HEARING ON INSURANCE FRAUD
House Insurance Committee
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Good morning. Thank you Mr. Chairman and thank you to Rep. Josh Shapiro who approached me about testifying today.

For the record, I am Stewart Anmuth, Immediate Past President of the Pennsylvania Association of Health Underwriters (PAHU), an association made up of insurance agents and brokers who specialize in health insurance and employee benefits. My work involves meeting the insurance and benefits needs of businesses and individuals across a three-state area. Part of my professional background is accounting and finance and I have worked for hospitals as well as in insurance.

My testimony today will not focus necessarily on the package of bills being reviewed except to say that they seem prudent. Generally speaking, these bills appear to be justified since they have the support of the Insurance Department, the Attorney General's Office, and the Insurance Fraud Prevention Authority. PAHU believes that insurance fraud is a cancer that erodes the value of the consumer's ability to purchase insurance. It adds to the cost of insurance and makes it more difficult for individuals and businesses to have it.

What can be done to strengthen the war against insurance fraud besides acting on this package of important legislation? There are three areas of legislation where lawmakers should look at as additional tools against insurance fraud. They are increasing the Budget for the Insurance Department, exempting fraud efforts from the medical loss ratio legislation, and re-tooling false claims legislation so that fraudulent claims are segregated from bookkeeping mistakes.

Increase the Department's Budget

The most important thing you can do is to improve financing for the work being done by the PA Insurance Department. The Governor will shortly deliver his vision of the State Budget for Fiscal year 2010-2011. In this time of fiscal austerity, brought about by the

recession, I urge the members of the General Assembly to look at the numbers for the Insurance Department and significantly increase them.

As you know, the Insurance Department has been forced to re-trench because of budget woes faced by the Commonwealth. One Deputy Commissioner has to supervise three functional areas, MCARE, CHIP and adultBasic, each one of which could justify its own Deputy because each is a substantive program. The Insurance Department is supposed to be the people's first line of defense against unfair insurance practices but they are less accessible now than they have ever been. The Erie office of the Insurance Department is closed. The Pittsburgh office of the Insurance Department is closed. These closures may have been forced because of budget but they are shortsighted because the Budget proposed by the Governor and passed but the General Assembly did not provide sufficient resources.

I am not here to yell at you. Rather, I am pointing to a budget problem which makes combating insurance fraud (and other abuses against the consumer) harder to combat. Having fewer job slots for consumer services caseworkers or Insurance Department enforcement staff means less service, less responsiveness, and frankly more disillusionment by consumers that their specific situation will be dealt with in an efficient and timely way. We have already made the Department harder to reach physically. They do not even have a receptionist for the Department. That's how bad it is. Now, a heightened caseload and not enough staff means that the Department is hindered from doing its job.

This has specific impacts on insurance fraud because a deterrent to fraud is the certainty of being caught. If the Department is swamped by consumer complaints and is limited in terms of manpower, it is not going to be servicing those complaints as aggressively as it should. This does not imply any disrespect whatsoever to the civil servants over there now. They work hard but they need more resources to do their jobs.

Insurance agents and members of my association feel that we are the eyes and ears of the Department in spotting cases of insurance fraud or market abuses. How successful can we be in bringing situations to the Department of bogus marketing operations or shady market practices if the Department is slow to follow up and resolve the situation, not because it doesn't want to but because it can't.

I call to your attention a study done by the GAO entitled "Private Health Insurance: Unauthorized or Bogus entities have Exploited Employers and Individuals Seeking Affordable Coverage". It pointed to 144 entities selling health insurance covering 15,000 employers and more than 200,000 policyholders with $252 million in unpaid medical claims. The Insurance Department has made targeting these scams a priority. In tough economic times like today's expect more fraudulent entities to surface. Will the Department have enough resources to investigate these sorts of insurance fraud and close them down before they leave people stranded with unpaid medical bills?

Allow an Exemption for Fraud Efforts from the 85% Medical Loss Ratio

This committee has moved legislation that establishes a medical loss ratio of 85%. This means that for every dollar received by an insurer in premium, 85 cents will be spent on claims. First of all, know that PAHU disagrees with this approach, believing that it is an arbitrary figure that may work against smaller insurance companies trying to establish a base by which they can compete in the marketplace. My point here is not to re-hash the arguments since I respect the point of view that a medical loss ratio is the only way to hinder profit-taking.

Rather, it is to suggest that fraud prevention and investigation be exempted from the 15 percent. Fraud work is a discretionary expense and might be reduced if the insurer is looking at ways to reduce overhead. Taxes, payroll, advertising etc. are all essential to the insurer's existence. Fraud efforts might be cut back as the company strives to make the 85% ratio.

Exempting fraud from the ratio would be a way to guarantee insurer resourcing of this important effort. The insurer efforts to combat fraud are critical.

False Claim Legislation

The third area is false claims. As you know, legislation has been introduced over several sessions of the General Assembly to put real teeth into the law regarding the filing of a false claim to the government. Granted this applies to all bogus requests for payment including such things as construction work or not delivering contracted services etc. It also applies to the social services arena. Medicaid according to the Kaiser Family Foundation covers about 13 percent of Pennsylvania's population. That does not include the 197,150 kids in CHIP or the 40,685 enrolled in adultBasic. The government is actually the largest insurer in the commonwealth. As a result, there are hundreds of thousand of claims using billions of the taxpayers' dollars.

This public sector expenditure by its very size alone makes it a target for those wanting to commit insurance fraud. A study done by the George Washington University Medical Center School of Public Health funded by the Robert Woods Johnson Foundation estimated that health insurance frauds accounts for between three and ten percent of all health spending. If their figures are right, of the 2.3 trillion dollars spent by the U.S. each year on heath care, between $69 billion and $220 billion is lost to insurance fraud.

Given the role of Medicare and Medicaid of covering fully 25% of the U.S. population, false claims prosecution begins here. Unfortunately, the legislation contains a section that might hinder the voluntary correction of an unintentional bookkeeping error. The bill correctly penalizes firms and persons that willfully attempt to defraud the taxpayers by filing a false claim. Title 18 defines insurance fraud as an intentional attempt to receive gain for an action. The false claims legislation penalizes those businesses that, through their own internal review, found errors and corrected them. Someone who discovers their own error deserves to be praised, not punished. Although the bill has a lesser penalty, it is

still a penalty. Government health programs are complicated and the rules are hard to understand…

I know that this legislation is not in the House Insurance Committee but when it comes before the House, I ask that you keep this observation in mind. It may be that some members of the House Insurance Committee sit on the Health and Human Services Committee too and as such might be in a position to influence the final form of the bill.

Conclusion

In conclusion, the members of the Pennsylvania Association of Health Underwriters have a direct stake in the battle against insurance fraud. Our goal as licensed insurance producers is to be able to offer affordable choices to consumers and businesses. Insurance fraud makes health insurance more expensive and hurts the people who can no longer afford it. Accessibility and affordability walk hand in hand and insurance fraud harms us all. Fraud is only one element of cost but it is the subject for today. Again, I was honored to be asked by Rep. Shapiro to testify and I appreciate this committee's good work in this vital area.