I am proud to be invited back to SC.
My name is Doug Quinn I am the executive director of the American Policyholder Association. I am also on the board of directors for the coalition against insurance fraud as well as on the property and casualty fraud task force and the internal fraud subcommittee; a work group focused on identifying the issue of fraud committed by vendors hired by the insurance industry such as TPA's and engineering firms. Prior to that I was an insurance agent and financial advisor working in the insurance industry for three decades. I helped found the APA after I lost my home and everything I own in a natural disaster and was subsequently defrauded by the use of a fraudulent engineering report commissioned by my insurance company. Despite paying an exorbitant price for the maximum legal amount of insurance coverage, it took me 7 years to rebuild and return to my home. My situation was not unique, as uncovered by the raiding of an insurer-hired engineering firm and subsequent arrest of their supervisor which spurred the reopening of over 100,000 claims and the return of over $350 million dollars to policyholders who had been cheated.

The APA is Nonprofit consumer watchdog organization that promotes integrity honesty and best practices in the property loss adjustment sector of the insurance industry. As such, we're in a position to observe trends in the insurance industry. One of the trends we are particularly concerned about is a shift in the industry from a business model based on indemnifying consumers for a loss at a reasonable profit, to a model of profit harvesting to the detriment of the American consumer.
This harvesting starts with the initial pricing of the insurance contract and using credit scores to inflate such pricing. Policyholders with poor credit can pay up to twice as much as those with good credit scores in some regions. Once the contract is in place, Policyholders are often hit with an onslaught of premium increases to the point where they struggle to afford their coverage. When I was a financial advisor I noticed how American consumers were struggling. Savings rates are dropping dramatically while personal debt is increasing. Many families are living paycheck to paycheck with only a nominal amount of money in the bank. For this reason, their insurance protection is that much more important for them. The affordability crisis is hitting many American families hard. When faced with the choice of paying their insurance premium or putting food on the table, many consumers will look to cut their insurance to the bare minimum, purchase stripped down policies, or "go bare" and drop their coverage altogether. This is particularly true with senior citizens who

have worked their whole life to pay off their mortgage and are not required to carry insurance on their homes.

We all know that insurance is an incredibly important risk management tool that allows consumers to recover from a loss that would otherwise be catastrophic. Pricing increases undercut the foundation of the safety net that consumers need to put in place to protect their families and businesses. With either reduced or no coverage at all, many hit with a loss do not have the financial resources to recover. The combination of inadequate coverage and limited savings can be devastating. How do we expect struggling working class families and businesses to get ahead under such circumstances?

The insurance industry has used many reasons to justify premium increases: mostly by claiming they are losing money due to inflation on materials, increased loss due to climate change, alleged fraud and frivolous litigation among them. Some of these are valid, while others have been exaggerated. I would encourage your committee to look deeply into the losses alleged by the insurance industry. More often than not, when losses are discussed, they are referring to "underwriting losses". Underwriting losses and even combined ratio do not reveal whether an insurance company is profitable or not. Insurers' investment portfolios generate long term returns to offset underwriting losses, expenses and generate significant profit.

In fact, looking at some of the expenses insurers are claiming contribute to losses you will see those that they have tremendous control over; Such as executive bonuses, advertising, and lobbying expenditures. The insurance industry is one of the top lobbying interests in America. Campaign and PAC contributions are used to solidify their position and secure favorable treatment. Such money is funded by our premium dollars. Insurance is also one of the biggest advertisers in the country. The insurance industry spent $15 billion on digital advertising alone last year. It is hard to watch a live TV show, sporting event or listen to the radio without seeing multiple insurance commercials. Again, those are our premium dollars being spent. There are some questionable practices as well; Transferring assets thru affiliate companies is a practice that most people are not aware of and few regulators track. In this practice, insurers pay affiliate companies with common ownership for services. There have been instances where companies have dramatically overpaid for services or paid for services that were never rendered. The APA has a criminal referral in two states

alleging exactly this: a whistleblower came forward with proof that the insurer he worked for was paying four times market rates for restoration services performed by one of its own affiliates. Claims personnel were alleged to have been instructed that when they saw that affiliate's invoice, not to question it, just pay it. Those who did question the exorbitant payments were fired. The company in question was put into insolvency with many conveniently blaming "frivolous litigation" when In fact it was the insurers owned business practices that caused the failure skip. Such Transfers, often consisting of billions of dollars, become in effect a profit shifting shell game. Insurers can then cry poverty and raise rates. Another example is the use of surplus notes. An insurer's parent will purchase surplus notes from the subsidiary insurance company to boost its capital position. The capital structure of the note is not considered debt on the subordinate insurer's balance sheets, but rather equity by many insurance departments. Payments of interest on the notes are claimed as expenses which contribute to loss calculations, when in reality it is just another way to shift profits off to the parent company and claim losses to justify rate hikes. According to Statistics uncovered by Weiss research, in 2024, 51 insurers doing business in South Carolina use surplus notes. Those insurers paid $531 million in interest on $7.95 billion of surplus notes. Furthermore, those same 51 insurers transferred $3.65 billion in affiliate fees. This is money South Carolina families need in the form of reduced premiums and claims payments on losses.

Claims underpayments and denials are a growing problem. Consumers are not only paying more in premiums, they're getting less on claims. Much of the insurance industry's shift from a business model of indemnifying consumers for a loss at a reasonable profit to a "Profits before people" model can be traced to Allstate's hiring of consultant McKinsey and company in the 1990s. McKinsey showed the insurance industry how to use the claims department as a profit center rather than just a service function, normalizing the strategy that most today refer to as "Delay Deny Defend". The impact on consumers has been devastating.

On May 16th of this year I was invited by Senator Josh Hawley to testify to the US Senate Homeland Security committee's Disaster Management subcommittee. Committee chair Hawley and ranking member Senator Andy Kim were alarmed by the tremendous increase in the percentage of claims closed without payment in the wake of hurricanes Helene and Milton. Testifying alongside of me were policyholders who had been dramatically undercut on their claims as well as the insurance

industry's own adjusters who were coming forward as whistleblowers to testify that they had been pressured to dramatically cut claims. The penalty for not submitting to this pressure was loss of business or being outright fired. In case you think that this is a problem that only happens "elsewhere", National Association of insurance commissioner statistics show that in 2024, 42.5% of all home insurance claims in the state of South Carolina were closed with no payment whatsoever to the homeowner. 100% of those homeowners had dug deep to pay their insurance premium with the expectation that if they suffered a loss they would be made whole by their insurance company. More and more often these days, that is not the case.

The problem doesn't always lie with insurance company personnel, it can often be carrier-hired vendors such as Third Party Administrators, Consultants, and Engineering firms who are shorting consumer claims. The Washington Post & CBS' 60 minutes covered the story of insurance adjusters who came forward as whistleblowers alleging that their damage reports had been cut by up to 90% after they submitted them to the TPA they worked for and the reports were then sent out to policyholders with the adjusters' names still on them falsely representing it as their work.

This is not unique, those who perpetrate such acts of theft from consumers can do so secure in the fact that consequences are all but non existent. While arrests of those who steal from insurance companies are fairly common and there is a robust public-private partnership with law enforcement to crack down on the very real problem of fraud against insurance companies, arrests of those on the carrier side who commit crimes to cheat consumers on claims are almost unheard of.

It can be very intimidating, if not impossible for the average person to stand up to a large insurance company who is underpaying them. Policyholders in such a position are forced to choose between either accepting the denied claim or hiring professional representation. Many states are being pressured to enact tort reform to limit consumers' ability to get justice in civil court. The promise, of course is that premiums will go down, but this has not happened in states like Florida where tort reform was passed. In fact, one of the conclusions reached by experts after the Hawley hearings was that limiting consumers ability to hold their insurer accountable in civil court was one of the driving reasons for the dramatic increase in claim denials after hurricane Helene and Milton. A lack of accountability and a lack of transparency translate into abusive practices to underpay consumers.

Families go through a lot of trouble to protect themselves by putting insurance in place as a safety net. When that safety net fails what they go through is devastating. To make up the difference in what insurance didn't pay, policyholders will spend down their savings, dip into their retirement, drain their children's college funds or go deeper into debt. The impact can be multi generational and go far beyond the financial calculation. In displaced families we will see not only financial difficulties, but marital problems, children underperforming in school, increased dependence on drugs and alcohol, physical and mental health issues such as heart attacks, depression, anxiety, and even suicide. The longer a family is displaced from their home after a loss, the more aggravated these symptoms.
The impact can be community wide since out of control insurance premiums and unrepaired or poorly repaired properties also have an adverse impact on the real estate market. The pending government shutdown and resultant inability for consumers to buy or renew flood insurance policies with the NFIP will also have a severe impact on the real estate market.

To summarize, rising insurance premiums and declining payments on claims impact all citizens of South Carolina. We strongly encourage this body to enact reforms that bring transparency to the finances and operations of the insurance industry as well as criminal accountability for those who would cheat South Carolina policyholders. Particular attention should be paid to transparency in figures calculating loss to justify premium increases as well as changes made to adjusters claims reports after the fact.
I want to thank you for inviting me here today and assure you that I am available if you need any further help on thee critical issues. As I've already mentioned, insurance is an incredibly important risk management tools for South Carolina families. We all benefit with a healthy, resilient insurance market in place to protect our families and businesses. I commend the work this committee is undertaking to help ensure that goal.
Thank you.