

A Review of the

Insurance Fraud Regulatory Function at the Texas Department of Insurance



Office of the State Auditor
Lawrence F. Alwin, CPA

April 1995

Report No. 95-117



OFFICE OF THE STATE AUDITOR

TWO COMMODORE PLAZA
206 EAST NINTH ST., SUITE 1900
AUSTIN, TEXAS 78701

MAILING: P.O. BOX 12067
AUSTIN, TEXAS 78711-2067

PHONE: (512) 479-4700 FAX 479-4884

LAWRENCE F. ALWIN, CPA
State Auditor

SHARON W. COBB, CPA
First Assistant

April 19, 1995

Members of the Legislative Audit Committee:

The Texas Department of Insurance has an infrastructure in place to regulate fraud committed while engaging in the business of insurance. However, the importance of fraud detection and referral is unclear, particularly in relation to the Department's other regulatory responsibilities. Organizational instability has created uncertainty about the Department's strategies and priorities. In addition, agency records show a 33 percent decrease in budgeted funding for the fraud function from fiscal year 1993 to fiscal year 1995 and a continued decrease in requested funding for fiscal years 1996-1997. Management should restate its policy regarding fraud regulation and clearly describe program responsibilities.

The Department has shown signs of improvement since 1992. In addition to establishing the basic infrastructure, performance measures show an increase in fraud-related outputs. However, inconsistencies were noted with some of the figures. In addition, there has been little evaluation of the outcome of fraud-related activities. The Department should continue to evaluate its performance measure reporting systems to ensure that controls are in place and to measure the quality of the fraud regulation function.

Other existing control systems are inconsistently implemented. For example, information systems are not used effectively in the detection and referral of potential fraud. Policies and procedures have been established primarily for the *reporting* of potential fraud. However, there is inadequate guidance for the *detection* of potential fraud. Action should be taken to improve these areas.

This audit was done in response to a request from the Department, and its management generally concurs with the recommendations in this report. We appreciate the courtesy and cooperation they showed during the course of this audit.

Sincerely,

A handwritten signature in cursive script that reads "Lawrence F. Alwin".

Lawrence F. Alwin, CPA
State Auditor

LFA:ggh

Key Points Of Report

A Review of the Insurance Fraud Regulatory Function at the Texas Department of Insurance

April 1995

Key Facts And Findings

- The Texas Department of Insurance has not clearly defined the role of fraud detection and referral in relation to its other regulatory responsibilities. Organizational instability has created uncertainty, and funding for the fraud regulatory function has been decreasing.
- The Department has shown some signs of improvement since 1992. An infrastructure is in place to facilitate the detection, investigation, and referral of fraud committed while engaging in the business of insurance. Fraud-related performance measures, compiled by the Department, generally show an increase in activity from fiscal year 1993 to 1994.
- While the Department's performance measures provide an indication of its performance in fraud detection and reporting, inconsistencies were noted with some of the figures. In addition, there has been little evaluation of the quality or outcome of fraud-related activities.
- While the infrastructure exists, it has not been implemented effectively. For example, existing information systems are not used effectively in the detection and referral of potential fraud. In addition, policies and procedures are not consistently implemented.
- Relations with other agencies and law enforcement authorities are generally good. However, relations with the Travis County District Attorney's Office could be improved.

Contact:

Barnie Gilmore, CPA, Audit Manager (479-4785)

This audit was conducted in accordance with Government Code, section 321.0133. The former Commissioner of the Department of Insurance requested this audit.

Table of Contents

| | |
|--------------------------------|---|
| Executive Summary | 1 |
|--------------------------------|---|

Detailed Issues And Recommendations

| | |
|--|---|
| The Department's Role In Fraud Detection And Referral In Relation To Other Regulatory Responsibilities Has Not Been Clearly Defined | 5 |
|--|---|

| | |
|--|---|
| Organizational Instability Has Created Uncertainty | 5 |
|--|---|

| | |
|---|---|
| Funding For The Fraud Regulatory Function Has Been Decreasing | 6 |
|---|---|

| | |
|--|---|
| The Department Has Shown Some Signs Of Improvement Since 1992 | 7 |
|--|---|

| | |
|--|---|
| Performance Measures Are Not Reported Consistently | 8 |
|--|---|

| | |
|--|---|
| Performance Measures Do Not Address The Quality Or Outcome Of Fraud-Related Activities | 9 |
|--|---|

| | |
|--|----|
| Existing Information Systems Are Not Used Effectively | 11 |
|--|----|

| | |
|---|----|
| Policies And Procedures Have Been Established, But They Are Not Consistently Implemented | 12 |
|---|----|

| | |
|---|----|
| Fraud Detection Procedures Should Be Enhanced In The Financial Program Division | 13 |
|---|----|

| | |
|--|----|
| The Consumer Protection Division Should Analyze Patterns Of Complaints | 14 |
|--|----|

| | |
|--|----|
| The Compliance Intake And Fraud Units Should Enhance Procedures For The Investigation Of Fraud | 15 |
|--|----|

| | |
|---|----|
| Relations With Other Agencies And Law Enforcement Authorities Are Generally Good | 17 |
|---|----|

Appendices:

| | |
|---|----|
| 1 - Objective, Scope, And Methodology | 19 |
|---|----|

| | |
|------------------------|--|
| 2 - Agency Information | |
|------------------------|--|

| | |
|--|----|
| 2.1 - Agency Financial Information | 22 |
|--|----|

| | |
|----------------------------|----|
| 2.2 - Agency Profile | 24 |
|----------------------------|----|

| | |
|--------------------------------|----|
| 2.3 - Organization Chart | 25 |
|--------------------------------|----|

| | |
|--------------------------|----|
| 3 - Reference List | 26 |
|--------------------------|----|

| | |
|-------------------------|--|
| 4 - General Information | |
|-------------------------|--|

| | |
|---|----|
| 4.1 - Background On Insurance Fraud | 27 |
|---|----|

| | |
|--|----|
| 4.2 - Results Of Employee Survey | 29 |
|--|----|

Executive Summary

The Texas Department of Insurance has an infrastructure in place to regulate fraud committed while engaging in the business of insurance. However, the importance of fraud detection and referral is unclear, particularly in relation to the Department's other regulatory responsibilities. Organizational instability has created uncertainty about the Department's strategies and priorities. Since 1990, seven different commissioners have served the Department.

There are Different Types of Insurance Fraud

Various studies and reports indicate that fraud is prevalent in the insurance industry. Insurance fraud can occur by:

- Insurance companies or their officers and management
- Unauthorized insurers, such as persons selling insurance without a license
- Insurance agents
- Claimants or policyholders
- Providers of services, such as doctors, lawyers, etc.

The extent of insurance fraud is difficult to quantify. A widely accepted estimate of claimant fraud is ten percent of total claim dollars or gross premiums. In Texas, this would range from \$2.7 billion to \$3.7 billion. Although it is virtually impossible to quantify, insurers and investigators recognize insurer fraud as being potentially one of the costliest issues facing the industry.

The scope of this audit was to evaluate regulatory functions related to fraud committed by insurance companies. It did not address regulatory functions in regard to allegations of fraud on the part of insurance agents, claimants, policyholders or service providers.

In addition, agency records show a 33 percent decrease in budgeted funding for the fraud function from fiscal year 1993 to fiscal year 1995 and a continued decrease in requested funding for fiscal years 1996-1997. It is

noteworthy that funds for the fraud regulatory function are not provided to the Financial Program Division, which is a key program for fraud detection. This may contribute to uncertainty about the importance of fraud detection in relation to other job duties.

The Department has shown some signs of improvement since 1992

The Department has defined goals and objectives that specifically address the detection, investigation, and reporting of fraud in the insurance industry. Other control systems have been established to achieve these goals in the form of an organization structure, performance measures, information systems, and policies and procedures.

In addition to establishing the basic infrastructure, the Department has taken steps toward implementing it. Fraud-related performance measures were first officially reported in fiscal year 1993. Figure 1 shows two performance measures that relate to fraud and unlawful trade practices, as reported in the Department's annual performance measure reports.

Other measures show an increase in the number of internal reports of possible fraud and unlawful trade practices and the number of referrals for administrative or regulatory action. Although the performance measures provide an indication of the Department's performance in fraud detection and reporting, inconsistencies were noted with some of the figures. Problems noted during the audit include a lack of control over data collection procedures and unclear definitions of performance measures.

While the Department's performance measures have captured output-oriented information, there has been little evaluation of the outcome of fraud-related activities. The

Executive Summary

only measure used in fiscal years 1993-1994 to depict an outcome was dollar amount of fines, penalties, and restitution. There has been no formal, ongoing evaluation of the usefulness of information supporting fraud allegations or the outcome of fraud referrals to other agencies or law enforcement authorities.

The Department should continue to evaluate its performance measure reporting systems to ensure that controls are in place and to measure the quality of the fraud regulation function.

Figure 1
Key Performance Measures

| Performance Measures | FY93 | FY94 |
|--|-------------|-------------|
| Dollar amount of penalties collected for fraud and unlawful practices | \$2,310,703 | \$2,945,586 |
| Number of referrals to Attorney General, District Attorney, or other appropriate agency or law enforcement authorities | 104 | 117 |

While The Infrastructure Exists, It Has Not Been Implemented Effectively

Existing control systems are inconsistently implemented and used. For example, existing information systems are not used effectively in the detection and referral of potential fraud. There is no comprehensive review of the information systems to identify and evaluate indicators of fraud. The Department recognized this issue during its recent business planning and analysis project. Action should be taken to build on this issue and to better utilize existing information systems.

Policies and procedures have been established primarily for the *reporting* of potential fraud. However, there is inadequate guidance for the *detection* of potential fraud. In addition, there are different expectations among Department personnel regarding the depth of coverage in the detection of potential fraud. As a result, there is no assurance that fraud detection efforts are being effectively carried out.

Within the Department, there are four sections primarily involved in the detection, investigation, and referral of fraud committed while engaging in the business of insurance. There are opportunities to improve policies and procedures in all four areas.

- Fraud detection procedures should be enhanced in the Financial Program Division.
- The Consumer Protection Division should analyze patterns of complaints.
- The Compliance Intake and Fraud Units should enhance procedures for the investigation of fraud.

Relations With Other Agencies And Law Enforcement Authorities Are Generally Good

While teamwork internally is necessary, the overall system of insurance fraud regulation involves other agencies and law enforcement authorities. Communication and coordination between the Department and other agencies and law enforcement authorities generally appears to be good, according to representatives from eight external agencies. However, relations between the Department and the Travis County District Attorney's Office can be improved. There appear to be different expectations between the two agencies regarding the Department's role in fraud detection, especially as it fits into the Department's overall regulatory responsibilities. Resolution of this problem

Executive Summary

will require frequent and constructive communication.

Summary Of Management's Response

In response to recent criticism of the Department's regulatory effectiveness, management asked the State Auditor's Office to review existing fraud related processes and recommend improvements. In general, the new administration under Commissioner Bomer agrees with the audit results and suggestions made by the State Auditor's Office. This report will serve as a basis for upgrading the Department's fraud detection and reporting policy, procedures, and processes. Management takes insurance fraud seriously and is developing a comprehensive plan for correcting problems noted in this report.

Summary Of Audit Objective And Scope

The audit objective was to evaluate the Department's current processes for detecting,

reporting, investigating, and referring fraud committed while engaging in the business of insurance. The Department has regulatory responsibilities over all forms of insurance fraud. However, the scope of this audit was to evaluate regulatory functions related to fraud committed by insurance companies. It did not address regulatory functions in regard to allegations of fraud on the part of insurance agents, claimants, policyholders or service providers.

The scope of this audit included consideration of the Department's strategic planning, organizational structure, performance measures, management information systems, and policies and procedures. In addition, the scope included a review of communication and coordination between divisions and sections of the Department, communication and coordination between the Department and outside agencies, and the Department's allocation of resources to fraud-related activities.

This page intentionally left blank.

Section 1:

The Department's Role In Fraud Detection And Referral In Relation To Other Regulatory Responsibilities Has Not Been Clearly Defined

Employees of the Department understand that the detection and referral of potential fraud is a part of their job duties. However, there is a lack of clear direction for getting the job done, particularly in relation to other regulatory responsibilities. Departmental strategies are broader than just fraud regulation. For example, to achieve the Department's goal to protect consumers' insurance assets, the Department analyzes the financial condition of insurers, identifies weak companies, and rehabilitates, liquidates, or takes other action against financially weak companies. In addition, the Department investigates potential insurer fraud and brings enforcement action when appropriate. To effectively carry out these strategies, priorities must be clearly established, and clear direction must be given on the depth of coverage.

Section 1-A:

Organizational Instability Has Created Uncertainty

Since 1990, seven different commissioners have served the Department. Effective September 1, 1994, the State Board of Insurance was abolished, which placed policy-making authority in the hands of the Commissioner. Such change has created uncertainty about strategies and priorities.

Organizational changes involving the fraud function have contributed to uncertainty about the relative importance of fraud detection and referral. Effective September 1, 1991, the 72nd Legislature created the Insurance Fraud Unit.¹ By May 1992, the new fraud unit was established as a separate division, reporting directly to the Commissioner. Then, in May 1993, the Insurance Fraud Unit was placed in the Legal and Compliance Division. During 1993, there were personnel changes in key positions, and the number of full-time employees in the Insurance Fraud Unit went from approximately 40 to less than ten.

In the Financial Program Division, uncertainty has been caused by the designation of several "acting" managers over a span of several months. One of those positions is the Chief Examiner, for which a job posting has existed since March 1994. This situation can hinder the accomplishment of important responsibilities, such as fraud detection.

¹ Texas Insurance Code, Art. 1.10D.

Recommendations:

- Establish continuity with the overall regulatory philosophy and the organizational structure of the Department.
- Establish permanent key management positions in the Financial Program Division.

Management's Response: Management agrees that the continual changes in administration since 1990 have contributed to uncertainty within the agency as to the priority of fraud detection and reporting. Commissioner Bomer's updated policy will clarify that fraud detection and reporting are key responsibilities of each employee in a regulatory position at TDI.

The new administration found that three key positions in the Financial Program had been in an "acting" status since May 1994. On March 16, 1995, the Commissioner appointed a "permanent" Associate Commissioner of the Financial Program. The new Associate Commissioner will expedite and complete the remaining two appointments.

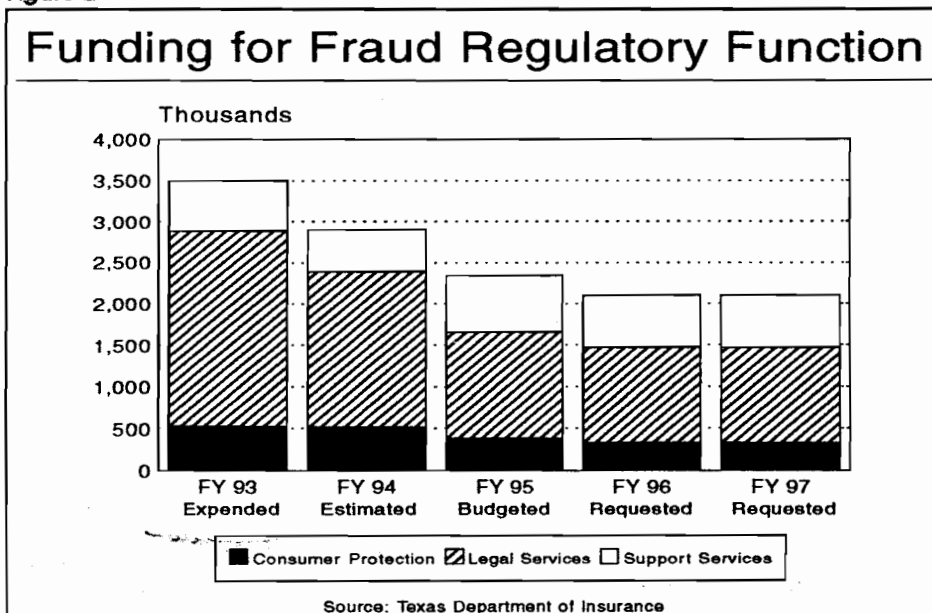
Section 1-B:

Funding For The Fraud Regulatory Function Has Been Decreasing

Agency records show a 33 percent decrease in budgeted funding for the fraud regulatory function from fiscal year 1993 to fiscal year 1995, and a continued decrease in requested funding for fiscal years 1996-1997. (See Figure 2.) Funds for the fraud regulatory function are distributed to the Consumer Protection Division, Legal and Compliance Division, and support services. Support services are an allocation of indirect costs from other divisions. While support service costs remain

relatively constant over this five-year period, funds to Legal and Compliance decrease 52 percent, and funds to Consumer Protection decrease 36 percent. In addition, funds for the fraud regulatory function are not provided to the Financial Program Division, which is a key program for fraud detection. This could imply that the Financial Program Division does not have any responsibility in the

Figure 2



fraud function. Yet, that program is of primary significance when it comes to fraud detection and reporting.

Recommendations:

- Management should restate its policy regarding fraud detection and reporting and clearly describe program and division responsibilities.
- Management should provide a portion of fraud regulatory funds to the Financial Program Division.

***Management's Response:** The Department's fraud detection and reporting policy is being updated and strengthened to reflect Commissioner Bomer's emphasis on strong, effective regulation. In its planning to strengthen the detection, deterrence and prosecution of insurance fraud, management will consider the recommendation to reallocate a portion of TDI's budgeted anti-fraud funding to the Financial Division.*

Section 2:

The Department Has Shown Some Signs Of Improvement Since 1992

The Texas Department of Insurance has established an infrastructure to facilitate the detection, investigation, and referral of fraud committed while engaging in the business of insurance.

- The agency strategic plan includes strategies that specifically address the investigation of fraud.
- A fraud investigative unit is established in the Legal and Compliance Division.
- Some performance measures have been defined to monitor the Department's activities.
- Automated information systems have been designed to capture data that will help detect potential fraud.
- Policies and procedures for the reporting of potential fraud have been documented.

In addition to establishing the basic infrastructure, the Department has taken steps toward implementing it. Fraud-related performance measures, compiled by the Department, generally show an increase in activity from fiscal year 1993 to 1994. These measures were first officially reported in fiscal year 1993. Figure 3 shows performance measures that relate to fraud and unlawful trade practices, as reported in the Department's annual performance measure reports.

Figure 3
 Fraud-related Performance Measures

| Performance Measures | FY93 | FY94 |
|---|-------------|-------------|
| Number of reports of possible fraud and unlawful trade practices | 1,698 | 4,290 |
| Number of referrals for administrative or regulatory action | 1,713 | 2,734 |
| Number of investigations closed for fraud and unlawful trade practices (definition of this measure changed; 854 was reported in FY93 but is not comparable to FY94; the FY93 figure was obtained from agency records) | 108 | 108 |
| Dollar amount of penalties collected for fraud and unlawful practices | \$2,310,703 | \$2,945,586 |
| Number of referrals to Attorney General, District Attorney, or other appropriate agency or law enforcement authorities | 104 | 117 |

Section 2-A:

Performance Measures Are Not Reported Consistently

Although the performance measures provide an indication of the Department's performance in fraud detection and reporting, inconsistencies were noted with some of the figures. Problems noted during the audit include a lack of control over data collection procedures and unclear definitions of performance measures. For example, the Department reported that it made 117 referrals to the Attorney General, District Attorney, or other appropriate agency or law enforcement authorities

during fiscal year 1994. However, 13 referrals were not entered into the automated case management system in a timely manner, which means the Department under-reported the number of referrals.

Inconsistencies were found in the count of reports and referrals between divisions and between the Department and external entities. While records were maintained to support the count at both ends, the differences were caused by contrasting interpretations of the term *referral*. For example, the Financial Program Division recorded a referral made to the Fraud Unit regardless of a pre-existing case. However, if the Fraud Unit already had an open case from another originator, the "referral" from the Financial Program Division was not recorded as such. In other words, the Fraud Unit did not count the report as a referral, even though the Financial Program Division may have been providing new information. This same problem existed between the Department and external entities.

In addition, performance measure figures were inconsistently recorded between the fiscal year 1994 Annual Performance Measure Report and the fiscal year 1996-1997 Request for Legislative Appropriations for several fiscal year 1994 performance measures. For example, the number of referrals to the Attorney General, District Attorney, or other appropriate agency or law enforcement authorities was reported as 117 in the Annual Performance Measure Report and 101 in the Request for Legislative Appropriations.

Recommendations:

- The Department should continue to evaluate performance measure reporting systems to ensure that controls over documentation, measure calculation, and information gathering are in place.
- Performance measures should be clearly defined. For example, the term *referral* should be clarified or changed.
- Performance measures should be consistently reported among all documents released from the Department.

Management's Response: Commissioner Bomer concurs with these recommendations. Each manager has been instructed to take steps to strengthen controls over the performance measurement process. The State Auditor's Office and TDI Internal Audit are evaluating those controls.

The updated agency-wide fraud policy will include a revised definition of the term "referral" and a streamlined internal fraud reporting process to ensure accuracy in tracking and reporting performance measures.

Section 2-B:

Performance Measures Do Not Address The Quality Or Outcome Of Fraud-Related Activities

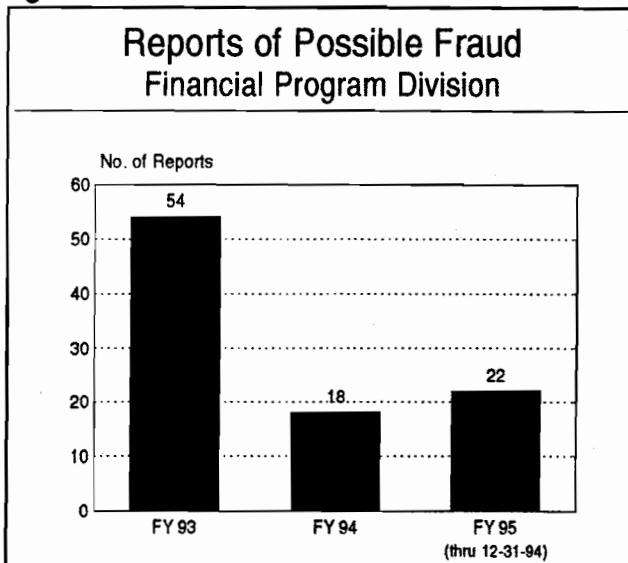
While the Department's performance measures have captured output-oriented information, e.g., number of reports, number of investigations, number of referrals, there has been little evaluation of the outcome of fraud-related activities. The only measure used in fiscal years 1993-1994 to depict an outcome was the dollar amount of fines, penalties, and restitution. The Department has defined a new outcome measure for fiscal years 1995-1997, which is the estimated dollar amount of insurer fraud

eliminated. However, there has been no formal, ongoing evaluation of the outcome of fraud referrals to other agency or law enforcement authorities.

Recent correspondence from the Travis County District Attorney's Office showed a list of 79 insurance fraud convictions since January 1990 and 16 indictments pending. The Department's participation is not described on an individual case basis, yet this information would provide the basis for an evaluation of the outcome of fraud referrals from the Department.

In addition, there has been no formal, ongoing evaluation of the usefulness of information gathered internally to support fraud allegations. For example, there are no performance measures to

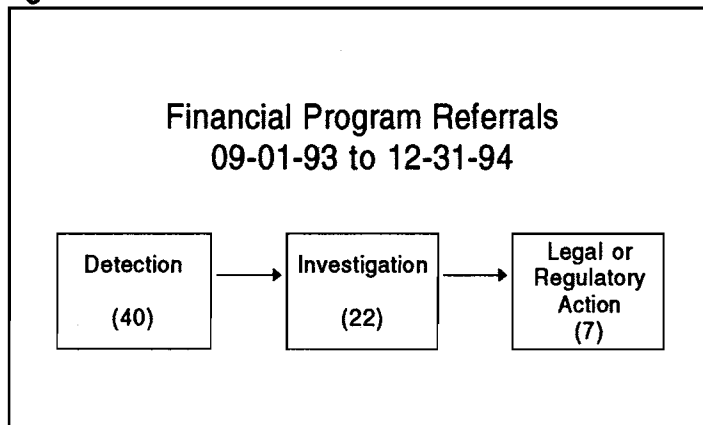
Figure 4



evaluate the Financial Program Division in the area of fraud detection and referral. In our effort to evaluate fraud referrals from the Financial Program Division, we identified 94 reports of possible fraud and unlawful trade practices from September 1, 1992, to December 31, 1994. (See Figure 4.)

While we were unable to determine the status of reports in fiscal year 1993, we traced 40 reports during the period from September 1, 1993, to December 31, 1994.

Figure 5



Twenty-two out of the 40 (55 percent) were forwarded to the Fraud Unit or other sections for further investigation, and 18 were closed. Seven out of the 22 (32 percent) were referred to another agency or law enforcement authority. (See Figure 5.) This information provides the basis for an evaluation of the quality of information supporting fraud allegations. Without a method for measuring results and establishing accountability, the responsibility for fraud detection is easily neglected.

Recommendations:

- The Department should continue to refine performance measures to improve performance monitoring. Specifically, management should define performance measures to evaluate the outcome of fraud-related activities.
- The Department should evaluate all appropriate divisions on their performance in fraud-related activities. Internally, performance indicators should be defined to measure the number of cases of potential fraud detected and the quality of information to support cases of potential fraud. For example:
 - number of referrals made within the Department for compliance or further regulatory action, by Division
 - ratio of cases opened to referrals received, by Division
 - ratio of external referrals to cases opened, by Division

Management's Response:

- *To monitor the quality of fraud referrals, the Department is exploring the possibility of sending an annual survey to recipients of TDI referrals. The survey would ask recipients to rate the overall quality and completeness of referrals and solicit comments on improving TDI's referrals.*
- *Management agrees with this recommendation. Internal fraud detection and reporting performance measures will be used to facilitate evaluation of fraud-related activity. The quality and number of actual referrals will be*

monitored for a one-year period and performance benchmarks will be established.

Section 3:

Existing Information Systems Are Not Used Effectively

Existing information systems are not used effectively in the detection and referral of potential fraud. In January 1995, as the result of an internal planning and analysis project, a review team reported on the lack of an integrated approach to monitoring insurance companies, which would include the detection of potential fraud. The review team noted that the Department "lacks an integrated agency-wide tracking system, although it has several program-specific tracking systems for individual processes." The early warning process is the closest thing to an integrated system, but "it falls short of the 'holistic' approach needed to effectively monitor the overall health of an insurance company."

The Early Warning Information System was designed to identify financially troubled companies. The information is used to recommend actions by the Department. Ideally, the information system can be used to trigger fraud investigations and referrals since a characteristic of a financially troubled company may be fraud by owners or management. However, there is no focused review of the information system to identify and evaluate indicators of fraud. In addition, there are shortcomings in the early warning process that prevent the most effective use of the information system. For example, data collection procedures are not enforced, which means all information about a company is not considered. In addition, the Early Warning Information System doesn't capture information on individuals and agents.

Since the Early Warning Information System does not have a comprehensive set of data, other sources of information must be accessed, including other automated information systems and informal channels. Yet, data collection procedures are not enforced for other information systems, such as the Complaint Inquiry System and the Compliance Tracking System. Also, communication between the Financial Program Division and the Fraud Unit is poor. While steps have been taken to improve communication and coordination, they have not been completely affected in these areas.

Recommendations:

- The Department should fully utilize the Early Warning Information System by enforcing data collection procedures and periodically reviewing and analyzing fraud-related indicators. The Department should evaluate the cost/benefit of adding information on individuals and agents to the System.
- There is a need to demonstrate to Department staff how automated systems, such as the Complaint Inquiry System, Compliance Tracking System, and other Oracle applications, can increase their effectiveness. This would be a necessary step to enforcing data collection procedures for all automated information systems.

- The Department should continue efforts to improve communication and coordination among all programs and divisions, particularly between the Financial Program Division and the Fraud Unit.

Management's Response: A cross-divisional team will be appointed to identify ways to more effectively use automated systems to detect patterns or indicators of potential fraudulent activity. Communication between the Financial Program and the Insurance Fraud Unit will be improved through such steps as joint training, routine planning and strategy sessions, and a Fraud Unit liaison assigned to work with the Financial field staff on a daily basis.

Section 4:

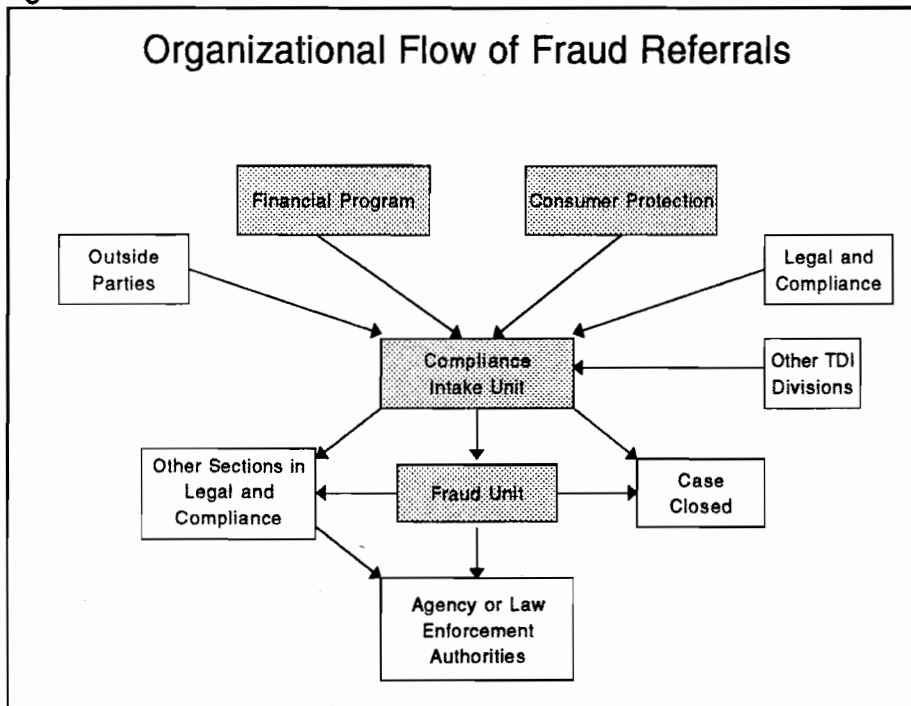
Policies And Procedures Have Been Established, But They Are Not Consistently Implemented

In May 1992, the Commissioner stated the Department's policy (in a written memorandum) that requires all employees to report any potentially fraudulent activities which are encountered in the course of their work. Policy and procedure manuals document methods for reporting potential fraud. However, there is little guidance provided for the detection of fraud, which causes gaps and inconsistencies in the implementation of the stated policy. As a result, there is no assurance that fraud detection efforts are being effectively carried out. In addition, there are different expectations among Department personnel regarding the depth of coverage in the detection of potential fraud. However, that is not unusual, given the nature of fraud. According to one expert in fraud investigation, the detection of insurance fraud is

particularly difficult due to the complicated regulatory framework, the sophisticated schemes and transactions perpetrated by knowledgeable individuals, and the time lag between the payment of premiums and the denial of claims. A typical "paper" case requires a forensic audit which involves voluminous documents.

Within the Department, there are four sections primarily involved in the detection, investigation, and referral of fraud committed while engaging in the business

Figure 6



of insurance. (See Figure 6.) Beginning with the detection of fraud, there are opportunities to improve the Department's policies and procedures in all four areas.

Section 4-A:

Fraud Detection Procedures Should Be Enhanced In The Financial Program Division

Each manual for the primary activities in the Financial Program Division contains varying amounts of guidance on fraud detection. However, there is no requirement to document consideration of fraud. Fraud referrals from the Financial Program Division originate primarily from the activities of financial monitoring, examinations, and conservation. The policies and procedures that govern these activities are included in the National Association of Insurance Commissioners (NAIC) handbooks and the Department's policy and procedure manuals. The NAIC manuals do not adequately address procedures for fraud detection. Financial program personnel rely primarily on fraud detection procedures described in the Department's manuals.

There is no requirement to document a review of an independent auditor's compliance with fraud detection standards. Article 1.15A of the Texas Insurance Code requires an annual audit by an independent certified public accountant for insurers with more than \$1 million in direct premiums written in this State during a calendar year. These independent audits are conducted in accordance with professional standards that require the detection and reporting of irregularities and illegal acts that cause a material misstatement to the insurance company's financial statements. In addition, Article 1.10D, Section 4(a) of the Texas Insurance Code, requires a person to report to the Department information regarding a fraudulent insurance act or one about to be committed. This must be done in writing within 30 days of the determination.

Planning and scheduling of examinations, including financial and market conduct, do not explicitly address indicators of fraud. While there is a systematic method for planning and scheduling financial examinations, planning for market conduct examinations is ad hoc. At the date of this review, approximately 60 examiners were assigned to conduct financial examinations and five examiners were assigned to conduct market conduct examinations. Financial examinations are used to determine the financial condition of an insurance company and its compliance with the insurance laws of the State of Texas. Market conduct examinations are used to evaluate compliance by insurance companies with statutes and regulations relating to market conduct practices in their dealing with policyholders and claimants. Market conduct examinations concentrate on an insurance company's general business practices, which present additional opportunities to detect fraud.

There has been little fraud-related training since 1993, especially to meet the needs of personnel who are in a position to detect fraud. This is a major barrier to detecting fraud, according to a survey of personnel in the Financial Program Division. (See Appendix 4.2 for survey results.) During 1992, there was a big push for training on insurance fraud. However, most of the training was focused on general investigative techniques to be used after fraud is detected.

Recommendations: Financial Program management should restate its policy and procedures regarding fraud detection and reporting and clearly establish its priority in relation to other regulatory responsibilities. Appropriate supervisory review should be conducted to ensure compliance with fraud detection policies and procedures. In addition, certain procedures can be enhanced to provide adequate attention to fraud detection.

- Documentation of the consideration of fraud should be required for all primary activities. Procedures should include a checklist or form to document consideration of fraud at an insurance company during financial monitoring, examination, supervision, and conservation.
- Examination and conservation procedures should include a review of an independent auditor's risk assessment regarding fraud.
- The Department should notify insurance companies and independent auditors, in writing, of their responsibility to report information regarding fraudulent insurance acts, as cited in Article 1.10D, Section 4 (a) of the Texas Insurance Code.
- Planning and scheduling of financial and market conduct examinations should include explicit consideration of the risk of fraud. Consideration should be given to more emphasis on market conduct examinations for the purpose of detecting and reporting possible fraud.
- Ongoing training and education in fraud detection and referral should be provided. Training should be focused on fraud detection through financial monitoring and analysis, and address specific detection techniques, fraud warning signs, referral criteria and expectations. Other methods for developing expertise could include:
 - Obtain input and assistance from external professional organizations in the presentation of relevant training sessions.
 - Assign fraud investigative staff to work side-by-side with Financial Program personnel on selected projects.
 - Establish a specialized fraud detection task force to actively look for indicators and *red flags* associated with fraud. Personnel could come from different units of the Department.

Management's Response: Management agrees with the auditor's recommendations. Examination and review procedures will be strengthened. An administrative rule issued under the authority of Sec. 10, Article 1.15A specifying that independent auditors must comply with Sec. 4(a), Article 1.10D is under consideration. Planning and scheduling processes will be reviewed to identify opportunities for improvement. The Financial Program has already begun developing training tailored for its employees.

Section 4-B:

The Consumer Protection Division Should Analyze Patterns Of Complaints

The Consumer Protection Division has documented procedures for referring potential fraud to the Compliance Intake Unit of the Legal and Compliance Division for

investigation. However, procedures for *detecting* potential fraud are not adequate. Currently, the assignment of incoming complaints to Consumer Protection staff is done randomly. In addition, specialists do not routinely review company or agent history information from the Complaint Inquiry System. Within this setting, patterns of complaints and activities can be missed.

One of the major responsibilities of the Consumer Protection Division is to resolve consumer disputes with insurance companies, agents, or other regulated insurance businesses. Within this process, the staff examines complaints for violations of the Texas Insurance Code and the Texas Administrative Code. Another responsibility of the Division is to review industry marketing materials for compliance with rules governing advertising, solicitation, and unfair trade practices. When appropriate, recommendations are sent to the Legal and Compliance Division for enforcement action.

Recommendation: Procedures within the Consumer Protection Division should be enhanced to identify patterns of complaints. At a minimum, procedures should be documented to ensure that staff review existing information/data bases for relevant case information. As mentioned in Section 3 of this report, there is a need to demonstrate to Department staff how automated systems, such as the Complaint Inquiry System, Compliance Tracking System, and other Oracle applications, can increase their effectiveness. Additional procedures should include supervisory review and performance measurement to ensure compliance with documented procedures. Management should consider assigning complaints specific to a company/agent to a designated area specialist.

Management's Response: *Management agrees that the Consumer Protection Program needs to concentrate more on reviewing patterns of suspicious agent and company activities and systematically analyzing complaint data. Consumer Protection will continue to seek more effective processes for analyzing complaints for patterns of fraud. Training will be provided to Consumer Protection employees on a monthly basis to keep them informed.*

Section 4-C:

The Compliance Intake And Fraud Units Should Enhance Procedures For The Investigation Of Fraud

The Compliance Intake Unit analyzes and prioritizes all incoming reports of possible fraud and unlawful trade practices for the Legal and Compliance Division. The Unit has documented policies and procedures, with a systematic method for closing cases or referring them for further action. However, the automated case management system is not effectively used to record the reason for a complaint or the reason for case closure. This prevents usage of the system for management reporting and hinders a review of the appropriateness of case closure. There are 53 codes available to record the reason for a complaint and 29 codes available to record the reason for case closure, yet, the category, *other*, was used excessively. During fiscal year 1994, the reason for 33 percent of incoming complaints was recorded as *other*. The reason for 57 percent of the cases closed was recorded as *other*.

While there is a mechanism in place to communicate the disposition of a referral back to an external party, there is no formal mechanism for communicating the disposition of a referral back to an originator within the Department. This is a major barrier to reporting fraud, according to a survey of personnel in the Financial Program Division.

The Compliance Intake Unit refers cases to any one of several sections in the Legal and Compliance Division, including the Fraud Unit. The Fraud Unit is charged with the investigation of potential fraud by insurance companies and unauthorized insurers. The Fraud Unit does not have documented policies and procedures for investigating, closing, or referring cases. Although certain standard procedures are followed, there is no assurance that each and every case will be consistently worked.

While the Fraud Unit staff have adequate investigative skills, they are lacking in financial and insurance industry expertise. Additionally, the biggest barriers to detecting and reporting fraud, according to a survey of personnel in the Legal and Compliance Division, are insufficient personnel and time.

Recommendations:

- The Compliance Intake Unit should effectively utilize the coding schemes in the automated case management system to record the reason for complaints and the disposition of cases closed. If necessary, additional codes should be defined to minimize the use of the category *other*. Management reports should be generated and reviewed on a regular basis. Periodic supervisory review of complaints/cases should be conducted to ensure proper handling of complaints and cases.
- The Compliance Intake Unit should consider sending an acknowledgment of receipt of a report to Department employees when they are the internal originator. However, an alternative is to demonstrate to Department staff how the Complaint Inquiry System (CIS) and the Compliance Tracking System (CTS) can be accessed to determine the status of individual reports.
- The Fraud Unit should prepare written policies and procedures to ensure consistent case work. In addition, certain procedures can be enhanced to provide adequate attention to fraud investigation. For example:
 - Review examination reports and management letters related to individual cases.
 - Ensure consistent utilization of the Early Warning Information System to identify indicators directly related to fraud.
 - Notify the originator of case disposition or demonstrate to Department staff how the Complaint Inquiry System and the Compliance Tracking System can be used to determine the status of individual cases.
- Additional financial and insurance industry expertise should be provided within the Fraud Unit. This can be achieved in various ways:
 - Training and education of existing staff
 - Employment of personnel with the necessary expertise

- Rotation of Departmental staff from the Financial Program Division on a periodic basis

Management's Response: Management will take the following actions to implement the audit recommendations:

- *Excessive use of the case category "other" will be curbed. Additional codes will be included as appropriate.*
- *A process, possibly through the CIS and CTS systems, will be developed to provide feedback to department employees on the status and final disposition of the cases they referred. Additionally, suggestions for improving future referrals, such as sufficiency of information provided, will be communicated to the employee making the referral.*
- *Key employees in the Financial Program will be trained in the effective use of the CIS and CTS automated systems.*
- *The Insurance Fraud Unit will develop an internal operations manual to guide employees and ensure consistent application of management directed policies and procedures.*
- *Financial and insurance training will be provided to pertinent Fraud Unit and Compliance Intake Unit employees. Examination reports and management letters related to individual cases will be provided routinely to the Compliance Intake Unit. Compliance Intake Unit and the Fraud Unit will work with the Financial Division to identify key financial and non-compliance information conveyed in these examination reports.*

Section 5:

Relations With Other Agencies And Law Enforcement Authorities Are Generally Good

Communication and coordination between the Department and other agencies and law enforcement authorities generally appears to be good, according to representatives from several external agencies. Generally, the Fraud Unit provides valuable information as a result of its investigations. However, there is no formal communication on the status of individual cases from external agencies back to the Department.

Relations between the Department and the Travis County District Attorney's Office have been strained since the inception of the Fraud Unit in 1992. There appears to be different expectations between the two agencies regarding the Department's role in fraud detection, especially as it fits into the Department's overall regulatory responsibilities. Given the significant role that the Travis County District Attorney has in fighting insurance fraud, good relations must be established and maintained in a cooperative atmosphere.

Recommendations:

- Periodically request status reports from other agencies and law enforcement authorities on case referrals.
- Personnel from the Fraud Unit and the Financial Program Division should work with the Travis County District Attorney's Office to establish consistent expectations regarding the depth of coverage by the Department. This will require frequent and constructive communication.

***Management's Response:** At intervals not to exceed six months, the Insurance Fraud Unit will request status reports from recipients of TDI's external referrals and enter a summary of the status into TDI's automated Case Tracking System case record.*

While the Department's statutory responsibilities are much broader than those assigned to the Travis County District Attorney's Office, we share the common goal of deterring and prosecuting insurance fraud. Management agrees that to maximize effectiveness, the Department and prosecutors must function as a team. The Department already has taken steps to improve the working relationship with the Travis County District Attorney's Office and to clarify roles. Those efforts will continue.

Objectives, Scope, And Methodology

Objectives

The audit objectives were:

- to evaluate the Department's current processes for detecting, reporting, investigating, and referring fraud committed while engaging in the business of insurance
- to determine the reliability and accuracy of performance information on fraud detected, reported, investigated, and referred from fiscal year 1993 to the present

The audit evaluated the processes in place as of January 1995. The evaluation focused on answering the following questions:

- Does the Department have a comprehensive system to detect, report, investigate, and refer fraud in the insurance industry?
- What are the results of fraud-related activities at the Department since September 1992?

Scope

This audit was done in response to a request from the former Commissioner of Insurance, Ms. Rebecca Lightsey. Her request was prompted by a letter dated December 21, 1994, from the 299th District Court Grand Jury to then Governor-Elect George Bush describing the Grand Jury's conclusion that the Texas Department of Insurance is not properly handling criminal insurance fraud matters. In its letter, the Grand Jury quotes extensively from findings of the April 1990 Special Grand Jury, 147th District Court, and concluded that little has changed.

The scope of this audit was to evaluate regulatory functions relating to fraud committed by insurance companies. It did not address regulatory functions in regard to allegations of fraud on the part of insurance agents, claimants, policyholders, or providers of services. The scope of this audit included consideration of the Department's strategic planning, organizational structure, performance measures, management information systems, and policies and procedures. In addition, the scope included a review of communication and coordination between divisions and sections of the Department, communication and coordination between the Department and outside agencies, and the Department's allocation of resources to fraud-related activities.

Methodology

The methodology used on this audit consisted of collecting information, performing audit tests and procedures, analyzing the information, and evaluating the information against pre-established criteria.

Information collected included the following:

- Prior reports related to fraud functions within the Department
- Documentary evidence such as:
 - Texas Insurance Code
 - Various management reports
 - Performance Measure Reports since fiscal year 1992
 - Department documents, memoranda, and publications, including the Agency Strategic Plan and 1996-1997 Request for Legislative Appropriations
 - Policy and procedures manuals
- Interviews with management and staff of the Department
- Survey of all staff in the Financial Program and Legal and Compliance Divisions
- Interviews with representatives from eight external organizations: Office of the Attorney General, Department of Public Safety, Texas Workers' Compensation Commission, Travis County District Attorney's Office, Harris County District Attorney's Office, Dallas County District Attorney's Office, Federal Bureau of Investigation, and the United States Attorney's Office
- Interviews with former employees of the Department
- Interviews with insurance industry and consumer representatives
- Agency generated data on fraud cases detected, investigated, and referred
- Selected case files and histories

Procedures and tests conducted:

- Comparison of listings of fraud referrals between divisions
- Comparison of listings of fraud referrals between the Department and selected external organizations

Analysis techniques used:

- Review of internal controls
- Trend analysis of expenditures and performance statistics
- Process flowcharting of fraud detection, reporting, investigation, and referral
- Comparison of strategies and budgeted amounts
- Review of performance measures

Criteria used:

- Generally accepted auditing standards for auditor's responsibility to detect and report irregularities and illegal acts
- Other standard audit criteria established during fieldwork

Fieldwork was conducted from January 4, 1995, through February 10, 1995. The audit was conducted in accordance with applicable professional standards, including:

- Generally accepted government auditing standards
- Generally accepted auditing standards

There were no instances of noncompliance with these standards.

The audit work was performed by the following members of the State Auditor's staff:

- Jon Nelson, CISA (Project Manager)
- Helen Baker
- Ester Jayme
- Kyle Kelly
- Clint Loeser, CPA
- Monday Rufus, CPA
- Barnie Gilmore, CPA (Audit Manager)
- Craig Kinton, CPA (Director)

In addition, the Department's internal audit staff provided assistance by conducting employee interviews.

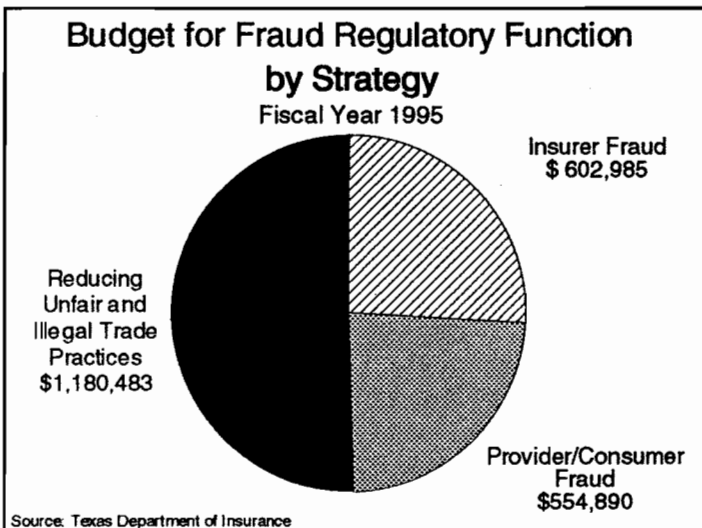
Agency Information

Appendix 2.1:

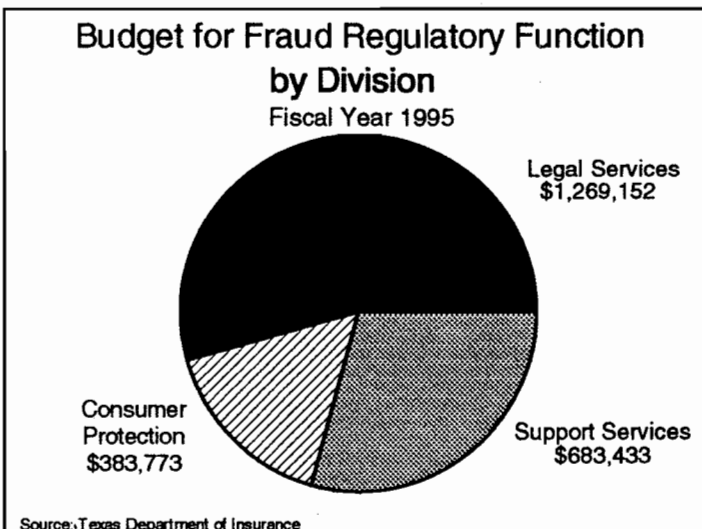
Agency Financial Information

Fiscal Year 1995 Budget Structure By Strategy

| | |
|--|----------------------------|
| Remove impediments to competition | \$11,825,589 |
| Reduce unfair and illegal practices | 8,307,858 |
| Accident and loss prevention | 4,256,365 |
| Investigate provider and consumer fraud | 554,890 |
| Identify and take action on insolvencies | 17,135,618 |
| Investigate insurer fraud | <u>602,985</u> |
| TOTAL BUDGET | <u>\$42,683,305</u> |



Per agency records, in fiscal year 1995, the budget for the fraud function is \$2,338,358. Twenty-six percent is targeted specifically to insurer fraud, 24 percent to provider/consumer fraud, and 50 percent to reducing unfair and illegal practices.



Funds for the fraud regulatory function are distributed to the Consumer Protection Division, Legal and Compliance Division, and support services. Fifty-four percent is distributed to legal services, 29 percent to support services, and 17 percent to consumer protection.

Total Operating Budget and FTEs

| Fiscal Year | 1990 | 1991 | 1992 | 1993 | 1994 |
|-----------------------------------|------------|------------|------------|------------|------------|
| Operating Budget(A) | 44,757,722 | 44,954,733 | 50,725,000 | 44,275,000 | 43,742,476 |
| Budgeted Full-Time Equivalents(B) | 1,408 | 1,476 | 1,225 | 1,215 | 1,005 |

Source: (A) Texas Department of Insurance

(B) As reported to the State Auditor's Office Classification Office by the Department

Agency Profile

The Department's mission statement is the following:

The Texas Department of Insurance works for the availability of quality insurance products for all Texans at reasonable prices and under reasonable terms and strives to protect consumers' insurance assets. We will enforce solvency standards and promote competition in the industry while protecting consumers from fraud, misrepresentation and unfair practices. We will educate the public about insurance so that Texans can make informed choices, and we will insist that the industry be responsive to its customers.

The Department's major legislative responsibilities are to regulate the business of insurance in this State and efficiently implement the purpose of the Texas Insurance Code, other insurance laws of this State, and other laws providing jurisdiction in or applicable to the Department or Commissioner.

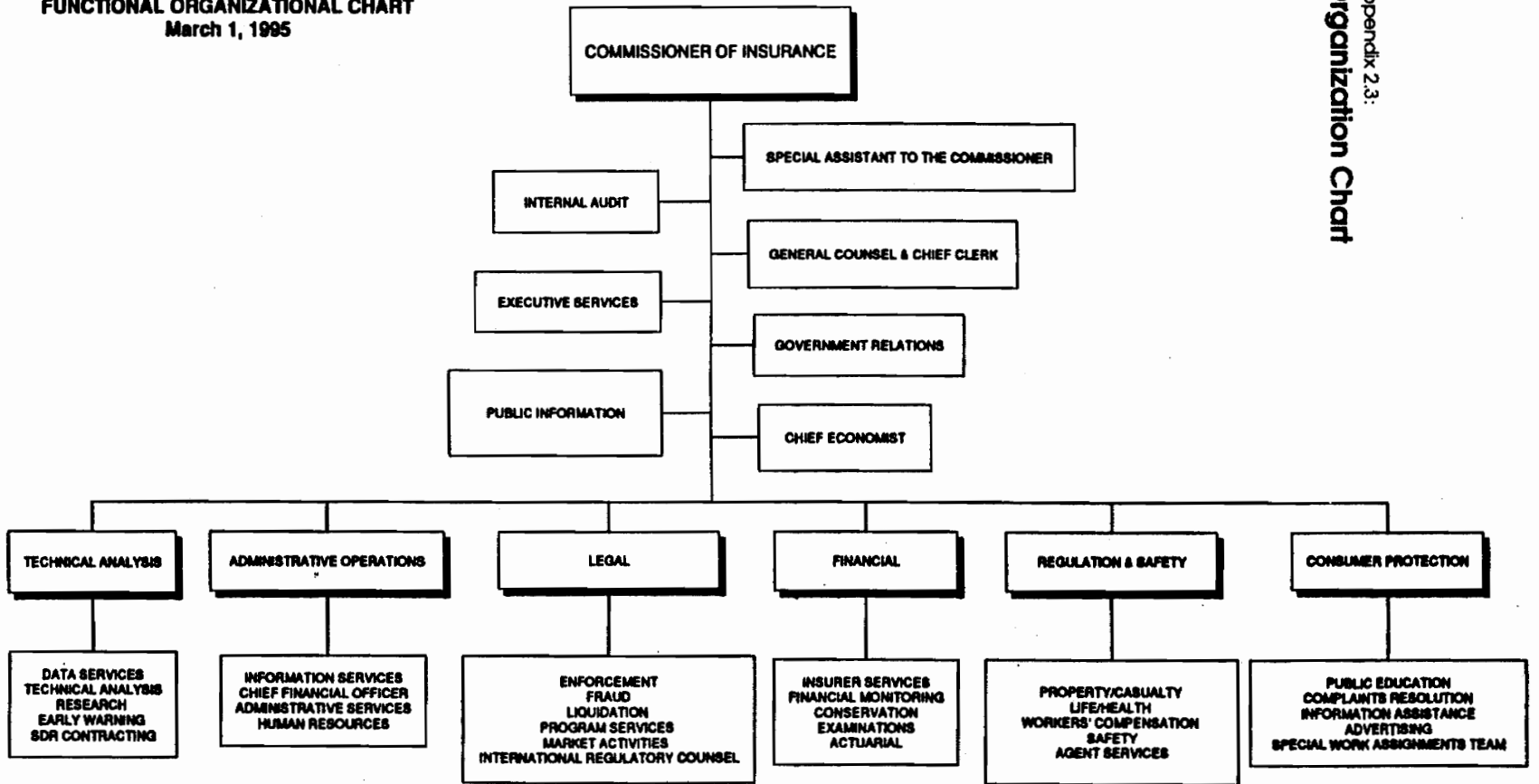
Agency activities related to fraud detection and referral are currently organized in the following areas:

- **Financial Program:** Monitors the solvency of insurance companies operating in Texas and licenses new companies.
- **Consumer Protection:** Operates a toll-free consumer hot line; handles consumer complaints; reviews advertising for compliance with statute and Department regulations; provides speakers and consumer education materials to the public; and monitors trends affecting insurance consumers.
- **Legal and Compliance:** Enforces compliance with the Texas Insurance Code and related rules and regulations; investigates and develops cases, including allegations of fraud and illegal market activities; and oversees the liquidation process for companies in receivership.

Within the Legal and Compliance Division, there are two units primarily involved with fraud committed by insurance companies: the Compliance Intake Unit and the Fraud Unit. Article 1.10D of the Texas Insurance Code requires the creation of the insurance fraud unit in the Department to enforce laws relating to fraudulent insurance acts.

Texas Department of Insurance
FUNCTIONAL ORGANIZATIONAL CHART
March 1, 1995

Appendix 2.3:
Organization Chart



Reference List

A.M. Best Company. *Best's Insolvency Study Life/Health Insurers 1976-1991*. June 1992.

_____. *Best's Insolvency Study Property/Casualty Insurers 1969-1990*.

Covaleski, John. "Stamping Out Insurer Fraud." *Best's Review*, October 1994.

Foppert, David. "Waging War Against Fraud." *Best's Review*, March 1994.

Insurance Information Institute. *Insurance Issues Update*. New York, N.Y. September 1994.

Keever, Jack. "The Fraud Fighters." *Texas Insuror*, November/December 1994.

Schneider, Andrew, and Doug Sword. *The Insurance Game: When Protection Becomes a Racket*. Scripps Howard News Service, February 1995.

State of Texas, Office of the State Auditor. *An Audit Report on Performance Measures at 25 State Agencies*, Report 94-136, August, 1994.

_____. Office of the State Auditor. *A Review of Management Controls at the Texas Department of Insurance*, Report 95-036, December 1994.

United States General Accounting Office. *Insurance Industry: Chronology of F.T. Riley's Activities and Related Regulatory Actions*. October 1994.

_____. *Insurance Ratings: Comparison of Private Agency Ratings for Life/Health Insurers*. September 1994.

147th District Court, Report of the April 1990 Special Grand Jury.

General Information

Appendix 4.1:

Background On Insurance Fraud

Various studies and reports indicate that fraud is prevalent in the insurance industry. The FBI, in its *Insurance Company Solvency Study*, states, "The business of insurance is uniquely suited to abuse by mismanagement and fraud." The Coalition Against Insurance Fraud, Washington, D.C., estimates total fraud in the industry costs \$100 billion per year nationwide, which translates into higher premiums for policyholders.

The nature of the insurance business makes it susceptible to fraud.

- Insurance is a risk distribution system which permeates our personal and business activities. A defined group shares in the losses of all other members through the payment of predetermined premiums. The insurance premiums paid by the many are used to cover the losses of the few.
- There is a high and constant demand for insurance products.
- Risk distribution requires the accumulation of liquid assets in the form of reserve funds in order to pay claims.
- There is a natural time lag between the payment of premium and the claims settlement.
- The insured relies on the regulatory system.
- State regulators are reluctant to investigate and prosecute insurance fraud cases because of budget and jurisdictional problems.

There are different types of insurance fraud.

- Insider fraud or "white-collar crimes" within insurance companies
- Unauthorized insurers, e.g., selling insurance without a license
- Claimant/consumer fraud, which is considered to be the most prevalent type of fraud
- Provider fraud, i.e. fraud perpetrated by unscrupulous agents, insurers, doctors, lawyers, etc.

The extent of insurance fraud is difficult to quantify. A widely accepted estimate of claimant fraud is 10 percent of total claim dollars or gross premiums. In Texas, this would range from \$2.7 billion to \$3.7 billion, based on claim payments and premiums during 1993. Although it is virtually impossible to quantify, insurers and investigators recognize insurer fraud as being potentially one of the costliest issues facing the industry. The Executive Director of the Coalition Against Insurance Fraud, Dennis Jay, notes that while claims fraud is more prevalent, individual cases of insurer fraud can be far costlier.

An A.M. Best study found that allegations of fraud existed in eight percent of the life/health companies that became insolvent or otherwise financially impaired from 1976 to 1991. The study also found that inadequate pricing and overstated assets, which sometimes indicate fraudulent activity, was evident in 41 percent of the cases. Another A.M. Best study found that allegations of fraud existed in 10 percent of the property/casualty companies that became insolvent or otherwise financially impaired

from 1969 to 1990. Deficient loss reserves (linked with inadequate product pricing) and rapid growth accounted for 50 percent of the insolvencies.

Results Of Employee Survey

In order to gain an understanding of the current Departmental processes for detecting, investigating, and referring insurance fraud, the State Auditor's Office surveyed 280 employees from the Financial Program and Legal and Compliance Divisions. The specific objectives of the survey were to 1) determine whether policies and procedures exist and are understood, 2) identify barriers to *detecting* insurance fraud, 3) identify barriers to *reporting* insurance fraud, and 4) suggest improvements. There were 199 responses received and analyzed. The results are presented according to each question.

1. Are you aware of policies and procedures within your section that address the detection and reporting of fraud within insurance companies?

| | <u># Responses</u> | <u>Distribution</u> |
|-------------|--------------------|---------------------|
| Yes | 170 | 85.43 |
| No | 13 | 6.53 |
| Not sure | 14 | 7.04 |
| No response | <u>2</u> | <u>1.01</u> |
| Total | <u>199</u> | <u>100.00</u> |

2. If you are aware of such policies and procedures, do you feel that you understand them enough to apply them when required in your job?

| | <u># Responses</u> | <u>Distribution</u> |
|-------------|--------------------|---------------------|
| Yes | 152 | 76.38 |
| No | 16 | 8.04 |
| Not sure | 17 | 8.54 |
| No response | 12 | 6.03 |
| Other | <u>2</u> | <u>1.01</u> |
| Total | <u>199</u> | <u>100.00</u> |

3. Do you feel that detecting or reporting fraud is a part of your job duties?

| | <u># Responses</u> | <u>Distribution</u> |
|-------------|--------------------|---------------------|
| Yes | 167 | 83.92 |
| No | 23 | 11.56 |
| Not sure | 7 | 3.52 |
| No response | <u>2</u> | <u>1.01</u> |
| Total | <u>99</u> | <u>100.00</u> |

4. Have you ever detected potential fraud in an insurance company?

| | <u># Responses</u> | <u>Distribution</u> |
|--------------|--------------------|---------------------|
| Yes | 102 | 51.26 |
| No | 81 | 40.70 |
| Not sure | 10 | 5.03 |
| No response | <u>6</u> | <u>3.02</u> |
| Total | <u>199</u> | <u>100.00</u> |

If yes, how many cases? (Note: While 102 respondents noted that they had detected fraud, only 91 respondents provided an answer to this question.)

| <u>Number Of Cases</u> | <u>Count</u> | <u>Distribution</u> |
|------------------------|--------------|---------------------|
| 1 | 23 | 25.27 |
| 2 | 29 | 31.87 |
| 3 | 7 | 7.69 |
| 4 | 7 | 7.69 |
| 5 | 6 | 6.59 |
| 6 | 5 | 5.49 |
| 8 | 1 | 1.09 |
| 10 | 2 | 2.19 |
| 12 | 1 | 1.09 |
| 15 | 1 | 1.09 |
| 16 | 1 | 1.09 |
| 17 | 1 | 1.09 |
| 20 | 4 | 4.40 |
| 100 | 2 | 2.19 |
| 200 | <u>1</u> | <u>1.09</u> |
| Total | <u>91</u> | <u>100.00</u> |

5. From the list below, select only those factors you feel may currently inhibit you from effectively **detecting** potential fraud within an insurance company and rank them in order of importance to you. (Note: The results depict the percent of respondents choosing each factor, regardless of rank.)

| <u>Factor Listed</u> | <u>Percent of Respondents</u> | |
|----------------------------------|-------------------------------|-------------------------------|
| | <u>Financial Program</u> | <u>Legal & Compliance</u> |
| No factors apply | 24% | 42% |
| Insufficient time available | 31% | 24% |
| Inadequate training | 32% | 19% |
| Insufficient personnel available | 21% | 33% |
| Little fraud activity occurring | 21% | 10% |
| Inadequate policies/procedures | 19% | 9% |

Factor Listed (continued)

Percent of Respondents
Financial Program Legal & Compliance

| | | |
|---|-----|-----|
| Incidents are insignificant | 15% | 6% |
| Political pressure | 11% | 13% |
| Inadequate financial reports | 13% | 6% |
| Management override | 12% | 1% |
| Inadequate supervisory review | 8% | 3% |
| Insurance company pressure | 7% | 6% |
| Other various factors (i.e. inadequate access to data, fraud difficult to detect from desk reviews, inadequate computer systems, lack of enforcement power) | 20% | 15% |

6. Have you ever reported potential fraud you suspected within an insurance company? (Note: While most respondents answered this question, only 102 respondents were noted to have detected potential fraud in response to question 4.)

| | <u># Responses</u> | <u>Distribution</u> |
|-------------|--------------------|---------------------|
| Yes | 99 | 49.75 |
| No | 91 | 45.73 |
| Not sure | 1 | .50 |
| No response | <u>8</u> | <u>4.02</u> |
| Total | <u>199</u> | <u>100.00</u> |

If yes, how many cases? (Note: While 99 respondents noted that they had reported fraud, only 82 respondents provided an answer to this question.)

| <u>Number</u> <u>Of Cases</u> | <u>Count</u> | <u>Distribution</u> |
|----------------------------------|--------------|---------------------|
| 1 | 22 | 26.83 |
| 2 | 23 | 28.05 |
| 3 | 10 | 12.20 |
| 4 | 6 | 7.32 |
| 5 | 7 | 8.54 |
| 6 | 5 | 6.10 |
| 8 | 2 | 2.44 |
| 10 | 2 | 2.44 |
| 12 | 2 | 2.44 |
| 15 | 1 | 1.22 |
| 20 | 1 | 1.22 |
| 100 | <u>1</u> | <u>1.22</u> |
| Total | <u>82</u> | <u>100.00</u> |

7. If you have reported potential fraud, whom did you notify? (Please indicate all that apply.)

| | <u>Number of respondents</u> |
|----------------------|------------------------------|
| Immediate supervisor | 83 |
| TDI Fraud Unit | 71 |
| Another TDI section | 30 |
| An external contact | 20 |

8. From the list below, select only those factors you feel may currently inhibit you from effectively reporting potential fraud within an insurance company and rank them in order of importance to you. (Note: The results depict the percent of respondents choosing each factor, regardless of rank.)

| <u>Factor Listed</u> | <u>Percent of Respondents</u> | |
|---|-------------------------------|-------------------------------|
| | <u>Financial Program</u> | <u>Legal & Compliance</u> |
| No factors apply | 30 | 51 |
| Insufficient personnel available | 15 | 21 |
| Inadequate training | 19 | 13 |
| Unsatisfactory follow-up | 24 | 4 |
| Insufficient time available | 15 | 19 |
| Little fraud activity occurring | 19 | 10 |
| Incidents are insignificant | 15 | 4 |
| Poor coordination within TDI | 11 | 7 |
| Political pressure | 11 | 10 |
| Inadequate policies/procedures | 13 | 3 |
| Management override | 11 | 4 |
| Inadequate financial reports | 7 | 3 |
| Insurance company pressure | 5 | 3 |
| Inadequate supervisory review | 3 | 3 |
| Other various factors (i.e. professional liability, indirect contact with company activities, inadequate computer systems, difficulty locating proof) | 16 | 6 |

9. What suggestions can you offer to improve the current process in which TDI sections detect and report insurance company fraud? (Note: The top ten suggestions are shown below, with the number of respondents in parenthesis.)
- a. Improve type and delivery of training and continuing education (64)
 - b. Improve feedback, direct communication, and follow-up on referrals made (41)
 - c. Improve the quantity, quality, and use of resources (41)
 - d. Improve policies and procedures (29)
 - e. Analyze probability of detecting fraud from a desk review (27)

- f. Improve access to data and documents (14)
- g. Remove the politics from the pursuit of fraud cases (11)
- h. Analyze the role of Travis County District Attorney's Office (10)
- i. Stabilize agency structure and management philosophy (10)
- j. Consider changes to statutes and regulations (6)

10. What is your length of employment with the Texas Department of Insurance?

| | <u># Responses</u> | <u>Distribution</u> |
|------------------------------------|--------------------|---------------------|
| Less than 1 year | 15 | 7.54 |
| From 1 year to less than 3 years | 36 | 18.09 |
| From 3 years to less than 5 years | 41 | 20.60 |
| From 5 years to less than 10 years | 71 | 35.68 |
| Greater than 10 years | 35 | 17.59 |
| Left blank | <u>1</u> | <u>50</u> |
| Total | <u>199</u> | <u>100.00</u> |

Copies of this report have been distributed to the following:

Legislative Audit Committee

Honorable James E. "Pete" Laney, Speaker of the House, Chair
Honorable Bob Bullock, Lieutenant Governor, Vice Chair
Senator John Montford, Chair, Senate Finance Committee
Senator Kenneth Armbrister, Chair, Senate State Affairs Committee
Representative Robert Junell, Chair, House Appropriations Committee
Representative Tom Craddick, Chair, House Ways and Means Committee

Governor of Texas

Honorable George W. Bush

Legislative Budget Board

Sunset Advisory Commission

Texas Department of Insurance

Mr. Elton Bomer, Commissioner
Mr. Dennis Veit, Internal Auditor
Mr. Don Switzer, Special Assistant to the Commissioner
Mr. Stan Wedel, Associate Commissioner for Administrative Operations
Mr. C. H. Mah, Associate Commissioner for Technical Analysis
Ms. Mary Keller, Associate Commissioner for Legal
Mr. Jose Montemayor, Associate Commissioner for Financial
Ms. Audrey Seldon, Associate Commissioner for Consumer Protection