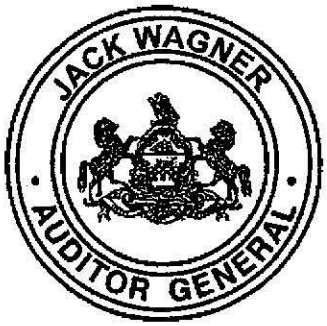
TESTIMONY ON INSURANCE FRAUD

HOUSE INSURANCE COMMITEE



Auditor General Jack Wagner

Jan. 28, 2010

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Department of the Auditor General
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Good morning, Chairman DeLuca, Chairman Micozzie, and committee members.

During these difficult economic times, we in state government must do all that we can to make every dollar count. To that point, I would like to commend both of the chairman and the members of this committee for looking into the issue of insurance fraud, which is costing taxpayers millions, if not billions, of dollars.

As Pennsylvania's fiscal watchdog, the Department of the Auditor General is dedicated to finding and eliminating the waste, fraud and abuse of taxpayer dollars. Our auditors are in all 67 counties every day, auditing school districts, volunteer firefighters' relief associations, liquor stores, county welfare offices, and many other agencies and organizations that receive state money or federal funds that pass through state government.

The Department of the Auditor General produces more than 5,000 audits each year, and they are available to the public at www.auditorgen.state.pa.us. In addition, our Office of the Taxpayer Advocate is available to help Pennsylvanians cut through bureaucratic red tape or to receive reports of waste, fraud or abuse. The toll-free number for the Taxpayer Advocate hotline is 1-800-922-8477.

It's no surprise that insurance fraud is on the rise, especially when the economy is hurting.

According to the Pennsylvania Insurance Fraud Prevention Authority, the United States insurance industry pays as much as $160 billion per year in fraudulent claims. They range from staged auto accidents and phony theft claims to arson and falsely billing for health care services.

The Department of the Auditor General is responsible for auditing the state's Medicaid program, which is administered by the Department of Public Welfare.

Better oversight and review always deters fraudulent behavior and also detects it more readily. We believe that insurance fraud will be deterred if there is more oversight by the legislature and the insurance industry as a whole. With a potential for up to $900 million in additional funds coming from the federal government for Medicaid, steps must be taken immediately to prevent potential fraud and abuse.

In a series of reports issued beginning in December 2007, our department found widespread errors in the state's Medicaid program that are costing Pennsylvania taxpayers millions of dollars each year.

Our auditors found that DPW, through its county assistance offices, failed to make proper Medicaid eligibility determinations on more than 1,900 randomly selected Medicaid applicants between January 2005 and January 2009, resulting in $3.5 million in improper payments made on behalf of ineligible recipients.

Many of the improper eligibility determinations were due to DPW's failure to perform semi-annual reviews and annual renewals when they were due. Consequently, information that would have deemed the recipient ineligible was not reviewed in a timely manner, and benefits continued to be paid. This lack of proper oversight could encourage an environment of potential fraud on the part of the recipient.

Another eligibility problem that we found was related to citizenship issues. Some recipients may have been U.S. citizens, and therefore eligible for the program, but they did not have the proper documentation to prove it. I want to be clear: my goal is to save money by eliminating ineligible individuals from the program, not by cutting the program for those who are truly needy and eligible.

We found errors in 1,951, or 14.7 percent, of 13,225 Medicaid cases selected randomly from 567,984 Medicaid cases from 90 county assistance offices in 64 counties. Even though DPW has asserted that the error rate is only 4%, eliminating just 4% of those errors would save Pennsylvania taxpayers $320 million per year.

DPW's policy of reviewing certain income information at six- and 12-month intervals, rather than when this information becomes available on the state's data information system, contributed to improper eligibility determinations. The improper eligibility determinations occurred because recipients' increases in

income placed them above the eligibility limits. We recommended that DPW require a review of these increases as soon as the information becomes available. The sooner DPW detects increases in income from ongoing employment, the sooner the recipient can be deemed ineligible and the improper payments can be stopped.

This is especially critical when the recipient is enrolled in a managed care organization to which DPW makes monthly capitation payments for recipients, regardless of whether they receive medical services. If a recipient is not in a managed care organization, DPW pays on a fee-for-service basis -- in other words, only when the recipient actually receives medical attention. Of the $3.5 million in improper payments we uncovered, $3,215,650 were monthly capitation payments made to managed care organizations, which are in essence insurance companies.

DPW has 89 county assistance offices in 67 counties that administer benefits such as cash assistance, food stamps, and Medicaid benefits to needy Pennsylvanians. Twenty-five counties fall under the mandatory managed care program for physical health services. All 67 counties fall under mandatory managed care for behavioral health services.

Our audits made several recommendations to DPW to correct the identified deficiencies, including changing its policy of reviewing increases in income only at six- and 12-month intervals, as mentioned earlier, and improving monitoring to ensure compliance with established internal controls.

DPW told us that it is trying to improve its eligibility determinations by updating its data information system and that it has secured the services of a forensic accounting firm to review its eligibility processes, including those regarding income determination. DPW has informed us it has changed its policy of reviewing increases in income when the information becomes available, and we will look to verify this in our future follow-up audits. These are good first steps, but more must be done to stop the continued waste of taxpayer dollars.

In a related issue, I would like to note that the problems we uncovered in the Medicaid program are only part of a disturbing pattern of waste and potential fraud within several of the other programs administered by DPW, including LIHEAP, or the Low Income Home Energy Assistance Program, where we found the potential

for taxpayer fraud through the use of fraudulent Social Security Numbers that DPW had failed to validate.

In the special allowances program, our auditors found that DPW had approved hundreds of thousands of dollars in cash assistance to welfare recipients who were seeking jobs without requiring receipts or any other form of documentation to prove that the money was being spent on legitimate purchases.

In closing, I would again like to commend the chairmen and committee members for investigating the issue of insurance fraud. I can assure you all that the Department of the Auditor General will continue to monitor this issue. I would be happy to answer your questions.

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