## PENNSYLVANIA ASSOCIATION OF MUTUAL INSURANCE COMPANIES

## TESTIMONY OF STEVEN C. ELLIOTT
## ON INSURANCE FRAUD LEGISLATION
## HOUSE INSURANCE COMMITTEE
## JANUARY 28, 2010

Good morning Mr. Chairman and members of the Committee.

My name is Steven Elliott. I am president of the Pennsylvania Association of Mutual Insurance Companies (PAMIC). I am happy to be here to testify on behalf of the 63 member mutual property and casualty companies which belong to PAMIC. Thank you for this opportunity to present the observations and concerns of this constituency.

Insurance fraud is obviously something that every insurance company has a vital self-interest in combating. We are gratified that Chairman DeLuca, the members of the House Insurance Committee, and the sponsors of the bills under consideration today obviously share this deep concern. We at PAMIC thank you for this interest and concern.

I want to share with you very briefly PAMIC's thoughts on the bills under consideration today, some of which may well provide insurance companies with some useful fraud fighting tools.

First, House Bills 1736, 1737 and 1740. These bills are part of a package introduced by Representative Godshall. House Bill 1737 enhances the penalty for violation of the Public Adjuster Law to a felony of the third degree. As valuable as public adjusters can be in complex claims, they sometimes can be the catalyst of claim activity that ultimately proves fraudulent. Public adjusters are lightly regulated in Pennsylvania when compared with nearby states, and anything tightening up current statutes is to be welcomed.

House Bill 1737 requires health facilities to place posters in each facility announcing a $25,000 reward for reporting insurance fraud. Our companies have no particular comment on this proposal. On its face, it appears sensible.

HB 1740 establishes an asset forfeiture program. The assets used in the perpetration of insurance fraud could be forfeited after appropriate court procedures and distributed to the Insurance Fraud Prevention Authority, law enforcement, and affected insurance companies. This is a good idea and we support it, although it would seem that most of the valuable assets forfeited would be autos. Most PAMIC members (all but 18) do not write auto.

Next, HB 2041, introduced by Chairman DeLuca and co-sponsored by Minority Chairman Micozzie and others, and reported out of this committee on January 25, establishes a long needed consumer bill of rights on towing and storage issues. An auto issue, it is a useful reform and PAMIC strongly supports it. PAMIC also strongly supports HB 2154, also introduced by Chairman DeLuca with Chairman Micozzie among the co-sponsors. This bill is a strengthened immunity bill which would include certain insurer-to-insurer communications within its scope.

It is when we get to HB 1739 and HB 1750 that we start to have some serious problems. Both bills would extend the requirements for development and maintenance of insurance fraud plans from the current mandate for such plans for auto and workers comp only to all lines of insurance. Further, both bills contain reporting and penalty provisions that are burdensome and unnecessary and, in the case of the penalties provided, draconian.

Both bills require plans to contain certain specific provisions. HB 1739, introduced by Representative Godshall, is a stand-alone bill focused on insurance fraud plans. HB 1750, sponsored by Representative Barbin, is comprehensive, amending the Title 18 insurance fraud criminal statute and reenacting the Insurance Fraud Prevention Authority act in the Insurance Department Law. This includes a new general provision requiring fraud plans for all lines of insurance. In the interest of time, I will focus solely on the insurance fraud plan provisions of these two bills.

The Godshall plan (HB 1739) does not require as much as HB 1750. That bill, the Barbin plan, in addition to the requirement for participation in an industry wide database also found in the Godshall plan, requires the employment of a professional fraud investigator. Both bills require that loss costs be stripped of fraudulent claims and claim payments. Both permit companies to add the costs of maintaining the fraud activities set out in the fraud plans to the rate base.

Both bills would impose costs that are unrealistic and unproductive in the case of the typical PAMIC member company. Most of our membership consists of companies writing personal lines in Pennsylvania. For our average member, commercial lines constitutes 25% or less of its book of business. Most often, these commercial lines policies are small business coverages or landlord property. For the average member, the preponderance of homeowners premiums and losses are on the property side, not liability. For our companies, the biggest source of loss related to criminal activity is arson. That is important because arson does not constitute insurance fraud under the criminal statute. Granted, an arson case will inevitably generate a false claims report, which is covered, but that is just an additional count on a basic arson criminal case. The underlying crime is arson and the investigation, the science, and the law enforcement contacts that arson investigations require are far different from the false claims that are the standard fare of the typical insurance fraud claim. Our smaller companies know how to employ good, solid cause and origin investigators. They have good relationships with the fire marshals and the fire chiefs in their communities. In fact many insurance claims people also serve as volunteer fire fighters. They understand arson investigations and they readily and aggressively conduct them.

That is why the Insurance Fraud Prevention Authority does not deal with arson. And, presumably, that is why the Insurance Fraud Prevention Authority does not include preponderantly property and preponderantly personal lines carriers in it board representation of insurers. Look at page 8 of HB 1750, starting at line 3. The insurer representatives on the board are to be a representative of a workers comp writer, an accident and health writer, an auto writer, and a "general commercial liability" writer, and I emphasize liability, not property. This board representation itself shows a legislative recognition of where the problems are and, outside auto, it is not personal lines and not property insurance.

The typical PAMIC member company writes about $10,000,000 in annual direct written premium (DWP), with 75% personal lines, the commercial remainder being small business packages.

The president of a member company in an adjacent state told me that his company was realizing about $180,000 per year in fraud recoveries or reserve take-downs. He had a full time fraud investigator on staff at a cost of about $150,000 including salary and all benefits. So he was happy with his return. However, when I continued the dialogue with him, I found that half of his business was commercial lines, that most of his fraud recoveries were from those commercial lines, and that 60% of the recoveries were in fact arson related. The staff investigator, as it happens, is fully trained in arson as well as fraud.

Assuming those results are typical and applying them to a $25M PAMIC member with the more common 75/25 split in personal versus commercial business, the company could expect a return of about $160,000 on its $150,000 investment. And the number goes down to $130,000 for a $20M company, and less than $100,000 for a $15M company. So somewhere at the $20 to $25M point utilization of an investigator becomes counterproductive. That is important because the proven fraud dollars are to be stripped out of loss costs, but the costs of fraud prevention are to be added in.

So let me suggest a couple of things. Instead of sweeping the entire industry into a new bureaucratic structure with attendant costs and fines and penalties, why not adopt an incremental approach? Surely this series of public hearings has generated sufficient evidence, anecdotal or otherwise, to determine where, and if, certain additional lines of business should be covered. Adopt an incremental approach. Second, regardless of what you do, be mindful of the differential impact of these new burdens on smaller companies. Pennsylvania has one of the oldest housing stocks in the nation and small town and county seat mutuals throughout the Commonwealth are one reason why you do not hear about availability and affordability problems in rural and small town areas such as you frequently do in urban areas.

Finally, why do this at all? The industry and you, the legislature, have a common interest in fighting insurance fraud. Instead of multiplying expenses, reporting requirements, and paperwork, why not give the insurance industry some tools that will help them in our

common fight against fraud? What are some good examples? At last summer's hearing, our IFP colleagues mentioned several interesting and worthwhile proposals, some of which have been acted on by introduction of some of the bills I mentioned earlier in my presentation. I will instance one of Sam Marshall's proposals in particular, one that has not yet resulted in a filed bill. He asked that homeowners insurers be given the same opportunity that auto insurers enjoy whereby insurers can cancel policies on the basis of claims frequency. Think about it. Before mandating that all insurers contract with an ISO, or a Lexis-Nexis, or some yet to be designed common database so that claims patterns may be detected, why not permit insurers to act when the activity of their own policyholder on their own company's insurance policy is already exhibiting such a pattern? With simple reforms such as these, we can together go a long way toward our common goal of combating insurance fraud.