced similar results.

In 24 of the 50 urban regions, there was *at least one* lower-income ZIP code where annual premiums for a minimum limits policy exceeded $500 from every major insurer. In nine of these 50 areas—Miami/Ft. Lauderdale, Detroit, Minneapolis/St. Paul, Tampa/St. Petersburg, Baltimore, Orlando, Jacksonville, Hartford, and New Orleans—prices exceeded $500 in *all* lower-income ZIP codes.

This report included the finding from a recent national survey that more than three-quarters of Americans (76 percent) believe that a "fair annual cost" for state-mandated insurance for a typical good driver with no accidents and no tickets should be less than $500.

Uninsured Drivers: A Societal Dilemma in Need of a Solution *Consumer Federation of America (2014)*

This report found that most uninsured drivers in America have low incomes and cannot afford to purchase the mandatory minimum liability coverage required by their state. The report also revealed that these low-income drivers are increasingly adversely impacted by state and local government actions, including raising liability requirements (driving up premiums), more rigorous enforcement, and stiffer penalties. However, there is little difference in uninsured rates between those states that penalize uninsured drivers harshly and those that do not. The report reviewed penalties for driving without auto insurance in every state and found some of these very harsh penalties for lower-income Americans who truly cannot afford the required insurance:

- Fourteen states allow jail sentences for a first offense.
- Thirty-two states allow for the possibility of license suspension for a first offense.
- Thirty-three states have possible fines of $500 or more for a first offense.

CFA Analysis Shows Auto Insurers Charge Higher Rates to Drivers with Less Education and Lower-Status Jobs *Consumer Federation of America (2013)*

Several major auto insurers place a heavy emphasis on their customers' occupation and education when setting prices, forcing lesser educated, blue collar workers with good driving records to pay substantially higher premiums than drivers with more education and higher paying jobs. For example:

- GEICO charges a good driver in Seattle 45 percent more if she is a factory worker with a high school degree than if she is a plant superintendent with a bachelor degree;
- Progressive charges the factory worker 33 percent more in Baltimore; and
- Liberty Mutual charges the worker 13 percent more in Houston.

The reported also highlighted a national survey that found that about two-thirds of Americans believe that it is unfair to use education and occupation when pricing insurance policies.

What Works: A Review of Auto Insurance Rate Regulation in America and How Best Practices Save Billions of Dollars *Consumer Federation of America (2013)*

Over the past quarter century, auto insurance expenditures in America have increased by 43 percent on average and by as much as 108 percent. These increases occurred despite substantial gains in automobile safety and the arrival of several new players in the insurance markets. Only in California, where a 1988 ballot initiative transformed oversight of the industry and curtailed some of its most anti-consumer practices, did insurance prices fall during the period, resulting in more than $4 billion in annual savings for California drivers. This report used NAIC data to assess the impact of different types of insurance market oversight (prior approval, file and use, use and file, flex rating, and deregulation) on rates, industry profitability, and competition. It also provided a detailed analysis of California's experience with the Nation's most consumer protective rules governing the auto insurance market.

Largest Auto Insurers Frequently Charge Higher Premiums To Safe Drivers Than To Those Responsible For Accidents *Consumer Federation of America (2013)*

CFA analyzed premium quotes from the five largest auto insurers in twelve major cities and found that two-thirds of the time, insurers would charge a working class driver with a 45 day lapse in coverage and a perfect driving record more than companies charged an executive with no lapse in coverage but a recent at-fault accident on their record. In 60 percent of the tests, the lower-income good driver was charged at least 25 percent more than the higher-income driver who had caused an accident.

Use of Credit Scores by Auto Insurers Adversely Impacts Low- and Moderate-Income Drivers *Consumer Federation of America (2013)*

Holding all other factors constant, the two largest auto insurers, State Farm and Allstate, charge moderate-income drivers with poor credit scores much higher prices than drivers with excellent scores. Using data purchased from a third party vendor of insurance rate information, this report showed that State Farm increased rates for the low credit score driver an average of 127 percent over the high credit score

customer and Allstate raised rates by 39 percent, costing State Farm and Allstate customers an average of more than $700 and $350, respectively, based solely on credit scores.

The report also pointed to a recent national survey conducted for CFA that found that, by a greater than two to one ratio, Americans reject insurer use of credit scores in their pricing of auto insurance policies.

Auto Insurers Charge High and Variable Rate for Minimum Coverage to Good Drivers from Moderate-Income Areas *Consumer Federation of America (2012)*

This report used extensive website testing to show that good drivers—those with no accidents or moving violations—who live in moderate-income areas in 15 cities were being quoted high auto insurance rates by major insurers for the minimum liability coverage required by those states. Over half (56 percent) of the rate quotes to two typical moderate -income drivers were over $1,000, and nearly one-third of the quotes (32 percent) exceeded $1,500.

The report also presents findings from a national survey that shows that lower -income families report knowing people who drive without insurance at a much higher rate than higher-income drivers. Further, nearly 80 percent of drivers agreed that "they [the uninsured drivers] do so because they need a car but can't afford the insurance."

Lower-income Households and the Auto Insurance Marketplace: Challenges and Opportunities *Consumer Federation of America (2012)*

Access to an automobile plays a critical role in creating economic opportunities for lower-income Americans and the affordability of auto insurance plays a key role in this access. This report provides an overview of the auto insurance market with a detailed discussion of low—and moderate-income (LMI) households' participation in the auto insurance market. The report summarizes pricing information collected by CFA as well as data related to availability, residual markets and uninsured motorists.

At the heart of this report, which was the first in the series of reports outlined above, is t he finding that for millions of lower-income Americans auto insurance is unaffordable and inaccessible despite their unblemished driving records. High priced auto insurance, which often leads LMI drivers to choose between giving up their cars or driving un insured, creates serious economic hardships, and the issue must be addressed by policymakers and regulators. The report concludes with a summary of the issues, obstacles and needs facing LMI customers and policy suggestions for addressing them.[1]

Senator MORAN. Thank you very much.

Let me just ask a few general questions, and then I'll turn to the Ranking Member.

Maybe it's with you, Mr. Doak. Our states share similar kind of casualty opportunities for insurance claims to be paid in tornadoes, windstorm, hail, and most recently, fires.

Mr. DOAK. Yes, sir.

Senator MORAN. Where is the circumstance in which that fraud is likely to occur? Somebody has a hailstorm or there's a tornado that goes through town, what are the places that are most significant opportunities for fraud?

Mr. DOAK. Sure. And thank you, Senator. Commissioner Selzer and I have talked about this, and he has actually attended the National Tornado Summit, which we host in Oklahoma City with several other of our colleagues from around the United States to talk specifically about natural catastrophes and disasters, and what follows after that is unfortunately there is a high propensity for fraud. And, unfortunately, most of the folks that are taken advantage of first in those natural catastrophe events, whether it be

[1] Links to the series with thumbnail descriptions of each report ac be accessed at: *http://consumerfed.org/cfa-studies-on-the-plight-of-low-and-moderate-income-good-drivers-in-affording-state-required-auto-insurance./*

Sandy, Katrina, some of those events, are seniors, who we want to protect and make sure that they're well educated.

But we also see some of the basic things as after that size scalable catastrophe example, the Moore tornado not too long ago, we had over 80,000 claims in a very concentrated area. The anti-fraud units worked, and we actually had the anti-fraud unit from the State of North Carolina came and joined us because of the very specific job that they do in deterrence. You have folks that go through these neighborhoods that really prey upon unsuspecting consumers that have never had this size of a catastrophe. So you have folks that are asking them, "We'll tarp your roofs," and then they'll put liens on their property, and they'll find out later through the claims process that there is a lien on the property. You have unscrupulous contractors that take advantage of folks relative to roof damage and hail. Whether it's a complete loss or partial loss, a lot of times those find out that they are full losses.

So there are many things that happen there. But consumers, at that particular point in time, for those large-scale losses—hail, tornado—we just recently showed you the picture of the one in Elk City, 100 homes, but the contractors that descend on the area, we try to encourage them, Senator, to use local reputable contractors from their community where they know who they are, but when folks come in across state lines, many times that's where you see the fraudulent activity happening.

Senator MORAN. A disreputable contractor, somebody who enters into a contract with a homeowner following a natural disaster, how does that become insurance fraud as compared to fraud?

Mr. DOAK. Right. Well, when it deals with the insurance policy, when they're actually doing work and then billing it back to the insurance company for some type of fraudulent activity, that's where it crosses the line into the insurance issues no matter what state they're in, is if they're getting payment from the insurance companies, that's where the fraud is happening. And that can even be a first dollar because if they've got a deductible to meet, many times consumers are using that out-of-pocket expense to tarp a roof, to have any type of activity done on their home. In a major catastrophe, they're keeping those receipts because all of those are applied toward that total insurance claim. So hopefully that answers your question.

But one of the things in Moore, Oklahoma, that really is I think a best practice for the country is the registration of contractors that come into an area. And we believe that that should be done at the local community level where there is recourse. If someone comes in from out of state, they register at the local municipality, which it's very, very economical, but they show that they've got liability insurance and there's recourse if their workers are hurt or injured on the insured's property, but there is some recourse to find them, they're just not flight-by-nights.

So there are some things that we've learned from other communities around the United States that really have been best practices.

Senator MORAN. Perhaps for all of the panelists, Ms. Weintraub raises the topic of fraud committed by the insurance company. I think perhaps stereotypically we think of a consumer or a third

party as the perpetrator of fraud. Do you see what Ms. Weintraub has described? And do you take that seriously? And are there efforts within the industry to make sure that the insurance companies and their employees, their agents, behave in a non-criminal manner, in an ethical way?

Mr. DOAK. Absolutely. If that's directed toward me, we absolutely do. We've got the insurance commissioners, whenever there are complaints that are levied, as you've outlined, the companies, the insurance commissioners, and the departments take those very, very seriously. Insurance fraud by companies, if there is unfair claims practices, if they're not treating people fairly, if they are using some type of practice behind the scenes, as she mentioned, that's something that state regulators take very, very seriously. Other colleagues might have some comments, but that's very high on our radar for all state departments around the country. When we hear of those things, we investigate those and follow up on them in a pretty timely manner.

Senator MORAN. Is there a way to estimate—to other panelists, is there a way to estimate the cost to consumers of that kind of fraud—fraud committed by companies and their agents?

Mr. KEVELIGHAN. Maybe I can—as an industry representative, maybe I can speak to that. And I've heard a term used both by Ranking Member Blumenthal as well as Ms. Weintraub, and it was "vast majority," and I think that's something to take into consideration. We all know that it only takes one instance to damage reputation, but the vast majority of insurers are working very closely with their regulators. All policies have to be—all policy terms, conditions have to be approved by the regulatory community and their state regulators.

So there's a very direct relationship here with the regulatory community. The insurers want to get this right. They want to make sure they're providing the right protection. And there are success stories. So if we look recently at Sandy, in the first 6 months, we had over 90 percent of the claims paid. Now, we can look at specific instances where we had troubles, and I think if you look at any industry, you're going to find those things. But the vast majority of this industry is dedicated to serving the consumer and to make sure that it's rebuilding their lives.

Senator MORAN. Anyone else? Mr. Jay?

Mr. JAY. Yes, Mr. Chairman, I think that's an excellent question. And following up on what Ms. Weintraub said as far as the industry doesn't like the few bad apples that are out there, but a lot of these scams are perpetrated by rogue insurance adjusters and especially rogue insurance agents. And at one time, insurers really didn't do a very good job in policing their own employees on this. I think that's changed today because of pressure from regulatory bodies, but also because I think it's in the insurers' best interest, and they do want to make sure the consumers are protected and that their own reputations are protected.

So in those areas, I think it is getting better, but some of these other instances that you're taking a look at, I think you also have to distinguish between what is a bad practice on behalf of an insurance company that's harming consumers and what may be deemed criminal or civil fraud as defined in the state statutes. And I think

we need remedies for both, but some may be abuse and some may be outright fraud.

Senator MORAN. Yes. I can see a difference between the frustration that comes with a slow payment for the indemnity, the check, or the bureaucracy that comes with filing the claim. That's different, I think, than outright fraud, trying to deny the consumer what they're due.

Senator Blumenthal.

Senator BLUMENTHAL. Thank you very much, Mr. Chairman.

And again welcome to all of you.

I want to talk about an issue that is of grave concern to Connecticut and possibly all of the Northeast and the country, and it goes by name of pyrrhotite. Few in this room would know how to spell it. And not many around the country would know about it, but it is well known in Connecticut and in Massachusetts and other parts of the Northeast, and it is an example of the kind of insurance practice that may be tantamount to fraud, certainly involve deceptive and misleading practices, and unfortunately has cost hundreds of Connecticut homeowners possibly their life saving.

Hundreds of homes in Connecticut, mostly working and middle class families, are reported to have cracking or crumbling foundations. Those homes are quickly declining in value. Some have approached the point of worthlessness. The only known solution is to replace the entire foundation at costs exceeding $150,000 each. The fear is that this condition could spread to thousands of other homes, whose foundations were also poured using concrete aggregate from a particular quarry that contains high levels of a naturally occurring mineral called pyrrhotite.

Insurers have been unwilling, they have been unwilling, to provide desperately needed assistance to these homeowners. Instead of alerting their customers about the risks once the insurer became aware of them, they surreptitiously changed the policies, they updated the policies, to strictly define coverage of, quote, collapse, end quote, to only, quote, abrupt collapse. And they added foundations to the list of policy exclusion.

They never properly told their customers what they were doing. They never told them the reason they were doing it. They never adequately notified them so the homeowners could take steps to protect themselves either by rebuilding or taking construction precautions about the foundation or taking new policies that cover this problem. Insurers clearly knew there was a problem with crumbling foundations before homeowners knew, and they immediately sought to shield their liability, in other words, protect themselves, rather than protect their customers.

I have highlighted the responsibility of insurers to do more. Some have offered, but most have refused to step up and honor their obligation to these homeowners. And I am out of patience. There have been lawsuits. So far, I have declined to enter them, but I think I and my colleagues and others are at the point of wanting more action and more compensation for these homeowners whose life savings are at risk, whose homes are not only crumbling, but whose financial well-being are crumbling as well.

So, Mr. Kevelighan, when insurers become aware of a problem, as they did here, don't they have an obligation to notify and inform

their consumers, as insurers failed to do here, that they are literally changing their policies, the wording of the policies, that will deprive them of adequate compensation for this kind of policy problem?

Mr. KEVELIGHAN. Well, I know this issue, and it is an unfortunate one, and we've paid very close attention to it at the Insurance Information Institute, and we understand people are very troubled financially as a result of this. It's something that happened as a result of construction and manufacturing that occurred 15 or so years ago. And as a homeowner's policy, it is standard, and we've seen this in other states before, where we have defective materials. Those are—it's a standard exclusion in an insurance policy, so it's not specific to Connecticut.

Senator BLUMENTHAL. So this issue is potentially widespread.

Mr. KEVELIGHAN. I don't know—we only know of this particular issue in Connecticut, and I——

Senator BLUMENTHAL. Well, when I say the issue, I don't mean pyrrhotite, I mean changing policies so as to, in effect, exclude a problem that the insurers know is looming that will in effect rob homeowners of their life savings. That is the issue, not pyrrhotite, it's a larger issue, it's the practice among insurers of changing policies. And you're telling me that this kind of, in your words, issue, in my words, potential fraud, is wider than just Connecticut.

Mr. KEVELIGHAN. I should clarify. The exclusion of defective construction materials is a standard exclusion in a homeowner's policy.

Now, back to what we were talking about earlier about the regulation of insurance. All policies, any changes, are approved by the regulator. We work very closely with our regulators to make sure that they understand what changes are made. And as far as I understand in the State of Connecticut, the insurance commissioner has stood by what the changes were.

Now, that doesn't exclude the fact that this is an unfortunate situation. And I know Governor Malloy has also asked FEMA for assistance, which has been denied. I understand that something needs to—everybody wants there to be a solution, but the solution and whether or not it was something intentional from the insurance companies, I'm not sure. Again, this is a standard exclusion.

Senator BLUMENTHAL. Isn't this precisely the reason why people buy insurance, homeowner's insurance specifically?

Mr. KEVELIGHAN. Everybody buys insurance in order to cover their risks. Now, what we do at the I.I.I. is to make sure that people understand how that insurance works, because there are things that need to happen in terms of standard exclusions for defective construction materials. That is not a homeowner insurance policy issue. That may be a manufacturer construction issue, but it's not one that falls to the personal homeowner insurance policy.

Senator BLUMENTHAL. I'm going to ask Mr. Doak, doesn't this situation make your blood boil as an insurance commissioner?

Mr. DOAK. Well, Senator, it's unfortunate. We have similar issues in my state as well. We had a 4.4 earthquake last night at 9:58 in Edmond, Oklahoma. We have Oklahomans whose foundations are having particular issues relative to seismic activity. However, with earthquake insurance, much like the policy that you're

talking about, I do agree with Mr. Kevelighan, that this, to me personally, is more of a commercial risk exposure due to the manufacturer or the quarry that was used, going back to the source, much like there are cases in Oklahoma are——

Senator BLUMENTHAL. I just want to make sure you understand, Mr. Doak, what happened here, and I'll analogize it to the earthquake situation. It is as though the insurers in your State of Oklahoma figured out, "Oh, we have earthquakes in Oklahoma, so we're going to change these policies, because this could mean a lot of losses for us, to exclude earthquakes, but we are not going to properly inform consumers." So they're going to wake up today, as many of your fellow Oklahomans did, with damage from earthquakes, and go to their policy, and the insurers are going to tell them, "Oh, we changed that policy. It's only earthquakes in April in leap years." That's the equivalent of what happened here. It's the lack of proper notification.

Mr. DOAK. Exactly. And this is what I——

Senator BLUMENTHAL. And as an insurance commissioner, and I would say this to our insurance commissioner, the insurers have an obligation to do better——

Mr. DOAK. No question——

Senator BLUMENTHAL.—and I think everybody on this panel agrees.

Mr. DOAK. No question. The disclosures whenever a product or a contract is changed, those disclosures, the clients, the consumers, should be educated on that. It's unfortunate, though, through the National Association of Insurance Commissioners, we have the Consumer Board of Trustees, and one of the challenging efforts that we have on consumer education is most consumers never read their policies before there is ever a claim, and when they get these endorsements or disclosures in the mail where some of the policies are changing based upon the terms and conditions and regulatory authority, some of these are changing, but many of them are not read.

But if the clients, if the folks, are not getting the proper disclosures, I agree with you. I think we're all in agreement there.

Senator BLUMENTHAL. Well, in my view, there is no question that the disclosures were totally inadequate, that this conduct is unconscionable and indefensible, and that there ought to be adequate redress in the courts.

Mr. DOAK. Sure.

Senator BLUMENTHAL. And I will take action to support the efforts in the courts more vigorously than we have before because, as I say, I have lost patience with FEMA, with other sources of recourse. Some of the insurers have stepped up, recognizing their obligation.

Mr. DOAK. Sure.

Senator BLUMENTHAL. But they rightly insist that all of the insurers be part of the solution so it doesn't fall unjustly on the ones who want to do the right thing. And so I would call upon members of this panel to use your moral suasion with your industry so that all of them do the right thing here because I think it is a really important example of following moral and legal responsibility.

I'm going yield, and then I hope we'll have a second round of questions.

Senator MORAN. The Senator from West Virginia, Senator Capito.

STATEMENT OF HON. SHELLEY MOORE CAPITO, U.S. SENATOR FROM WEST VIRGINIA

Senator CAPITO. Thank you. Thank you all. I'm sorry I missed your testimony, but I do have questions. It's kind of related along the lines of the tornado issue. In our state, it happens to be flood, flood catastrophes. I just toured Mannington, West Virginia, and I know McMechen, West Virginia, had tremendous floods, homeowners really caught unawares, and life-altering kinds of things. Unfortunately, we lost two folks, but a lot of property damage.

How do you recommend that, as a public servant who goes in, works with the EMS, works with FEMA, works with SBA, to try to facilitate those conversations with our constituents who are harmed, how do we inform them or make sure that rural Americans are not going to be ripe for issues like contractor fraud or insurance fraud in the case of really a once-in-a-lifetime sort of event? We can—it's for anybody. So, Mr. Doak, I don't know if you do anything in Oklahoma.

Mr. DOAK. I think one of the things that the NAIC has done very, very well is provide many different types of consumer education, consumer tools, at the state level. Many of the states like mine have put together PSAs. For instance, we have put together a series of PSAs relative to earthquake, wildfire, different types, to be able to drive that message at a local level to understand the claims process or what's covered or not covered. So in a flood process, those same principles apply because most folks, when they have that type of catastrophic event, have never been through it before.

Senator CAPITO. Right, right.

Mr. DOAK. And so it's very, very challenging. And also that's where the relationship with the insurers that we regulate, we expect them to provide some of that education, and through some of their marketing pieces, to be able to articulate that. But it is very, very challenging, Senator. And I do agree. I have been to too many sites in my state where folks have been totally devastated, and they don't understand the claims process, no matter what peril caused it.

Senator CAPITO. Right. And one of the things I've noticed, and I don't know how you avoid this except through education, is, for instance, in the flood, your first inclination in your home is to get everything out, just to get it out, obviously for obvious reasons, health reasons and other reasons, but I kept saying you've got to document every single thing, you've got to keep all your receipts for your cleaning fluids, all the stuff that you—and they sort of give me this blank look like, "Oh, well, that—," you know, you're in such a panic in the first 48 hours to try to——

Mr. DOAK. Yes, ma'am. One of the things my colleagues may agree on, but one of the things that the NAIC has put together, and it has been a very effective tool, is a home inventory tool. They can go out on the website. We try to encourage that in Oklahoma

with the number of catastrophes that we have, but take pictures of your home, document some of these things.

Senator CAPITO. Right, right.

Mr. DOAK. Because a picture is worth a lot of money when it comes time to a claims settlement if it's by a flood or wildfire or whatever the case is.

Senator CAPITO. Right. I think like I said, that's a good suggestion.

I'm going to go to Ms. Weintraub about the opioid issue. Our State of West Virginia unfortunately has a high use of—we've been hit hard with this opioid abuse issue. We've had some pain clinic doctors who were recently indicted on fraud charges. "Pill mills" is a term I've heard too much in our state.

How do you approach this—I read your testimony—in terms of insurance? How can you be helpful or how do you feel that the insurance industry can be more helpful in this area?

Ms. WEINTRAUB. Well, first, this is a huge problem across the country and West Virginia.

Senator CAPITO. Right.

Ms. WEINTRAUB. And our hearts go out to all of the people and all the families who are suffering as a result of this crisis.

Senator CAPITO. Right.

Ms. WEINTRAUB. Some insurers have the data to monitor opioid prescription levels, and I think should be, and some are, a force for good in finding ways to tackle this mounting problem. We encourage insurers' full cooperation in working with government and others seeking solutions, but in some ways, insurers could also be part of the problem.

First, some insurers will not pay for alternatives to opioids, such as steroid injections or physical therapy and nerve blocks. And some insurers try to do the right thing by limiting the amount of opioids a person should be able to obtain, but sometimes it's not done in the right way, and some patients have been on a drug for so long that they then turn to the streets and other much, much less safe alternatives. So in these occasions, this sort of turning to street drugs exacerbates the problem.

Senator CAPITO. I have one second left. So does anybody have anything to add on that from the insurance perspective?

Mr. Jay.

Mr. JAY. Yes, Senator, that's an excellent question. And part—almost every state, every state but one, has a drug monitoring——

Senator CAPITO. Right.

Mr. JAY.—prescription monitoring program. And some states have now recognized that if they share some of this data with insurers, both health and property/casualty, who pay reimbursement for these drugs, they can find some of these schemes much more quickly, not only people who are doctor shopping, but also some of the physicians who are prescribing and some of the pharmacists who are dispensing these drugs like giving candy out on the street, and those are the people we've got to shut down first.

Senator CAPITO. Right. I would say in terms of the insurance industry, our state has a pharmaceutical monitoring system, so if that person who is going to the pharmacy is using an insurance card, they can and are picked up much more readily. There is a

certain percentage who are paying cash for this. And some states are not required to input that data into a pharmaceutical monitoring system. I will say thank you to the insurance companies in that they have created systems where it's instantaneous, and if the person goes to the next pharmacy——

Mr. JAY. Right.

Senator CAPITO.—it can pop up if they're on insurance, but if they're paying cash, it's much, much more difficult. But I think our states are all working together to figure how to close that loophole.

And for a long time, some of the problems were the states weren't cooperating with one another. So you have West Virginia, and you can just go right across the river over to Ohio or to Kentucky, and you're in the same thing, and that problem is getting better. But we've got to have everybody, you all at the table, and everybody at the table because this problem is—the report that just came out, it's a preliminary report from the President, says it's a national emergency, and I believe that it is. And thank you all very much.

Senator MORAN. Senator Capito, thank you for persistence in regard to opioid abuse in West Virginia and across the country.

Let me tell my colleagues and to our panelists, we are expecting votes sometime around 11. My intention is to conclude the hearing when those votes are called. We'll wrap up here and we'll not resume. So we probably have 10, 15 minutes left in this hearing. Many of the questions that may be asked of you will be submitted to you in writing, and we'll request a response.

Let me say to you, Mr. Jay, in regard to your HIPAA legislation, I'd be interested—I think I'm speaking to the right person who raised this——

Mr. JAY. Yes.

Senator MORAN. I'd be glad to hear more about that if you would let our Committee staff know. It seems a place in which there may be a role for Federal legislation.

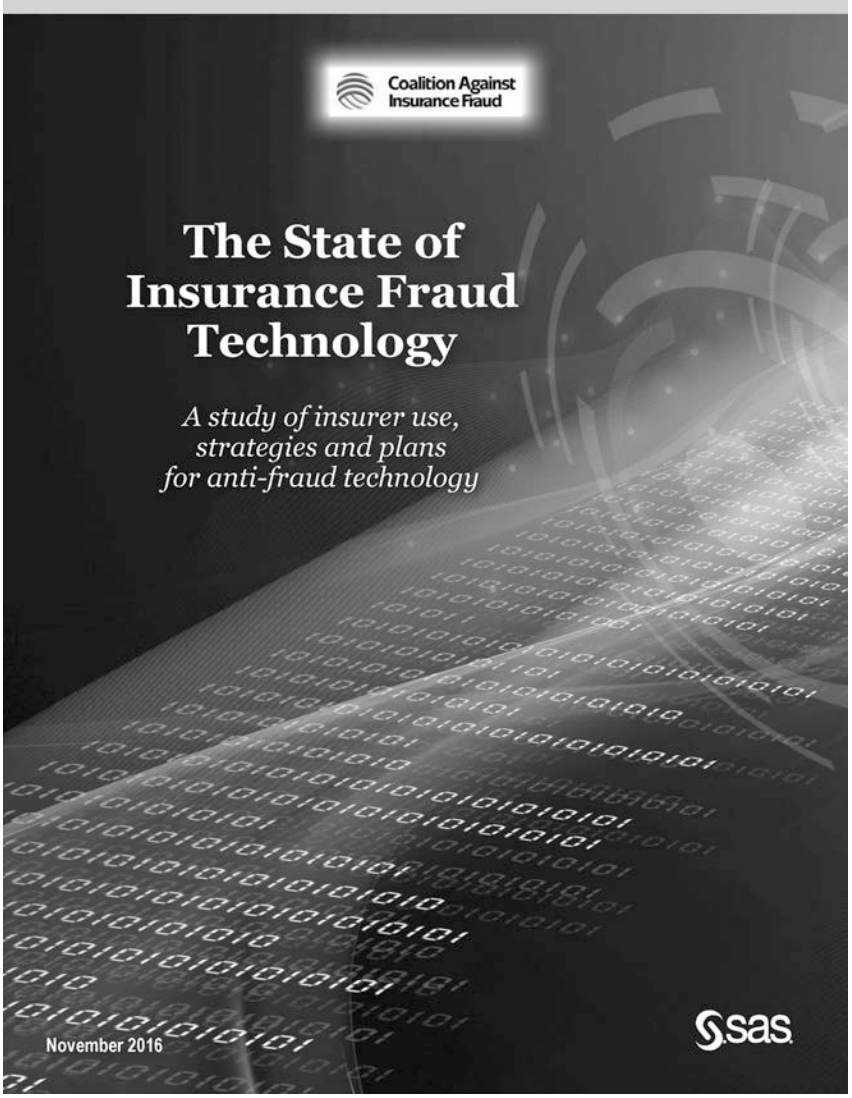
And I generally would ask the question of all of you. We're having a—we'll continue to have a health care debate. One of the things I think that has been missing in this conversation for a long time is, What do we do to reduce the underlying cost of health care? We spend a lot of time on trying to figure out who pays, but we're missing an opportunity that I think could be very bipartisan in trying to get rid of the things that drive up the cost of health care, and therefore, drive up the cost of health insurance.

And one of the things that comes to me in the testimony that I've heard from you is medical insurance fraud, which I assume is both committed by the provider, the health care provider, as well as the patient or consumer. I'd love to know information about—that you all may have in regard to the overall cost to the system that that kind of fraud creates. And if there is a way we can address it, it could be one of the things on a list I have of many that we could address in regard to the cost of health care as we continue to try to figure out who pays the bills.

Let me ask, Mr. Jay, I think this is directed at least initially to you. There are a couple of things I want—I'm going to ask you about your Coalition's 2016 annual report. There is also a 2016 study conducted by the Coalition, "The State of Insurance Fraud

Technology." I'd ask unanimous consent that both of those documents be made part of the record. Without objection, they will be.

[The information referred to follows:]



The State of Insurance Fraud Technology

A study of insurer use, strategies and plans for anti-fraud technology

Executive Summary

Insurance fraud continues to be a major issue for insurers, and for consumers who must bear the higher costs this crime adds to insurance premiums. A majority of insurers in this study say fraud has increased against their company over the last three years. Use of technology to detect fraud in claims, underwriting and other areas continues to climb. More insurers embrace and have expanded their use of tech systems as a key component of their anti-fraud strategies.

This study builds on similar Coalition studies conducted in 2014 and 2012 to better understand how insurers deploy technology to tackle insurance crimes. The study compares how insurance fraud has changed since the previous studies, and how advances in technology enable insurers to better combat insurance crime. The study consisted of an online survey of 86 insurers, which represent a significant share of the property/casualty market.

The 2012 study found that roughly half of insurers had fully integrated technology into their anti-fraud systems. That percentage is closer to 75 percent by 2016. Clearly, insurers are more-comfortable using technology and justifying its expense. As a growing trend, insurer senior management is becoming more analytically aware and increasingly feels technology investment helps improve their company's competitive advantage.

The perception of increased fraud may be a big reason why insurers justify greater investment in anti-fraud technology. Some 61 percent report that the number of suspect frauds increased slightly or significantly in the last three years (see Figure 1). This compares to 51 percent in

the 2014 study. The question remains whether fraud is increasing or whether insurers — in part through greater use of technology — are getting better at detecting it.

Among other findings:

• Claims-fraud detection continues to be the leading area for technology. The percentage of insurers using technology to detect suspect claims jumped from 65 percent to 76 percent in the last four years.

• The most-popular technology deployed is automated red flags/business rules, used by 90 percent of insurers that use anti-fraud technology.

"Technology is producing more referrals, and better-quality ones, insurers report. Another benefit many cite is increased mitigation of losses."

• More than half of insurers surveyed use predictive modeling, a significant increase from just two years ago.

• Internal data and public records continue to be the largest sources to feed technology systems. The number of sources and quantity of data available to insurers also continue to grow.

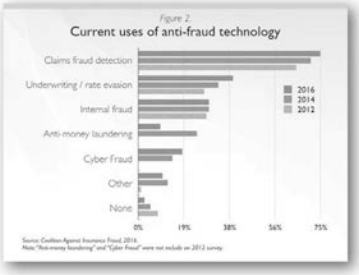
• Technology is producing more referrals, and better-quality ones, insurers report. Another benefit many cite is increased mitigation of losses.

• 70 percent of insurers said technology accounts for more than 10 percent of fraud referrals they receive. Six percent of insurers said they receive more than 60 percent of their referrals through technology.

• The two biggest challenges insurers face is the lack of IT resources available to maintain and expand programs, and excessive false positives their systems produce.

• One-third of SIU directors expect their IT budgets to increase in 2017. Tops on their shopping lists are predictive modeling and link analysis/social-media programs.

Current state of fraud & technology



The full scale of insurance fraud is unknown. Because this crime is designed to go undetected, the fraud-fighting community can only guess at the extent of crime and dollar losses. Fraud is perceived to be prevalent throughout the insurance lifecycle, from the application process through the claims arena. Insurers increasingly see more attempted fraud at "point of sale" — during the application and renewal process. This is most-common with online coverage purchases. Insurers also fight internal fraud, money laundering and, for the last few years, the emerging issue of cyber fraud.

Areas employing technology. Some 76 percent of insurers said detecting claims fraud is the primary use of anti-fraud technology. That is up from 71 percent in 2014 and 65 percent in 2012. Using technology to counter underwriting and automobile rate-evasion schemes saw similar increases from 2012 to 2016. The percentage who say they use no technology in the areas listed dropped from eight percent in 2012 to 2.5 percent in 2016.

Using tech to uncover internal fraud has plateaued at 29 percent. Insurers using anti-money-laundering software fell from 24 percent to nine percent over the last two years. The decline may stem from the small sample size for that question in 2014.

Cyber fraud continues to be a growing issue for insurer anti-fraud departments. Nearly one of five say they use technology to combat this growing threat.

Tools employed. Technology plays an important role in preventing fraud, but most insurers have found that no single technology tool is sufficient. A combination of techniques usually is required to identify opportunistic and organized fraud.

> *"...as the quality, quantity and variety of data expand, workflows will become more proactive and that will enable SIUs to focus on the most significant threats."*

The first line of defense most insurers employ continues to be automated red flags/business rules. They are the bread and butter of anti-fraud technology. Tied to existing claims systems, they can quickly help insurers tag honest claims for payment, and isolate suspect ones for routing to anti-fraud departments. In 2016, 90 percent of insurers surveyed reported using automated red flags and business rules, up from 64 percent four years earlier.

The use of predictive modeling also increased significantly as more insurers went online with this technology. The percentage of insurers using predictive modeling jumped from 40 to 54 since 2012

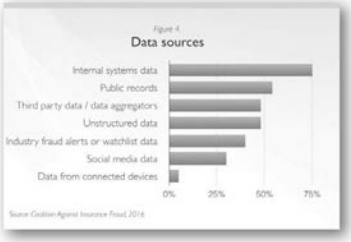
Link analysis and mining social media also saw substantial increases. Two-thirds of insurers surveyed said they use these tools.

Usage remained largely flat for exception reporting or anomaly detection, text mining, geodata mapping, data visualization and case-management systems. While the pure number of users are up likely because of the large sample size in 2016, the percentage remained the same. The 2016 study also included a larger percentage of insurers that are later adopters of anti-fraud technology — another reason for the potential lag in the apparent growth of these tools.

Insurers also were asked how often they refresh their automated red flags/business rules. The most common answer was annually (34 percent), though 32 percent say they refresh more frequently.

Sources of data. Insurers report plenty of options to feed data in their systems. Data sources have expanded as more data vendors have come online, and as insurers find greater use of internal

data from claims systems and elsewhere in their own files. While all data sources data have increased from prior studies, three areas — internal data, public records and social media — have grown the most. Integrating industry fraud alerts into internal systems also is becoming much more prominent since 2012 and 2014. The increased availability of such alerts likely is encouraging more insurers to integrate them into their systems.



SIU leaders suggest that as the quality, quantity and variety of data expand — in conjunction with the ability to automatically scrub data — workflows will become more proactive. That will enable SIUs to focus on the most-significant threats.

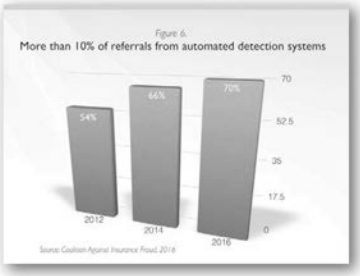
Benefits seen of employing anti-fraud technology

Most insurers reported receiving more referrals, better referrals and increased mitigation of losses when asked to list the top three benefits they experience with their tech systems. Those benefits are similar to the 2014 study. Two areas cited less-often than the earlier studies were uncovering complex or organized rings, and improving investigator efficiency.

The benefits of more referrals were echoed when insurers shared their experiences with referrals they receive from tech systems. Only 55 percent of insurers said they received more than 10 percent of their referrals from technology in 2012. That rose to 70 percent by 2016 — up from 66 percent in 2014. Interestingly, no insurers reported receiving more than 60 percent of referrals from their automated systems in the two previous studies. In 2016, six

percent of insurers reported so.

Insurers often ask if there is an optimum range of referral percentages their systems should produce. Discussions with insurers and technology experts suggest no standard optimum at this point. Results largely will continue to depend on sophistication of systems, training of users, claims philosophy and mix of business.



However, a meaningful benchmarking metric might be developed when anti-fraud tech matures and is used more-uniformly.

Challenges of implementing anti-fraud technology

Survey participants also listed their top three challenges in employing their technologies. The rankings are similar to the 2014 study:

• **Limited IT resources** – both in budgets and in-house expertise – topped the list. Technology is expanding rapidly in most areas of insurance operations, from marketing to underwriting to legal. The demand for internal IT services is high, yet budgets for outside services are not adequate for many companies to maintain existing technologies and add new ones.

• **Excessive false positives** are the second-most-cited challenge. SIU directors say their units spend far too much time investigating cases that are not legitimate fraud reports. While insurers vet most leads during the triage process, excessive false positives waste valuable resources that are in short supply in many SIUs.

The high level of false positives likely stems from the large number of late adopters of technology that participated in the study.

Excessive false positives are more likely to be a problem for insurers using a narrow scope of technologies and/or data. Insurers using a robust mix of technologies and those using several sources of data seem to experience a lower level of false positives.

There also is growing anecdotal evidence that the more experience insurers gain with their systems, especially with automated red flags/business rules and predictive modeling, the more they can tweak their systems to reduce false positives. Insurers talk about reaching a "sweet spot" where their systems produce a high level of suspect claims while generating far fewer false positives.

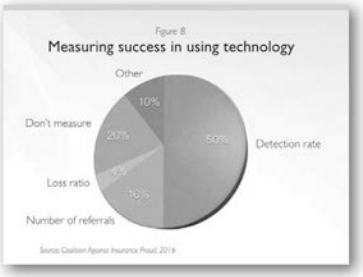
> *"Insurers talk about reaching a 'sweet spot' where their systems produce a high level of suspect claims while generating far fewer false positives."*

Justifying the benefits of using anti-fraud technology appears to be less of a problem for many insurers. It was the highest challenge cited in 2012. As insurers grow more comfortable with technology, it appears both SIU leadership and senior management understand the positive bottom-line benefits of using technology to detect more fraud, and earlier in the claims process.

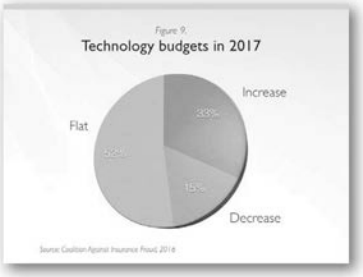
Measuring success of anti-fraud tech

Fraud-detection rate was the most-cited metric for measuring success, followed by number of referrals received. Interestingly, one in five insurers said they do not use metrics to gauge success of their technology.

Another potential measurement includes number of days from first notice of claim to detection. Automating



detection processes to assess all claims from first notice allows early claim-cycle detection opportunities to mitigate questionable loss severity.



Future investment in fraud technology

Anti-fraud technology likely will continue growing through next year. Nearly a third of insurers say they are budgeting to expand their technology. In fact, twice as many insurers said their tech budgets will rise as said budgets will decline. In 2014, only a quarter of insurers said they expect bigger budgets for the next year, so it appears technology investments are accelerating.

And how will insurers spend the new tech dollars? Most say they will invest in predictive modeling, followed by link analysis and social-media software, and then text mining.

Other findings

- 64 percent maintain their systems in-house. The rest outsource; and
- Anti-fraud technologies have the greatest impact on fraud dealing with personal auto, organized rings and medical providers.

Conclusion

Today's anti-fraud technology continues to expand and become more-effective, and just as important, evolve as fraud schemes shift. Software solutions today have advanced to where they can "learn" from experience and get even better at fraud detection and identifying patterns. This "learning" enables software to adapt and increase in sophistication as it gathers more data. The more-intelligent the tools, the greater chance of detecting fraud in the early stages, and even predicting potential areas of fraud before criminals uncover the opportunity.

One term that is a buzz phrase for many insurers is "speed of detection." This describes an aspect of technology that is helping get more claims handlers to embrace these new tools. For many

in the claims arena, suspect frauds take extra time and work, and lengthen cycle time. A natural tension exists in many insurance companies between claims departments that focus intently on closing files, and SIUs that want to slow the process to investigate.

Newer technologies such as predictive modeling can meet both goals: help detect fraud earlier in the process, and thus shorten cycle time. Conversely, the technologies more quickly validate legitimate claims and allow insurers to pay them more promptly.

> *"Insurers that embrace the right mix of tools, staffing, training and technologies will continue to experience reduced claims costs, more accurate pricing, (and) a competitive edge..."*

While referrals from claims staff will always be a factor in anti-fraud workflow, existing and future technologies likely will accelerate fraud detection, allowing faster resolutions of legitimate and suspect claims.

While not covered in this study, the human element in using technology — along with traditional investigative functions — should not be overlooked. Discussions with insurers that are getting excellent results from their anti-fraud programs underscore the importance of having knowledgeable and well-trained staff to use and support tech tools to their fullest degree. As promising as all these tools may be, unless they are employed in conjunction with investigators' instincts and savvy, results likely will fall short.

Insurers that embrace the right mix of tools, staffing, training and technologies will continue to experience reduced claims costs, more-accurate pricing, a competitive edge and lower premiums for policyholders.

About this research

The State of Insurance Fraud Technology was undertaken by the Coalition Against Insurance Fraud to better understand how and to what extent insurance companies use anti-fraud technology. This is a followup to similar studies conducted in 2012 and 2014. It addresses anti-fraud technologies insurers now use, and are considering using. Technical assistance was provided by SAS Institute, an international company focusing on technology solutions for businesses and governments.

In addition, technical review and oversight for the methodology, survey instrument and this report was provided by the Coalition's Research Committee:

- John Kloc, Sentry Insurance
- David Rioux, Erie Insurance
- Steve Friedman, Liberty Mutual
- Jack Dever, American Family
- Joseph Theobald, Citizens Property Insurance Corporation

The research for this report drew on two main initiatives:

- Online survey in which 86 mostly property/casualty insurers provided data in June and July 2016; and
- Qualitative research, including in-depth interviews with a range of subject-matter experts and senior insurance executives.

The Coalition Against Insurance Fraud thanks all who cooperated on this research for their time and insight.

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The State of Insurance Fraud Technology

Survey instrument

1. In which areas does your company currently employ anti-fraud technologies? (check all that apply)

Detection of claims fraud
Underwriting, or point-of-sale fraud / rate evasion
Internal fraud
Anti-money laundering
Cyber fraud
Other (please specify)_____
None

2. Concerning fraud detection, does your system incorporate? (check all that apply)

Automated red flags / business rules
Predictive modeling
Exception reporting / anomaly detection
Text mining
Link analysis / social network analysis
Geographic data mapping
Reporting capability / data visualization
Case management
Other (specify)_____

3. Is your fraud detection system?

Maintained in house
Hosted by a third party (e.g. vendor or cloud)

4. What data sources are used by your anti-fraud technology? (check all that apply)

Internal systems data (claims, policy, underwriting, application etc.)
Unstructured data (adjuster notes, emails, etc.)
Public records (criminal, civil, Motor Vehicle, etc)
Industry fraud alerts or watch list data (NICB, etc.)
Third party data / data aggregators (Lexis Nexis, ISO etc.)
Social media data
Data from connected devices (telematics, smartphones etc.)
Other (specify)_____

5. What percent of referrals come from your automated fraud detection solution?

Less than 10%
10 to 19%
20 to 29%
30 to 39%
40 to 60%
More than 60%

6. What are the top three benefits you receive from a fraud detection system?

More referrals
Higher quality referrals
Increased mitigation of losses determined to be fraudulent after investigation
More consistent claims investigations
Better understanding of referrals
Improved Investigator efficiency
Enhanced reporting
Uncovering complex or organized fraud activity
Other (specify)_____

7. What were the biggest challenges in deploying fraud detection technology? Please rank the top three with "1" as the biggest challenge.

Lack of cost / benefit analysis (ROI)
Limited IT resources
Delayed claims adjudication
Data integration and poor data quality
SIU cannot handle volume of potentially fraudulent claims
Excessive false-negative / false-positive rates

8. In what areas does anti-fraud technology have the greatest impact in your company? (please check up to three)

Personal auto – comprehensive, collision
PIP/No fault fraud
Medical provider fraud
Organized/professional fraud (staged accidents, complex claims, Rings)
Soft or opportunistic fraud (low impact soft tissue)
Application or underwriting fraud (premium fraud, misrepresentation)
Property claims (homeowners, commercial property)
Commercial claims (workers comp, liability)
Agency fraud
Internal fraud

9. How frequently do you review and refresh your business rules and analytical fraud models

Monthly
Quarterly
Semi-annually
Annually
More than annual
Never
Don't know

11. How do you measure success of your anti-fraud technology solutions?

Number of referrals
Fraud detection rate
Average days to detect fraud
Loss ratio
Other

12. During the last three years, has the amount of suspected fraud against your company:

Increased significantly
Increased slightly
Remained the same
Decreased slightly
Decreased significantly

13. In which areas does your company are you considering investing anti-fraud technologies in the next 12 to 24 months? (check all that apply)

Detection of claims fraud
Underwriting, or point-of-sale fraud / rate evasion
Internal fraud
Anti-money laundering
Cyber fraud
Other (please specify)_____

14. Which of the following anti-fraud technologies are you considering investing in within next 12 to 24 months? (Check all that apply)

Automated red flags / business rules
Predictive modeling
Exception reporting / anomaly detection
Text mining
Link analysis / social network analysis
Geographic data mapping
Case management
Reporting / data visualization
Other (specify)_____

None

15. Which of the following describes the overall anti-fraud technology budget during the next 12 months?

Decreased budget
Flat / no major changes in funding
Additional funding approved or anticipated

16. What is your company's primary business?

Accident & Health – go to 19b)
Auto – go to 19a)
Commercial – go to 19a)
Disability – go to 19b)
Homeowners – go to 19a)
Life – go to 19b)
Workers compensation – go to 19a)

17a. What is your company's direct written premium?

Less than $250 million
$250 million to $999 million
$1 billion to $2.4 billion
$2.5 billion to $5 billion
Greater than $5 million

17b. What is your company's size of business?

Fewer than 250,000 lives covered
250,000 to 500,000 lives covered
More than 500,000 lives covered

18. Which of the following best describes your job function?

Senior management
SIU director/manager
Claims director / manager
IT director / manager
Other (specify)_____

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Coalition Against Insurance Fraud

A passion for progress:

Eight trends that shaped fraud and fraud fighting in 2016

ANNUAL REPORT 2016

Coalition Against Insurance Fraud

State of the fight

What metrics best gauge our progress in combatting insurance fraud? Number of arrests and convictions? Referrals to SIUs or state fraud bureaus?

How about impact studies of insurer bottom lines? Or changes in people's tolerance of fraud?

Perhaps all of them, some, or maybe others.

In a Coalition study last year, two-thirds of insurers said they saw more fraud. Is there really more fraud? Or are insurers just getting better at detecting scams? Perhaps the best question is how much fraud would we face if insurers and government weren't spending many millions of dollars to combat this crime?

The Coalition Against Insurance Fraud is the only organization that monitors the fraud fight from a mile high. We gather and analyze data from all sectors of the anti-fraud community — taking the pulse of the fraud fight. Our Major Case Monitor *(see opposite page)* saw an increase of nearly 14 percent from 2015 to 2016, mostly due to more arrests and convictions in medical, workers comp and life insurance.

Is progress being made in curbing fraud? The answer is yes — with caveats. Most available metrics reveal a continuing, robust, anti-fraud effort that is better countering fraud schemes across the insurance spectrum ... from different lines, from private insurers to public payers.

With few exceptions, this anti-fraud force grows stronger each year. In 2016, we saw the continued evolution of technology as a vital tool to detect and investigate schemes. More organized rings were taken down — and longer prison sentences handed out. Insurers also launched more affirmative litigation against crooked medical providers.

Outreach to consumers — honest people and those tempted — has never been greater.

We also saw moderate success in enacting laws to crack down

All and all, 2016 was a positive year of progress in combatting fraud. But challenges did emerge.

on crooked contractors, and body shops that install fake airbags.

All and all, 2016 was a positive year of progress in combatting fraud. But challenges did emerge. At least two states backtracked on procedures that made it tougher for investigators and prosecutors. A court ruling limiting the use of examinations under oath also hampered fraud fighters.

State fraud bureaus say good case referrals from insurers are declining.

And severe weather events are rising — from Hurricane Matthew to tornadoes in Georgia to damaging hail storms in the Midwest. Fraud artists flock to storms and other weather events, but alert insurers work hard to keep scams in check.

So looking back on 2016, how would you grade the nation's anti-fraud efforts? How well did your organization combat this crime? More to the point ... how are you strengthening your efforts for the challenges ahead?

Coalition Against Insurance Fraud

Rebellion afoot

Startups tout easy insurance, less fraud

People's emotions can run high during claims — fear, anxiety, hope, anger. Consumers who think their insurer treats them well are less-likely to defraud. That's one meaning of a recent study of how anger can drive people's ethical choices.

Angry consumers are more-emboldened to defraud — especially businesses, the research says. The study probed people's ethical decisions in general. Still, it helps to show why many normally honest people bilk insurers with smaller home or auto claims — or may want to.

People who feel they had a positive claim experience tolerate fraud less than people with negative experiences, the Coalition's national consumer-attitude study confirmed in 2007.

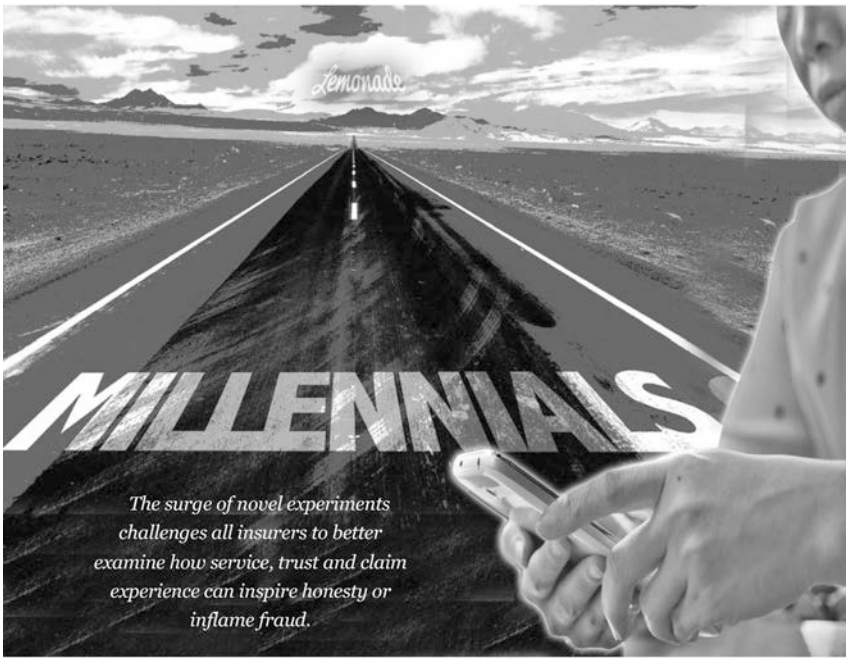
Implication. Customers who think they're treated fairly and well are more likely to stay honest in their insurance dealings. Elevated service thus becomes an anti-fraud strategy.

Rebellion. Yet rebellion is underway. Young, tech-savvy insurance entrepreneurs are making waves. Fair or not ... they contend insurance customer service needs a lot of improving. The raw emotions of difficult claims can encourage more people to defraud, they believe. The surge of insurtech experiments is catalyzing new thinking over what makes a good customer insurance experience.

Online peer-to-peer insurer startups, for instance, claim they're more transparent and make insurance easier. Happy customers have less desire to defraud an insurer, the thinking goes.

The new insurer Lemonade features a mobile app that proclaims a simple, fast insurance experience. Ease of use, transparency and investing underwriting profits in social causes make customers more likely to play fair in return, Lemonade contends.

Whatever the truth ... the surge of novel experiments challenges all insurers to better examine how service, trust and claim experience can inspire honesty or inflame fraud.



Coalition Against Insurance Fraud

Technology

Plentiful and powerful detection tools persist

Anti-fraud tech continued its inexorable maturing, gaining more potential to help investigators tilt the balance against insurance crime. Tech's greatest value stems from its muscular support of the savvy, instincts and 360 vision of fraud fighters. That partnership is flourishing, at the right time.

Insurance fraud is spreading, and more insurers are deploying automated systems to detect false claims, insurers say in the Coalition's 2016 survey of insurer use of technology. Automated systems are detecting false claims as more insurers adopt the technology, insurers also say.

Especially, analytics help investigators dismantle organized fraud rings and crooked medical providers, insurers say in the Coalition survey. Technology thus continues playing an ever-larger role in support of astute fraud fighters.

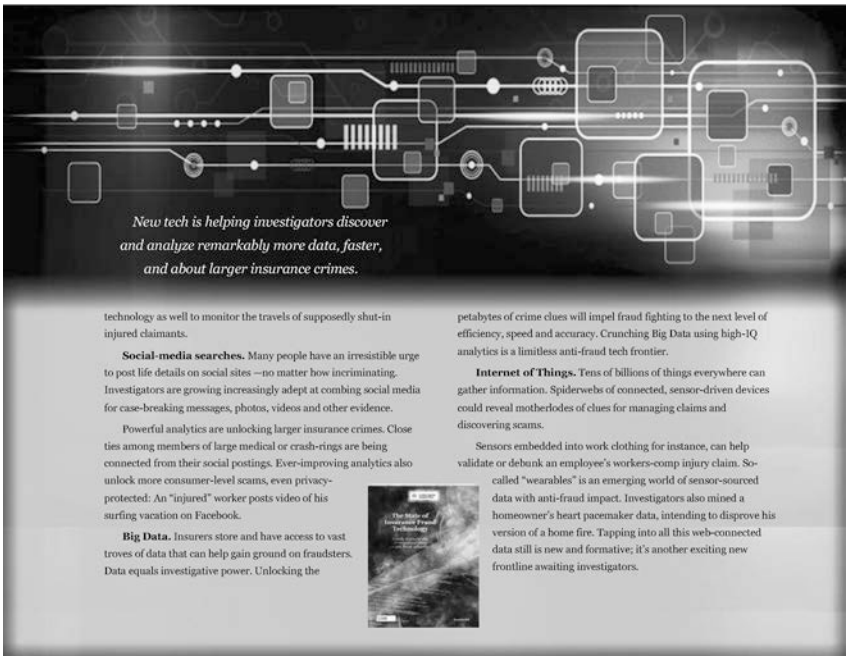
New tech is helping investigators discover and analyze remarkably more data, faster, and about larger insurance crimes. The constant challenge is to protect lawful privacy rights along the way. Among the welcome advances of 2016:

Telematics. So-called black boxes plus sensors embedded throughout vehicles are large vaults of clues that can help sleuth out auto schemes. Was painful whiplash from a claimed crash real? A driver's moves can be tracked from telematics data. Speed, braking reaction, G-force, vehicle location all give investigators a fuller grasp of a claim's truth.

Drones. Look for more drones buzzing overhead, scouting for evidence. The FAA relaxed rules to allow commercial drone use last year.

Coming soon: Wide-angle drone images and video routinely recording home damage after storms — thus preventing contractors or homeowners from inflating roof damage. Also viewed from above: building fires ... vehicle crash scenes ... supposedly injured workers in action ... crop damage. Drones especially can search in hard-to-reach places.

License readers. Live in high-premium New York but falsely say you drive in lower-premium state? Auto insurers use the devices to discover garaging schemes that illegally shave auto premiums. Motorists with fake or expired insurance cards can be found out. Workers comp and disability carriers are using the



New tech is helping investigators discover and analyze remarkably more data, faster, and about larger insurance crimes.

technology as well to monitor the travels of supposedly shut-in injured claimants.

Social-media searches. Many people have an irresistible urge to post life details on social sites —no matter how incriminating. Investigators are growing increasingly adept at combing social media for case-breaking messages, photos, videos and other evidence.

Powerful analytics are unlocking larger insurance crimes. Close ties among members of large medical or crash-rings are being connected from their social postings. Ever-improving analytics also unlock more consumer-level scams, even privacy-protected: An "injured" worker posts video of his surfing vacation on Facebook.

Big Data. Insurers store and have access to vast troves of data that can help gain ground on fraudsters. Data equals investigative power. Unlocking the petabytes of crime clues will impel fraud fighting to the next level of efficiency, speed and accuracy. Crunching Big Data using high-IQ analytics is a limitless anti-fraud tech frontier.

Internet of Things. Tens of billions of things everywhere can gather information. Spiderwebs of connected, sensor-driven devices could reveal motherlodes of clues for managing claims and discovering scams.

Sensors embedded into work clothing for instance, can help validate or debunk an employee's workers-comp injury claim. So-called "wearables" is an emerging world of sensor-sourced data with anti-fraud impact. Investigators also mined a homeowner's heart pacemaker data, intending to disprove his version of a home fire. Tapping into all this web-connected data still is new and formative; it's another exciting new frontline awaiting investigators.

Coalition Against Insurance Fraud

Court battles

Examinations under oath under fire

Imagine a world where anyone can legally say "no" when an insurer requests an interview about a claim. More criminals could defraud with less fear of being found out.

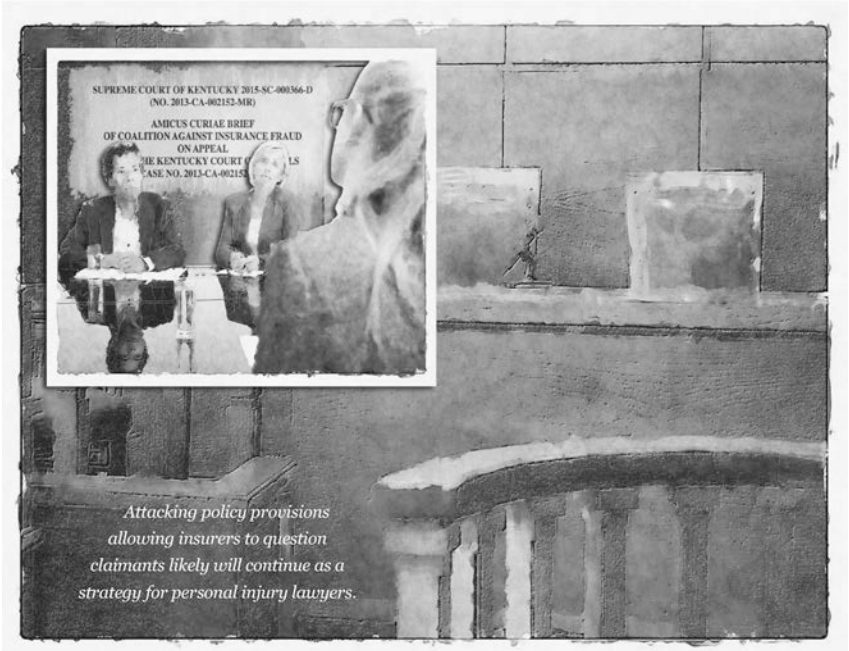
Critics sought to water down long-held insurer rights to interview claimants in Washington state's legislature and Kentucky's courts. At stake was the time-tested Examination Under Oath, or simply EUO.

Respectful questioning of claimants can expose scams, and validate honest claims. Clues to the truth often can be uncovered only by EUOs. Many fraudsters don't bother showing up, essentially dropping their claim under the threat of questioning.

A major victory came down in Washington state early in 2017. Fraud fighters quashed an ill-advised bill narrowing the statute of limitations for using EUOs. Staged-crash rings, especially, can take years longer to break open. Opposing the bill was a united front of insurance regulators, Coalition and other allies.

In Kentucky, a court rule members of a suspected staged-crash ring could refuse to show up for insurer EUOs, a Kentucky court ruled. More fraud rings likely will escape detection without EUOs, the Coalition and NICB contended in a joint amicus brief. The state Supreme Court to preserve insurer EUO rights. More claimants also will answer truthfully if they know they could face jail time for stretching the truth.

Attacking policy provisions allowing insurers to question claimants likely will continue as a strategy for personal injury lawyers. The Coalition thus will continue to defend EUOs vigorously.



Coalition Against Insurance Fraud

Stormy weather

Stormy times for swindlers?

Global warming has triggered widespread changes in weather patterns. Extreme weather events such as California's extended drought could become the new norm in many regions of the U.S. These events bring more opportunities for contractors and ethically challenged homeowners to inflate damage claims.

North America saw more loss occurrences in 2016 than in any other year since 1980, with 160 events recorded.

Hurricane Matthew caused serious damage on the East Coast. Tornados flattened towns in central Georgia. Flooding in Louisiana and other states imposed $10 billion in losses.

Potential fraud impact: Drought could spur more false crop-insurance claims by aggrieved farmers. Floods, hurricanes, hail and tornados routinely attract inflated loss claims by opportunist homeowners. Dishonest contractors also thrive by exploiting desperate homeowners.

More insurers are working to understand how extreme weather patterns will affect the fraudscape — and how to better head off bogus weather-inspired claims.

Forensic weather tools such as Doppler radar add remarkably detailed, high-altitude precision to ground-level investigations. Drones soon will gather yet more evidence now that the FAA has approved commercial use. Even claims for vehicle crashes involving slippery pavement, rain, fog or sun glare can be more-accurately analyzed.

Coalition Against Insurance Fraud

Painkillers

Pill mill crackdown gains momentum

America's opioid epidemic is part drug high and part insurance high. We're a nation struggling to contain addictive pain pills, muscle relaxants, anti-anxiety meds. The tragic price in overdoses, deaths, lost productivity and ruined lives is well-chronicled.

The untold story: Insurance fraud is a major bankroller of America's pill contagion, the Coalition's research shows. Workers-compensation and health Insurers lose up to up to $72 billion a year in bogus prescription claims a year. Fraud is helping finance a national health threat. Much progress in countering the epidemic and insurance losses was afoot in 2016.

The epidemic took many forms. Crooked pain doctors hand out insurer-paid painkiller prescriptions to addicts. The providers barely examine patients for medical need. Doctors then overbill private insurers, Medicare or Medicaid. Phantom exams, tests and other bogus care are inflated. Crooked pharmacies often fill the prescriptions.

Doctor-shopping addicts may fool doctors into pain prescriptions. Internet pharmacies make it easier to fill false prescription claims. Much is being done to tamp down false claims and opioid abuse. Among the positive signposts:

Some 49 states have prescription-monitoring databases. Doctors, pharmacists, health insurers and others can track opioid use by patients. Law enforcement can check if medical providers are overbilling;

Insurers are better discovering bogus prescription claims with improved analytics and stepped-up investigations;

More doctors are being cautious about prescribing opioids especially to doctor-shopping addicts; and

Partnerships of insurers, law enforcement and government are catching more pill mills and dishonest pharmacies in the act.

America still needs a coordinated national opioid strategy, and far more joint efforts are essential. That welcome day seems closer than ever.

America still needs a coordinated national opioid strategy, and far more joint efforts are essential. That welcome day seems closer than ever.

Coalition Against Insurance Fraud

Consumer Outreach

Messages louder, social, eye-friendly

Fraud fighters enjoyed a vibrant year of ever-growing agility in reaching consumers with deterrent messages. Creative experiments abounded — even daffy ideas — working to gain people's attention in a message-saturated society.

We're reshaping how we champion consumers to stay honest. The next-gen era of public outreach is asserting itself, along with traditional approaches that also persuade well.

Some 83 million Millennials are coming of age as insurance buyers. So make our anti-fraud consumer appeals brief ... blunt ... loud ... social ... visual. Increasingly, that's true for Americans of every age and lifestyle.

This means tapping the persuasive power of social media as a digital message carrier and conversation starter. Also humanizing fraud with eye-grabbing visuals. Our brains are DNA-wired image processors. Consumer videos, infographics and animated cartoons told the anti-fraud story quickly ... optically ... at a glance.

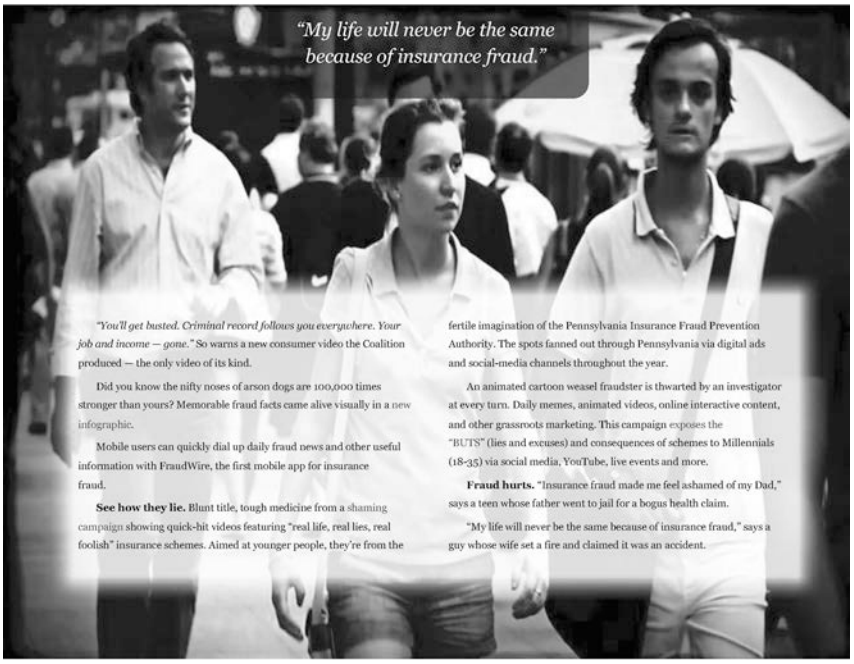
Mobile users gained much to cheer about as well. A new app made fraud information convenient for millions of mobile-reliant Americans. Numerous initiatives drove home anti-fraud messages in diverse ways last year. Several of the many 2016 highlights:

Persuasive power. Generous doses of social media, video and mobile friendliness defined much of the Coalition's success in reaching consumers last year.

Dan, on Twitter: "Hello everyone. If I wanted to make a stain on a wall — one that I could remove after — how could I do it. Insurance scam reasons."

Coalition: "Well, one, don't. Two... you'd probably get called out, embarrassed or arrested for that easy a scam."

Yet another flash moment of advising consumers to make smart life choices on @Insurance_Fraud. It's the busiest insurance-fraud hub on Twitter. Daily messages on Facebook, Instagram and other social platforms further urged upright insurance dealings.



"You'll get busted. Criminal record follows you everywhere. Your job and income — gone." So warns a new consumer video the Coalition produced — the only video of its kind.

Did you know the nifty noses of arson dogs are 100,000 times stronger than yours? Memorable fraud facts came alive visually in a new infographic.

Mobile users can quickly dial up daily fraud news and other useful information with FraudWire, the first mobile app for insurance fraud.

See how they lie. Blunt title, tough medicine from a shaming campaign showing quick-hit videos featuring "real life, real lies, real foolish" insurance schemes. Aimed at younger people, they're from the fertile imagination of the Pennsylvania Insurance Fraud Prevention Authority. The spots fanned out through Pennsylvania via digital ads and social-media channels throughout the year.

An animated cartoon weasel fraudster is thwarted by an investigator at every turn. Daily memes, animated videos, online interactive content, and other grassroots marketing. This campaign exposes the "BUTS" (lies and excuses) and consequences of schemes to Millennials (18-35) via social media, YouTube, live events and more.

Fraud hurts. "Insurance fraud made me feel ashamed of my Dad," says a teen whose father went to jail for a bogus health claim.

"My life will never be the same because of insurance fraud," says a guy whose wife set a fire and claimed it was an accident.

Coalition Against Insurance Fraud

Strong medicine in quick deterrent TV spots by fraud "victims." They're part of expansive statewide outreach campaigns by the New York Alliance Against Insurance Fraud. The spots aired in urban areas around the state. Fraud lays down damage on all New Yorkers, the message goes.

Barbie-size scam busting. "Errrgh," grunted a little girl doll as she pushed a plastic tree onto her tiny roof to scam a new master bedroom from her insurer. It was an animated video by the energetic anti-fraud outreach program of the Virginia State Police.

The state agency ramped up efforts to reach consumers on YouTube. A pair of 30-second video spots were released through the Google video network. The program grew its digital footprint by more than 50,000 views in four months. The Google video ad partner network spans more than two million websites.

Eyes on fraud, theft. Strong video warnings about automobile ploys flowed from the National Insurance Crime Bureau. NICB trekked to disaster scenes, warning consumers with TV public service announcements and TV news. Watch for flooded cars being sold to unwitting drivers after the record rainfall in the Baton Rouge area. News stories went out after hail storms blasted Colorado and Hurricane Matthew deluged the Carolinas.

NICB also aired national PSAs on contractor scams and cars stolen when owners left the keys inside.

Stirring lemonade. Want a glass of lemonade from the neighborhood kid's stand? Price tag: only $1,300. That's what fraud costs each New Jersey resident a year, warned an amusing video public service announcement that aired throughout the state.

Want to duel fraud zombies or dive into a whirlpool that's pulling stolen insurance money down into oblivion? Consumers had their photos taken with 3-D street art and shared virally on social media. The walking dead highlighted an outreach campaign by the New Jersey Office of Insurance Fraud Prosecutor.

Publicly naming, shaming and blaming extreme schemers makes insurance fraud stand out, be memorable and grab people's limited attention.

Putting a human face on fraud damage

Moral compasses whirred out of control for America's eight worst schemers named to the Insurance Fraud Hall of Shame. The No-Class of 2016 serves an important deterrent purpose. The Shamers put a human face on fraud. Publicly naming, shaming and blaming extreme schemers makes insurance fraud stand out, be memorable and grab people's limited attention. Among last year's eight masters of disaster:

Burning desire. "Oh well, they died," Bob Leonard remarked with zero remorse after botching a home arson that blew up a house and incinerated two next-door neighbors in an Indianapolis neighborhood.

Comp sex romp. A sex partner shot and paralyzed John Alfonzo Smiley after Smiley and his wife swapped partners with the shooter and his wife at a San Francisco sex club. Smiley was a prison guard. He made a false $4-million workers-compensation claim by lying that a former inmate with a grudge shot him.

Starving teen. Home caregiver Mollie Parsons let bedridden teen Makayla Norman starve to death while Parsons fleeced Medicaid with phony homecare claims in Dayton, Ohio.

Coalition Against Insurance Fraud

Legislative Advocacy

Skilled statecraft pressures auto scammers

Phony whiplash claims stole hundreds of millions of insurance dollars around the U.S. last year, helping drive up premiums. Thwarting four-wheeled fraudsters was a driving theme in statehouses throughout last year. Fraud fighters sought stronger penalties to tamp down staged-crash rings — and other automobile schemes.

Auto-related bills surfaced in more than 20 percent of states last year — by far the largest category of fraud legislation. Several became law. More than 100 anti-fraud bills of *all kinds* were introduced last year, with a respectable 20 signed into law. Thwarting dishonest contractors was another state theme important to fraud fighters consumers.

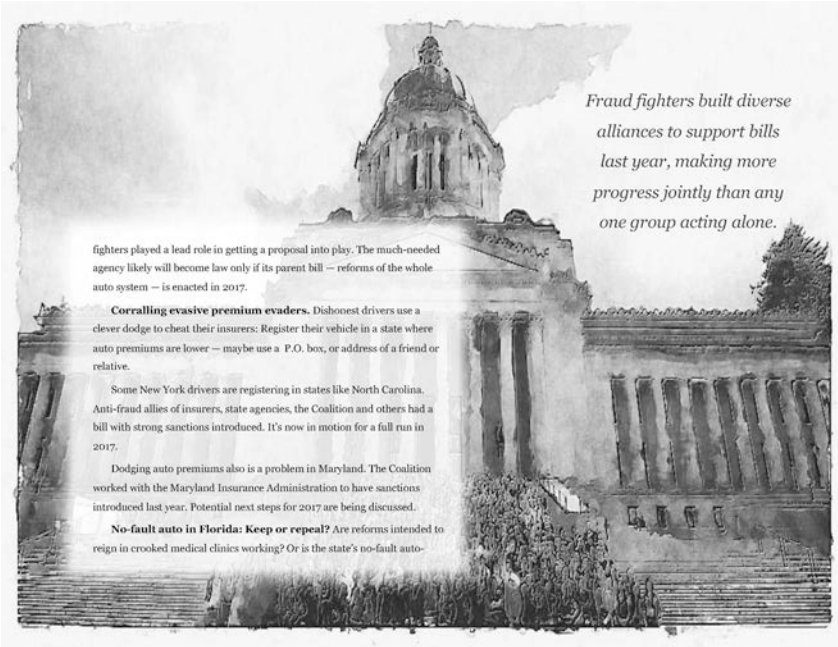
Astute statecraft exerted its impact in the process. Many bills required two or more years to build the support needed to become law. This involved the steady work of crafting buy-in among statehouse committees, bill sponsors, governors. Many bills thus were carefully positioned last year for deeper runs for potential enactment into law during 2017.

Shared destiny also abounded. Fraud fighters built diverse alliances to support bills last year, making more progress jointly than any one group acting alone. State agencies, anti-fraud groups, responsible consumer advocates, law enforcement, state-federal task forces and others came together in varied combinations.

Among the highlight states last year:

Seeking stronger crash penalties. Jail time for staging crashes in Nevada should be much stronger. Prosecutors will gain more incentive to take on crash cartels spreading in the state, stealing millions of dollars in bogus whiplash claims. A bill with stiff penalties was filed late in 2016, and will surface for an enactment run in 2017.

Creating a state auto-fraud agency. Crash rings are looting auto insurers in Michigan. This means an urgent need to create a state agency to help lead a counter-insurgency. Fraud



Fraud fighters built diverse alliances to support bills last year, making more progress jointly than any one group acting alone.

fighters played a lead role in getting a proposal into play. The much-needed agency likely will become law only if its parent bill — reforms of the whole auto system — is enacted in 2017.

Corralling evasive premium evaders. Dishonest drivers use a clever dodge to cheat their insurers: Register their vehicle in a state where auto premiums are lower — maybe use a P.O. box, or address of a friend or relative.

Some New York drivers are registering in states like North Carolina. Anti-fraud allies of insurers, state agencies, the Coalition and others had a bill with strong sanctions introduced. It's now in motion for a full run in 2017.

Dodging auto premiums also is a problem in Maryland. The Coalition worked with the Maryland Insurance Administration to have sanctions introduced last year. Potential next steps for 2017 are being discussed.

No-fault auto in Florida: Keep or repeal? Are reforms intended to reign in crooked medical clinics working? Or is the state's no-fault auto-

Coalition Against Insurance Fraud

insurance system too expensive and fraud-ridden to fix? That's the short version of a long debate over repealing no-fault that swirled in 2016.

Bills repealing no-fault are rearing up in 2017. Consumer groups, auto insurers, trial lawyers, chiropractors and other interest groups will weigh in.

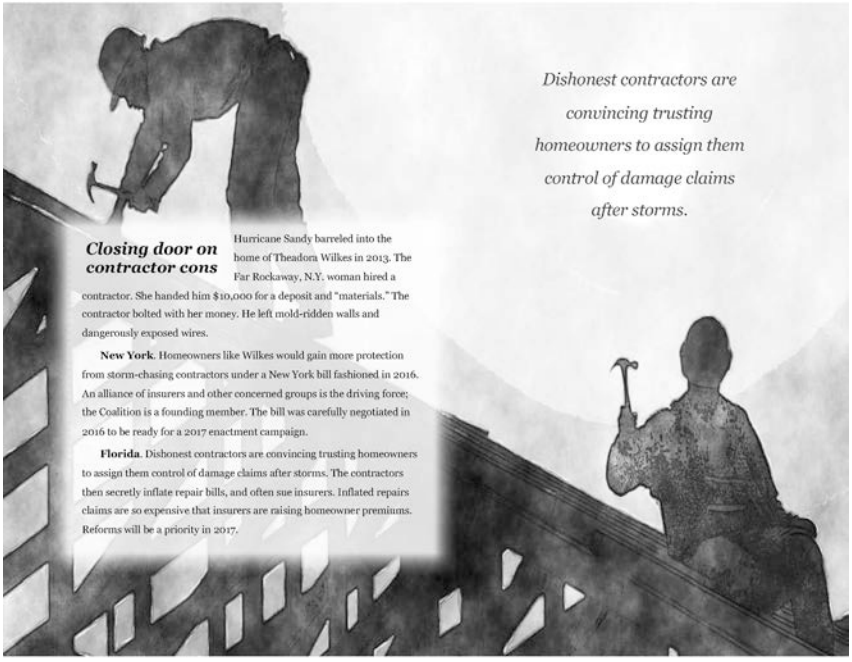
Hide and crash seek. Texas could become a haven for crash rings if they can camouflage bogus claims among legitimate ones, the Coalition said in an amicus brief to the state Supreme Court. The Coalition supported Allstate's suit against a medical clinic that allegedly inflated crash-injury claims. Success will prevent the damaging precedent from spreading to other states, given the stature of Texas courts. The Coalition and Allstate seek to overturn a lower-court decision.

Deflating airbag scams. Dai Zhensong tried to flood the U.S. with fake airbags secretly forged in China. His counterfeits exploded or never inflated in federal crash tests. Crooked body shops also bill insurers full price for cheap knockoffs. Drivers have died in crashes without working airbags.

Life-saving laws against such airbag schemes were booked in four states last year. Maryland, South Carolina, Washington and California made it illegal for auto body shops to traffic in counterfeits. A Coalition partnership with Honda North America helped shuttle the bills into law. More states are on tap in 2017.

Bills crash rings love. Crash and medical rings caught an undeserved break in New Jersey. A new law does away with pre-trial detention of fraud suspects. Low-level recruiters of crash rings have less incentive to turn in the operation's bigger fish in exchange for lenience.

Staged crashers would gain more freedom to steal in New Orleans under a state bill. Police wouldn't have to respond to fender benders. Just get an official report at the police station. Who needs to even crash cars? The bill is in play for 2017, though is an uphill challenge for fraud fighters.



Dishonest contractors are convincing trusting homeowners to assign them control of damage claims after storms.

Closing door on contractor cons

Hurricane Sandy barreled into the home of Theadora Wilkes in 2013. The Far Rockaway, N.Y. woman hired a contractor. She handed him $10,000 for a deposit and "materials." The contractor bolted with her money. He left mold-ridden walls and dangerously exposed wires.

New York. Homeowners like Wilkes would gain more protection from storm-chasing contractors under a New York bill fashioned in 2016. An alliance of insurers and other concerned groups is the driving force; the Coalition is a founding member. The bill was carefully negotiated in 2016 to be ready for a 2017 enactment campaign.

Florida. Dishonest contractors are convincing trusting homeowners to assign them control of damage claims after storms. The contractors then secretly inflate repair bills, and often sue insurers. Inflated repairs claims are so expensive that insurers are raising homeowner premiums. Reforms will be a priority in 2017.

Coalition Against Insurance Fraud

Sick Healthcare

Crackdowns squeeze crime rings

Zafar Mehmood ran a factory of uncaring homecare. The Ypsilanti, Mich. man hired pretend patients so he could bill for phantom home healthcare services. Mehmood grew rich off the $33 million Medicare handed out from his bogus claims. The federal court returned the favor, handing Mehmood 30 years in prison last year.

An assertive federal-state crackdown continued stanching large taxpayer losses such as Mehmood's in 2016. And for good reason. Healthcare fraud remained by far the largest form of insurance crime. Looting of Medicare and Medicaid, especially, likely stole tens of billions of taxpayer dollars.

Long sentences. Federal courts routinely sentenced health fraudsters to 10-30 years in federal prison. It's a deterrent and punitive trend of low judicial tolerance of these crimes. Jorge Lorenzo claimed he got rich working construction. In fact the Miami man ran a network of bogus home-health agencies that stole more than $40 million from Medicare with claims for phantom services. Lorenzo was given 15 1/2 years in federal prison last year.

Caught earlier. More Medicare fraudsters were caught earlier in the claim cycle by predictive analytics. The old and ineffective strategy of chasing suspect claims after paying them is giving way. Medicare is catching more bogus claims earlier in the process, using predictive analysis and other potent analytics.

Strike force strikes back. More Medicare swindlers are being rounded up by an imposing federal strike force. Fraud fighters are asserting their will in hotspot urban redoubts where Medicare crime is prolific — Dallas, Detroit, Los Angeles, Miami and others. Home healthcare, sober homes, blood testing and other high-crime scams were targeted.

The largest strike-force takedown in Medicare history nabbed more than 300 suspects charged last year with stealing more than $900 million in varied false-billing plots in cities around the U.S.

Sharing data. A network of chiropractic clinics in South Florida bilks Medicare and private health insurers. Stolen money is flowing out their doors, reflecting a truth of fraud: The same rings

The old and ineffective strategy of chasing suspect claims after paying them is giving way.

that fleece private medical insurers often go after Medicare and Medicaid.

Private and public health insurers need far better data sharing. That's the mission of an ambitious experiment aiming to shave $1 billion in false claims. The Healthcare Fraud Prevention Partnership has 60-plus members from the public and private healthcare sectors, law enforcement and others.

HFPP members already have jointly uncovered more than $280 million in suspect claims. Next comes the $1-billion milestone. The HFPP began in 2012. The Coalition was a founding member and continued a leadership role.

Coalition Against Insurance Fraud

Leadership

2016 Officers

John Sargent — MetLife *(co-chair)*
Don Rounds — The Consumer Alliance *(co-chair)*
Heidi Krumenauer — American Family *(treasurer)*
Dominic Dugo — San Diego Office of the District Attorney *(secretary)*

Members

Consumer organizations American Council on Consumer Interests • Call for Action • Center for Business & Economic Research, Marshall University • Center for Consumer Affairs-University of Wisconsin-Milwaukee • Citizen Advocacy Center • Consumer Action • Consumer Alliance • Consumer Federation of America • Consumer Federation of the Southeast • Families USA • Florida Consumer Action Network • Foundation for Payments Fraud Abatement & Activism • Indiana University • International Association of Letters Law Administrators • Michigan Arson Prevention Council • National Society of Professional Insurance Investigators • National Association of Consumer Affairs Administrators • National Center for the Prevention of Home Improvement Fraud • National Consumers League • National Fraud Information Center • National Urban League • Southern Utah University

Government organizations Alabama State Fire Marshall's Office • Bucks County (Penn.) DA's Office • DC Office of Risk Assessment • Federal Bureau of Investigation • Florida Division of Insurance Fraud • Florida Workers Compensation Joint Underwriting Association • Illinois Department of Insurance • International Association of Insurance Fraud Agencies • Iowa Insurance Fraud Bureau • Kansas Department of Insurance • Louisiana Auto Theft & Insurance Fraud Prevention Authority • Louisiana State Police • Maryland Automobile Insurance Fund • Maryland Insurance Administration - Insurance Fraud Division • Massachusetts Department of Industrial Accidents • Minnesota Insurance Fraud Bureau • National Association of Insurance Commissioners • National Conference of Insurance Legislators • National Criminal Justice Association • National District Attorneys Association • Nebraska Fraud Bureau • New Jersey Department of Banking & Insurance • New Jersey Office of the Insurance Fraud Prosecutor • New York Police Department • New York State Medicaid Inspector General • North Carolina Department of Insurance • Office of Attorney General, Arizona • Office of Attorney General, Colorado • Office of Attorney General, Pennsylvania • Office of the Cape May (N.J) Prosecutor • Office of the Insurance Commissioner, Georgia • Office of Medicaid Inspector General (NJ) • Ohio Department of Insurance • Oklahoma Insurance Department • Orange County (Calif.) DA's Office • Pennsylvania Insurance Fraud Prevention Authority • Pennsylvania State Police • Rhode Island Workers Compensation Fraud Unit • San Diego County (Calif.) District Attorney • San Francisco County (Calif.) District Attorney • Texas Department of Insurance - Fraud Unit • USDA Risk Management Agency • Virginia State Police • Washington State Department of Insurance • West Virginia Offices of the Insurance Commissioner

Insurance organizations AIPSO • Allstate Insurance Company • American Family Insurance • American Insurance Association • Amtrust North America • BlueCross BlueShield Association • Citizens Property Insurance Corporation • CNA • Country Insurance • EMC Insurance • Erie Insurance • Farm Bureau Insurance Tennessee • Farmers Insurance Group • GEICO • Grinnel Mutual • Hanover Insurance Group • Hastings Mutual • Harleysville Insurance • Homesite Insurance • IAT Group of Companies • Insurance Committee for Arson Control • Insurance Company of the West • International Association of Arson Investigators • International Associations of Special Investigation Units • John Hancock Financial Services • Kentucky Employers' Mutual Insurance • Lancer Insurance • Liberty Mutual Group • Mass Mutual • Merchants Insurance Group • MetLife • National Association of Public Insurance Adjusters • National Health Care Anti-Fraud Association • National Insurance Crime Bureau • Nationwide Insurance Company • New York Automobile Insurance Plan • OneBeacon Insurance • Pacific Specialty • Pinnacol Assurance • Progressive Insurance • Property Casualty Insurers Association of America • Prudential Insurance • Scottsdale Insurance • Selective Insurance • Sentry Insurance • State Farm • Stillwater Insurance • Swiss Re • The Hartford • Travelers Insurance • Zurich North America

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Staff: Dennis Jay – *executive director*, Kendra Smith – *executive assistant*, Howard Goldblatt – *director of government affairs*, James Quiggle – *director of communications*, Elijah Mercer – *research associate*, Matthew J. Smith, esq. – *legal adviser*

Senator MORAN. In that 2016 annual report, it highlights the use of technology to combat insurance fraud. Would you elaborate on the increasing use of vehicle telematics, drones, social media searches, insurance company databases, the Internet of Things? The broad jurisdiction of our Commerce Committee has a lot to do with these things, and I'd like to hear how we can combat fraud and what you're doing.

Mr. JAY. Absolutely. And as we said before, the use of technology and trying to uncover some of the suspect fraud schemes has really just exploded over the last few years as new technologies come online and as more players in the property/casualty industry utilize some of these. And, frankly, I think the Internet of Things, everybody is focusing on that right now.

We recently had a case, and we had the prosecutor do a briefing at our annual meeting in December, where a gentleman was charged with arson with burning down his home. He happened to have a pacemaker implanted in his chest. And the prosecutor got a court order to force him to sit and so they could take the data off his pacemaker, which somewhat demonstrated that what he said as far as the arson could not have happened. And the court just ruled in the last 2 weeks that the data can be used in court.

And I think that's one of the extreme examples we're seeing as far as use of data. But we're going to have a lot of these examples come forth, and with that, I think discussions as far as the privacy of Americans and, when is going too far even if it's looking at criminal fraud schemes?

In another recent case in Arkansas, and it was a murder case, they were able to take a look at the data in their Amazon Alexa—and, you know, maybe some of you own these devices, but you talk into it and it gives you answers, but all of the questions are maintained in a cloud that can be pulled down and listened to. And basically a woman was murdered in a hot tub, and her husband said certain things about the incident. They went back and got the data from Alexa, even though Amazon tried to squash it, and they were able to show that the story he told about her death was not true.

And so I think, as our cars have more computers, as our homes have more computers, everything is hooked to the Internet, as there are cameras everywhere in society today. The generation that's coming of age is going to have much less expectation of privacy than we have now, and that's a separate issue, but it's helping fraud investigation to no end, and that's only going to continue.

Mr. DOAK. Chairman Moran, I may make a comment there.

Senator MORAN. Please.

Mr. DOAK. The NAIC has just formed an innovation task force, which over the last several months we have been listening to the emerging technologies in all different areas that you highlighted, and it's one of something that the regulators have a very focused effort to stay on top of, whether it's cyber issues or the use of drones, telematics, big data. We have a big data working group that many of the commissioners are involved in. So I want to give you some assurances that the National Association of Insurance Commissioners are very focused on the emerging technologies and the uses of those.

Senator MORAN. I've seen evidence of this in the crop insurance world where big data can mine information about fraudulent behavior. And, again, you've testified today about finding fraudulent behavior in one kind of insurance arena that translates to the same kind of perpetration or the same individuals perpetrating those kind of criminal activities elsewhere. There's a lot of information out there. Does law enforcement have the tools necessary to—are they behind the curve in regard to this as compared to the insurance industry?

Mr. DOAK. We partner with law enforcement on a regular basis. We make any of the tools available to the investigations, no matter which way we're going back and forth. Mr. Lynch may have some comments related to that. But the regulators, through proper procedures, we're embedded in my state, as is the other states, to provide assistance, as a state agency, to any law enforcement agency that might be seeking some of that data, which is proprietary to an insurance company.

Mr. LYNCH. Mr. Chairman, yes, thank you. NICB is at the very early stages of working on this issue. Given our relationship with law enforcement, we're able to get into these communities earlier than most. And we're at the forefront, I think, of some neat things relative to social intelligence and helping policyholders and law enforcement better detect fraud. So I think more to come on that.

Senator MORAN. Ms. Weintraub?

Ms. WEINTRAUB. Yes. Thank you, Chairman Moran. I would like to add that, of course, as new technologies emerge and help all of the entities at the table and law enforcement, police, to enforce fraud more aggressively and effectively, it should be used. However, there should always be consumer protections as well. And we know in terms of privacy, we know in terms of the use of big data, being used to price for auto insurance, for example, that it provides opportunities for other factors not related to a safe driving record, but other aspects which are not directly related to safe driving to be used that cause a discriminatory impact on pricing for some especially low-income consumers. So that needs to be taken into account as well.

Senator MORAN. Thank you very much.

Let me turn to the Ranking Member.

Senator BLUMENTHAL. Thank you. I'm going to try to be as quick as possible, but perhaps with the Chairman's permission, if we can take a break and then come back, let's see how far we get. And I would just like to ask at the outset whether you are available for another 20 minutes or so.

[Witnesses nodding yes.]

Senator BLUMENTHAL. Well, let me see how far I can get.

Senator MORAN. What you're seeing is the Ranking Member trying to supersede the Chairman's intentions.

[Laughter.]

Senator BLUMENTHAL. I am asking the Chairman's permission to do it, but let me see if I can conclude before we go to vote.

I don't know how many of you—I'm sure Mr. Doak has seen the *60 Minutes* piece on audits leading to life insurance companies being discovered to have uncovered a systematic industry-wide practice of not paying beneficiaries who were unaware there was

a policy, something that is not at all uncommon. The *60 Minutes* piece uncovered that insurers routinely use the Social Security Death Master File, but only to their advantage, to cut off annuity or retirement payments once the policyholder has died.

When it came to life, insurance would claim that they had no idea that a policyholder had died. Even worse, an insurer would continue to pay themselves life insurance premiums out of the dead policyholder's nest egg. To put it most simply and bluntly, the insurer put the burden on the beneficiary to come forward, but often the beneficiary had no idea that the policy existed, and the insurer used that ignorance to its benefit. They have acknowledged, some of them have, their responsibility, and they have settled litigation, but some 35 still have not done so.

When one of your colleagues, Mr. McCarty was asked about this practice, he said he would release, quote, the hounds of hell on these insurers because, in effect, they were failing to pay benefits to beneficiaries, and that misconduct, in my view, was absolutely fraudulent.

We're here about insurance fraud, and I'd like to ask you and Mr. Jay what you are doing to prevent this kind of fraud?

Mr. DOAK. Well, thank you, Senator. I did have the opportunity to see a couple of those segments, and we do know some of the work that has been done by the NAIC and some of the settlements that have been basically run by lead states in that area.

One of the issues that the NAIC has recently put together is called a Lost Life Policy Locator Service, which was pioneered in a couple of states, and that has now gone nationwide. And for the record, we would provide, through the NAIC, an update to you on the actual stats of the findings of beneficiaries through that.

Senator BLUMENTHAL. I would appreciate that.

Mr. DOAK. So the NAIC is continuing to work on those settlements. And Commissioner McCarty is highly respected. And Commissioner Altmaier is the Florida commissioner who is continuing to work on some of those activities. So it has our attention, and we are remaining vigilant to make sure that those consumers get the monies that are due them.

Senator BLUMENTHAL. For the record, about 35 insurance companies still have not settled in that case.

Mr. DOAK. Right.

Senator BLUMENTHAL. Thirty-five major insurers have not settled.

Mr. DOAK. I would ask the——

Senator BLUMENTHAL. So people are going without these benefits as we speak.

Mr. DOAK. Yes, and——

Senator BLUMENTHAL. It needs to be a really urgent issue.

Mr. DOAK. Exactly. And I would ask your permission to have the NAIC put together some information on an update to those 35 insurers and follow up on that particular item. But I can tell you it's a high priority. And we are having some success in some other areas relative to finding beneficiaries, sir.

Senator BLUMENTHAL. Thank you.

Mr. Jay?

Mr. JAY. We've looked at the issue, and I agree with the Commissioner as far as it's a regulatory issue and administrative issue for the insurance departments to oversee. To my knowledge, in taking a look at the companies involved in this, there was no criminal fraud. It may come in the realm of abuse or certainly bad practices on the part of the life insurance industry for not proactively trying to find when benefits are deemed to be due. But we support the insurance commissioners as far as their actions on the issue.

Senator BLUMENTHAL. Well, perhaps in your further response to my question, you can tell me what you're doing proactively to prevent these kinds of practices in the future because, as we all know, this kind of practice may not have constituted criminal fraud, although as a former prosecutor, I would have been interested to investigate it as criminal wrongdoing. Kevin McCarty, the Insurance Commissioner, probably doesn't have criminal jurisdiction, but I would respectfully suggest that criminal authorities ought to have a real interest in it.

Mr. JAY. And we would support any attorney general, insurance commissioner, or fraud bureau to investigate it, and if they do find that there are criminal violations there, to prosecute it to the full extent of the law.

Senator BLUMENTHAL. Let me——

Mr. JAY. It's just not our knowledge that that's happened so far.

Senator BLUMENTHAL. I understand.

Mr. DOAK. And I would make a comment that through the process here, I think one of the things that I would like to note about the Lost Life Policy Locator Service is that we've had the opportunity to find these for Oklahomans, and it's a very impressive chart since it has been rolled out by the NAIC in assisting consumers.

But when the National Association of Insurance Commissioners, to the best of my knowledge, like in Oklahoma, when we find a beneficiary or match them up, there is no charge to them. There is no reduction in those fees. And I do believe that under some of the other circumstances, through the treasurers' departments in certain states, that there is a fee redacted. In my opinion, that's the wrong thing to do. Consumers should get 100 percent of the money that's owed them.

Senator BLUMENTHAL. I have one—I have a couple more brief questions.

Senator MORAN. To demonstrate my firmness, but also my accommodation, the floor is holding the vote open an extra 5 minutes, so if you can wrap up in the next 5 minutes, we will both accomplish what we want to accomplish.

Senator BLUMENTHAL. This is bipartisan cooperation at work before your eyes in real time.

[Laughter.]

Senator BLUMENTHAL. I will have more questions for the record. This area is very important to me. I want to commend Commissioner Kevin McCarty, of Florida, and your colleagues who have joined in the Task Force, as well as, of course, *60 Minutes* for exposing this fraud. I don't use that word lightly, it is a fraud, and exposure of it provides a tremendous warning to others to avoid this kind of fraud.

And I think you and we have a special responsibility here given that we're talking about life insurance. We're talking about insurance people buy in the expectation their sisters, their brothers, their children, and their spouses are going to rely on it to survive, to live, and to reap the benefits of that life.

A lengthy article in the *New York Times* last year detailed a new and disturbing trend in the whole life industry. I'm sure you're aware of it. Insurance companies have jacked up premiums on whole or universal life policies and have shifted the burden of dividend payments from the insurance company to other policyholders. People who bought universal life policies in the 1980s and 1990s, some of which guaranteed annual returns of 4 percent or more, are seeing their premiums now soar.

So the new exorbitant rates have left many older Americans with no choice but to drop coverage and lose, you guessed it, the entire value of their policy after years and years of investing in it.

And I am raising this issue. I know we're not going to have final answers today, but I want to ask Ms. Weintraub, realizing that many whole life policies were underwritten during a decade of high interest rates that could support more generous dividends. I also understand these insurance policies gave a guarantee, and policyholders seem to have kept their side of the bargain. Are these exorbitant increases in premiums fair and justified, or are they simply a way for insurance companies to reduce their liability and eliminate the most expensive policies, I understand they're expensive, but don't they have an obligation to do better?

Ms. WEINTRAUB. It certainly seems unfair to a consumer who has been paying into this policy and then only to find that it is unaffordable for them and they can't get the benefit of what they've been paying for. Certainly that has an unfair result. It's entirely the reason why consumers have insurance to begin with, and being unable to use it in the way that they've been paying for, for years and years is certainly problematic. And I would definitely recommend more research looking into how the disproportionate effect it has on especially older Americans and their ability to obtain coverage, and the investment they put into it.

Senator BLUMENTHAL. Thank you. I would invite other responses. I know we're short on time. Perhaps others can answer that same question for the record.

And again my thanks to the Chairman for his generosity and indulgence. Thank you.

Senator MORAN. Does anyone want to include anything?

Mr. DOAK. I would just close by thanking you from the National Association of Insurance Commissioners, the regulators. We believe that state-based regulation is the best place for insurance. We're the closest place to the consumer. Like in my state, we've been regulating insurance since statehood. And my colleagues that I represent, we're very proud of the work they do protecting consumers.

So we appreciate the opportunity to be here. This is a very, very timely topic and evolving topic relative to new trends in fraud. So thank you, Senators, for having us.

Senator BLUMENTHAL. If I may just make one concluding remark. I sat exactly where you are, Mr. Doak. I don't know whether it was 5 or 6 years ago, on a panel, actually I think I sat where Mr. Jay

is now, and to my right was the Attorney General of New York, who argued that insurance regulation should be turned over to the Federal Government. It has been, as you say quite correctly, a state role and responsibility. I said no, insurance regulation should continue to be a state responsibility, but I said that the states have an obligation to do better, to be more rigorous in their oversight and scrutiny, and I would hope that they would be because I'll continue to be an advocate of state regulation.

Mr. DOAK. Thank you, sir.

Senator BLUMENTHAL. But I would hope that we can work together and improve the efficacy of the regulation.

Thank you, Mr. Chairman.

Senator MORAN. I appreciate the cooperation from the Ranking Member. And I appreciate the witnesses testifying. And the record will remain open for 2 weeks for members to submit questions. I will have some, and it appears that the Ranking Member will, my guess is that other colleagues. We would ask you to respond to those. And again we thank you for your presence with us today.

The Committee is adjourned.

[Whereupon, at 11:15 a.m., the hearing was adjourned.]

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