



Dedicated to protecting access to quality healthcare for automobile accident victims

**NEW YORK STATE SENATE STANDING COMMITTEE ON INSURANCE
SENATOR JAMES L. SEWARD, CHAIR
APRIL 26, 2011**

**TESTIMONY OF STUART M. ISRAEL, ESQ., PRESIDENT
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Good morning Chairman Seward. I'm Stuart Israel, President of New Yorkers for Fair Automobile Insurance Reform, or "NYFAIR." I am also a practicing attorney who, for more than two decades, has represented medical providers seeking to recover for services rendered under New York's no-fault insurance system. My firm has been engaged in this field since the advent of no-fault in the mid-70's. Thus, unlike all the other speakers that you heard from today, I can offer the Committee a contextual "in the trenches" perspective of what's been referred to as "the no-fault crisis."

NYFAIR's mission is to ensure that New Yorkers have continued access to quality medical care after automobile accidents. Members of NYFAIR are affiliated with various doctors' advocacy groups, hospitals, medical professional corporations, trade groups, bar associations and concerned citizens. All told, the members of NYFAIR represent thousands of medical professionals throughout the State of New York.

Last year, as a representative of NYFAIR, I participated in the round-table discussions, legislative hearings and working group meetings held by Insurance Committee Chairs Senator Breslin and Assemblyman Morelle concerning No-Fault Fraud. These meetings included every major stakeholder, from the Insurance Industry and its trade organizations to the Insurance Department, the Medical Society, and the Trial Lawyers.

After three long months of often heated and contentious discussions, a bill addressing nearly every insurance industry concern was forged. The Automobile Fraud Prevention Act of 2010 allowed for the decertification of unscrupulous medical providers, allowed insurers to raise new defenses of fraud and over billing, made changes to improve and incentivize the arbitration forum, and increased the burden upon an applicant seeking to establish its entitlement to benefits. While not perfect, the Act was a thoughtful compromise that addressed virtually all of the insurer's complaints while preserving the ability of honest medical professionals to get reimbursed for necessary care.

In this context, NYFAIR is deeply concerned that last year's efforts are being abandoned by an insurance industry that seeks every advantage at the expense of honest consumers. It is unclear why we are back at square one, or what has occurred since last year's efforts that may have precipitated the introduction of S.2816, a bill that, while well-intentioned, will have detrimental consequences on the ability of New Yorkers injured in automobile accidents to find and receive quality medical care.

Since last year's meetings, things have improved. According to the Insurance Department's own statistics, reports of No-fault fraud DECREASED by 5%; filings for arbitration instead of litigation have literally doubled over the same period; and the Insurance Department is on the verge of promulgating the most sweeping changes to the No-Fault regulations in a decade.

NYFAIR condemns ANY level of abuse in the system and has dedicated considerable time and resources to work with policymakers to address the issue. However, the breadth of fraud suggested by the Industry is simply exaggerated and untrue. Industry-funded organizations casually report unverifiable "statistics" concerning the cost of fraud. Those "statistics" then become the basis for mainstream news stories that bombard the media wire and, in turn, the Legislature. However, there has been no independent verification of the "statistics" claimed.

Indeed, even a cursory review of the industry statistics leads them to be questioned. For example, one industry-funded source claims that no fault fraud cost New Yorkers \$229 million in 2009. However, a simple multiplication of the total number of reported questionable claims to the Insurance Department in that year by the average cost of an entire no-fault claim equals \$116 million, or literally half of what was asserted by the Industry.

And yes, while \$116 million in suspected fraud sounds like, and IS, a lot, it must be put into context. Consider that in 2009, according to the National Association of Insurance Commissioners, (NAIC) New York's auto insurers collected \$9.9 billion in premiums. Therefore, "*suspected*" fraud accounts for roughly 1% of all premium dollars collected – not nearly the crisis claimed by the Industry. Consequently, even if 100% of suspected fraud was eliminated, and carriers passed every cent saved on to their policyholders, the average New Yorker's automobile insurance policy would be reduced by about 1%.

To be clear, this entire analysis assumes that all reports of suspected fraud are valid. In this regard, it is important to note that the claim of fraud is a self-reporting, self-fulfilling prophecy: Insurance Law *requires* insurers to report suspected fraud to the Frauds Bureau. Statistics of fraud are based on Industry suspicion, not on any independent determination that a fraud was perpetrated. Indeed, by the Insurance Department's own admission, many suspected cases are later deemed unfounded or result from multiple referrals about a single situation. Such instances of "mis-filings" do not trigger the number of reported claims to be adjusted downward and contributes to the reporting of exaggerated numbers.

Moreover, the Frauds Bureau only opened 170 new health care fraud cases in 2010 – resulting in 159 arrests - or just 1% of the total of all suspected cases reported. Admittedly, this low percentage may be due, in part, to a lack of resources, but one is still left to wonder what percentage of the remaining 99% is not really fraud at all. Indeed, we have seen trial judges, panels of appellate judges, and arbitrators find that insurer claims of fraud are often baseless. For example, in Brooklyn a father was wrongly arrested and charged with insurance fraud at the request of an insurance company for seeking medical treatment for his 10 year old son whose name was not on the police report because his teacher came upon the accident scene and took the boy to school. After the charges were dismissed 18 months later, the insurance company wanted to settle the medical bills at a discount.

An examination of the NAIC data that I mentioned earlier puts this supposed “crisis” into further perspective. A 2007 report from the NAIC noted that the average loss ratio nationwide was @ 82%, meaning that out of every \$1 collected in premiums, insurers nationwide paid out about 82 cents. However, that same year, New York’s auto insurers enjoyed a loss ratio of just 58%, the lowest of all no-fault states. This report also came on the heels of a New York City Comptroller report in 2006 that revealed that New York’s auto insurers made 50% higher profits than auto insurers in the rest of the nation. Although the State subsequently required that many Insurers reduce its premiums, in 2009, New York’s auto insurers’ loss ratio was 66%, STILL better than the nationwide average. In this regard, last year the Legislature required HEALTH insurers to maintain a loss ratio of 82%. We believe if auto insurers were required to meet that same standard, premiums would drop by nearly 20%.

NYFAIR remains deeply concerned that this policy debate is being driven by incomplete and misleading “statistics.” Indeed, if we simply look at the IMPARTIAL statistics from NAIC and the Comptroller, rather than those produced by the Industry, NEW YORK premiums are not driven by a fraud epidemic, and insurers are making a tidy profit. Yes, many claimants are gaming the system but targeted legislation such as that proposed last year would address it without cutting off access to healthcare for the honest claimants.

Moreover, any discussion of No-fault fraud must also include insurance company fraud. We see virtually every single Insurer Medical Examiner and Peer review result in the denial of benefits. We see many insurers using the same group of a dozen or so doctors to review claims. We see reports of these different, allegedly independent, insurance company doctors contain the same typos and citations to non-existent medical authorities.

We also see insurers demanding examinations under oath solely to demand that a doctor, as a condition of ANY and all future payments, stop treating patients to attend these interrogation sessions. I represented a Board Certified Neurologist whom after giving 14 hours of testimony to “verify” a single day of treatment, was asked to return for a third day of testimony to address a single bill for a \$49 follow-up visit, even though that bill had already been paid. And the tragic part is that no one is doing anything about this.

Perhaps due to a lack of resources, the Insurance Department has provided little oversight of these abuses. The primary tool of the Insurance Department, the “Market Conduct Examination,” is insufficient to protect consumers from insurers that treat consumers unfairly. For example, in 2009 the department did not report imposing a single penny in fines on any insurer for violating the No-Fault regulations. One suggestion to help reduce these abuses cited would be the appointment of an Insurance Consumer Advocate.

In short, overreacting to insurers’ demands risks causing greater problems than the proposed legislation is intended to resolve. In a very real sense, this legislation will affect the availability of health care benefits for tens of thousands of New Yorkers, especially the poor and middle class, many of whom do not have the advantage of general medical insurance. These New Yorkers would not be able to get treatment for their auto injuries. Legislation such as S.2816 is overly broad, and akin to “throwing out the baby with the bathwater.”

Lifting the preclusion rule would do nothing more than permit insurers to indefinitely delay and belatedly deny claims that have absolutely nothing to do with fraud.

Mandating arbitration will NOT reduce fraud. Mandatory arbitration means no discovery and no rules of evidence, without which, unreliable information cannot be challenged by cross-examination.

Limiting the right to assign benefits to only instances where “coverage and compliance with the policy terms are not in dispute” is a very dangerous proposition. It will result in doctors refusing to treat accident victims since it is impossible to know at the time of treatment whether or not an insurer is going to claim any “coverage” or “policy” defenses.

Without providing any funding, the bill places the responsibility for policing health care providers solely in the Insurance Department, an agency charged with the regulation of financial institutions, and one with no experience regulating healthcare professionals.

Medical treatment guidelines, limiting the treatment accident victims are permitted to receive, strips doctors of the ability to determine the best course of care for their patients. Decisions regarding health care should be made by health care professionals based on the needs of the patient—not by the Insurance Department based upon the desires of the Insurance Industry.

In summary, I am not suggesting that the legislature cannot make changes to reduce real fraud and abuse within the No-Fault system. However, virtually all of the changes requested by the insurance industry are designed to increase its profits by denying legitimate claims from honest doctors.

Thank you for the opportunity to testify today and I would be happy to answer any questions you may have.