



**Department of
Financial Services**

**Investigating and Combating
Health Insurance Fraud**

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Introduction

This report, required under Section 409(c) of the Financial Services Law, summarizes the 2020 activities of the Department of Financial Services (“DFS”) in combating health insurance fraud.

2020 Highlights

DFS’s Insurance Frauds Bureau (“Bureau”) investigates and combats healthcare fraud, which affects three major types of insurance: accident and health, private disability, and no-fault. The Bureau is headquartered in New York City, with an office in Garden City and five offices across upstate New York: in Albany, Syracuse, Rochester, Buffalo, and Oneonta. The Bureau, working with DFS-regulated entities, has a longstanding commitment to combating insurance fraud and strives to serve the people of New York State. Highlights of the Department’s efforts in combating healthcare fraud in 2020 include the following:

- In response to COVID-19, the Governor’s Office assigned DFS investigators to multi-agency task forces to combat violations of executive orders related to Coronavirus;
- The Bureau opened 32 healthcare fraud investigations, resulting in 38 arrests;
- The Bureau received 20,982 reports of suspected healthcare fraud: 19,127 no-fault reports, 1,683 accident and health insurance reports, and 172 disability insurance reports;¹
- Reports of suspected no-fault fraud accounted for 64% of the 30,113 suspected insurance fraud reports received, which represents a 6% increase from the previous year.

DFS investigators have staffed a 24-hour daily hotline, created to allow the public to report violations of executive orders online or by telephone. Each report is logged and routed to the appropriate state or local agency for investigation. In addition, DFS investigators have been assigned to enforcement details at airports, licensed premises and areas that have been identified as COVID-19 “hotspots.” In instances of credible violations of executive orders, DFS investigators have issued summonses and have testified at administrative hearings.

Overview of Healthcare Fraud in New York State

The High Cost of Healthcare Fraud

Healthcare fraud is a costly and pervasive drain on the national healthcare system. Experts agree that the costs of healthcare fraud are exorbitant; the National Health Care Anti-Fraud Association estimates that losses due to healthcare fraud are in the tens of billions of dollars each year. Combating fraud and abuse helps reduce the escalating costs of healthcare in New York and the United States.

¹ Section 405 of the New York Insurance Law requires insurers to report suspected fraud to the Department.

Types of Healthcare Fraud

As discussed above, healthcare fraud affects three major types of insurance: accident and health, private disability, and no-fault. The more common types of healthcare fraud include:

- Prescription drug diversion and misuse;
- Medical identity fraud;
- Billing for services that were never rendered and products that were not provided;
- Billing for more expensive procedures or services than were actually provided, commonly known as upcoding;
- Performing medically unnecessary treatments and expensive diagnostic tests for the sole purpose of generating insurance payments;
- Misrepresenting non-covered treatments as medically necessary covered treatments, for example, billing a rhinoplasty (cosmetic nose surgery) as a deviated septum repair to obtain insurance payments;
- Unbundling—billing as if each step of a procedure were a separate procedure;
- Staging or causing auto accidents;
- Filing no-fault claims for nonexistent injuries;
- Filing false or exaggerated medical disability claims;
- Staging slip-and-fall accidents; and
- Accepting kickbacks for patient referrals.

In 2020, DFS received numerous reports of suspected fraud containing allegations of medical providers billing for services not rendered and prescribing unnecessary durable medical equipment. Reports of prescription drug diversion and misuse, as well as allegations of disability fraud, remained persistent issues.

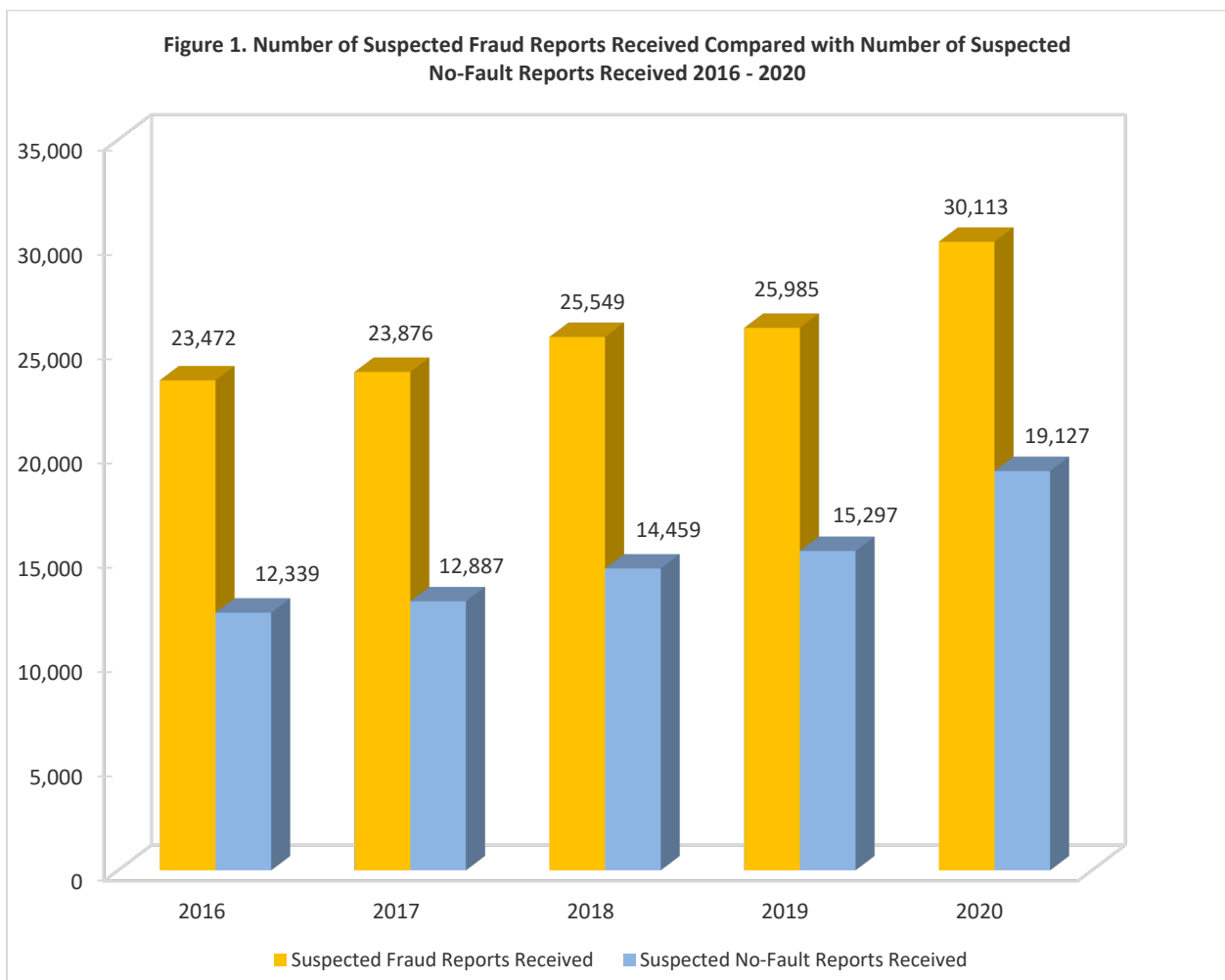
No-Fault Fraud

DFS conducted several no-fault investigations in 2020 in conjunction with other law enforcement agencies, prosecutors' offices, and the National Insurance Crime Bureau ("NICB") that led to the prosecution of a wide range of defendants who, in an organized fashion, are exploiting the no-fault system for personal gain. These cases have involved "runners" who stage accidents and refer the phony accident victims to unscrupulous medical clinics and corrupt law firms in exchange for monetary payments. In certain investigations, the defendants used two different scenarios in staging accidents: in the first, drivers intentionally crash into one another

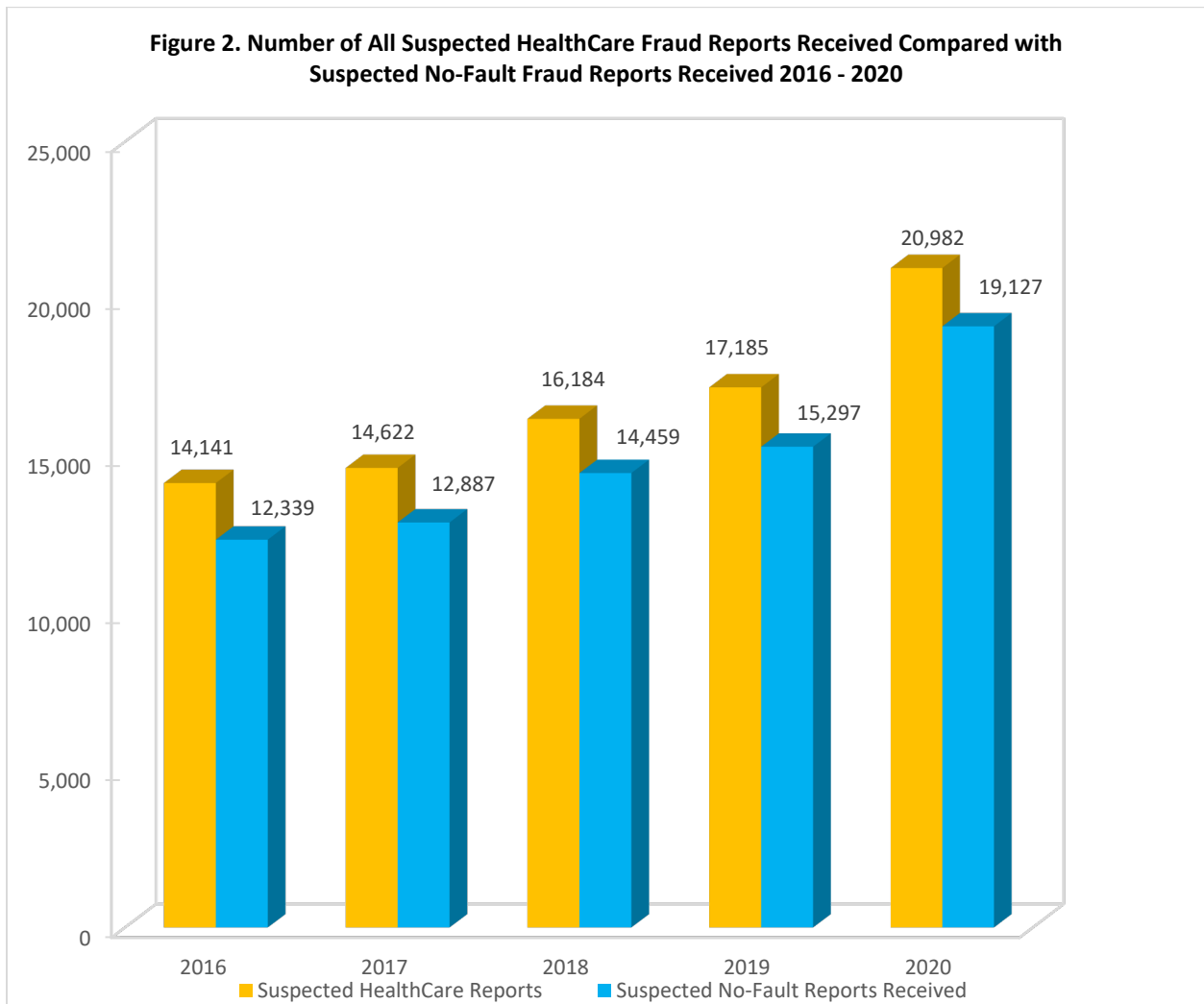
and, in the second, the driver of one vehicle causes an accident with an unsuspecting driver. Other no-fault investigations have involved “runners” who solicited victims of motor vehicle accidents at accident scenes to steer them to corrupt medical clinics and coached them to exaggerate and fabricate injuries. Other no-fault investigations involved individuals adding themselves to accident reports when they were not involved in the accident that was the subject of the report.

No-Fault Fraud by the Numbers

As shown in Figure 1, suspected no-fault fraud reports accounted for 64% of all fraud reports received by DFS in 2020.



As shown in Figure 2, the number of suspected no-fault fraud reports accounted for 91% of all healthcare fraud reports received in 2020 and at least 89% of all healthcare fraud reports received since 2016.



Collaborative Efforts to Combat Healthcare Fraud

DFS investigators work closely with the insurance industry and law enforcement agencies at the federal, state, and local levels to combat healthcare fraud schemes. DFS is a member of 10 task forces and working groups designed to foster cooperation and communication among the many law enforcement agencies involved in combating healthcare fraud. Those task forces and working groups include the following:

- Western New York Health Care Fraud Task Force
- Central New York Health Care Fraud Working Group
- Rochester Health Care Fraud Working Group

- FBI New York Health Care Fraud Task Force/Medicare Fraud Strike Force
- New York Anti Car Theft and Fraud Association
- National Insurance Crime Bureau Working Group
- High Intensity Drug Trafficking Area (HIDTA)
- Drug Enforcement Administration Tactical Diversion Task Force (Upstate/Downstate)
- Suffolk County District Attorney’s Office Insurance Crime Bureau
- New York Alliance Against Insurance Fraud

The DFS Insurance Frauds Bureau’s participation in working groups and task forces provides the opportunity for joint investigations, intelligence gathering, effective use of resources and the study of trends. Several DFS investigators have been assigned to groups and task forces and partner with other members investigating cases involving healthcare fraud. An example of successful collaboration is the DFS’s participation in the Drug Enforcement Administration Tactical Diversion Task Force (“Diversion Task Force”), which investigates organized drug diversion schemes.

In 2019, DFS, working jointly with the Drug Enforcement Task Force, initiated a healthcare fraud investigation into the illegal sale and distribution of oxycodone and other prescription pills. As a result of information gathered during the investigation, seven arrests were made during 2019 and 2020. The investigation revealed that the main subject was involved in the issuance of fraudulent prescriptions, which had no legitimate medical purpose other than to extract cash payments from patients and non-patients. Additional arrests were subsequently made, including a pharmacist and other involved individuals. Numerous interviews were conducted, surveillances run, and several search warrants issued, which resulted in uncovering key evidence of the illegal distribution of oxycodone and healthcare fraud involving the issuance of fraudulent prescriptions and illegal billing. This case is currently being prosecuted in the Southern District of New York.

Reporting and Preventing Healthcare Fraud

Insurance Company Reporting

Under Section 405 of the New York Insurance Law, insurers are required to report suspected insurance fraud to DFS. The Department’s web-based case management system, known as the Fraud Case Management System (“FCMS”), allows insurers to submit reports of suspected fraud electronically. In 2020, insurers electronically submitted approximately 98% of the 30,113 fraud reports that DFS received.

The benefits of the FCMS to insurers include automatic acknowledgment of receipt of fraud reports and notification of case assignments and eventual case disposition. Insurers also benefit from online help screens and an online manual of operations, as well as search and cross-reference features.

Consumer Reporting

DFS encourages consumers to report suspected fraud and maintains a toll-free hotline to facilitate reporting. Consumers may call 1-888-FRAUDNY (1-888-372-8369) for information regarding insurance fraud, including how to report insurance fraud. DFS recorded an average of 11 calls per month in 2020. The “Consumers” section of DFS’s website also includes a link to an electronic fraud reporting form and instructions for reporting fraud.

Compliance with Section 409 of the New York Insurance Law

Section 409 of the New York Insurance Law requires insurers that write at least 3,000 individual accident and health, workers’ compensation, and/or automobile policies, or group policies that cover at least 3,000 individuals issued in or issued for delivery annually in New York, to submit to DFS a Fraud Prevention Plan for the detection, investigation, and prevention of insurance fraud. Licensed health maintenance organizations (“HMOs”) with at least 60,000 enrollees must also submit a Fraud Prevention Plan. Plans must provide for a full-time Special Investigations Unit (SIU), as well as specific staffing levels within the SIU.

Fraud Prevention Plan Requirements

Section 409 specifies information that must be included in Fraud Prevention Plans. For example, a plan must provide for an SIU that is separate from claims and underwriting, and must include details regarding the staffing and other resources dedicated to the SIU. To be designated an SIU investigator, individuals must meet certain educational and/or professional experience criteria enumerated in Section 409 and Department Regulation 95.

Section 409 and Regulation 95 also require that all Fraud Prevention Plans include the following information and/or procedures:

- Interface or interaction of SIU with law enforcement and prosecutorial agencies;
- Coordination with other units of the insurer for the investigation and initiation of civil actions based on information received by or through the SIU;
- Development of a “fraud detection and procedures” manual to assist in the detection and elimination of fraudulent activity;
- Objective criteria for the level of staffing and resources devoted to the SIU;
- In-service training of investigative, claims, and underwriting personnel in identification and evaluation of insurance fraud;
- Development of a public awareness program focused on the cost and frequency of insurance fraud and the methods by which the public can assist in preventing fraud.

In 2020, there were 62 insurer SIUs committed to investigating health fraud in New York State that were housed within accident and health insurers, HMOs, life insurers, nonprofit medical,

and dental indemnity and health service corporations. In addition, 15 property and casualty insurers writing accident and health insurance had approved SIUs during 2020.

Health and life insurers reported \$273 million in savings resulting from SIU investigations in 2019 (the most recent year for which data are available). Health and life insurers reported \$47 million in recoveries from SIU investigations.

DFS monitors insurer compliance with Section 409 through the analysis of data provided by insurers in Annual SIU Reports. DFS may perform field examinations of insurer SIUs to assess compliance with Section 409, other sections of Article 4 of the New York Insurance Law, and Regulation 95.

2020 Healthcare Fraud Reports Received and Arrests Made

DFS received 20,982 reports of suspected healthcare fraud during 2020: 1,683 involved accident and health insurance, 172 involved disability insurance, and 19,127 involved no-fault claims. DFS opened 32 healthcare fraud cases for investigation. Of those, 25 involved accident and health insurance, 1 involved disability insurance and 6 involved no-fault insurance. DFS investigations resulted in 38 arrests in 2020.

Public Awareness Programs

New York Insurance Law requires that Fraud Prevention Plans address insurers' efforts to increase public awareness of the cost and frequency of fraudulent activities and the methods of preventing fraud. The New York Alliance Against Insurance Fraud and the National Health Care Anti-Fraud Association carry out advertising campaigns via newspapers, radio, television, and billboards targeting insurance consumers on behalf of HMOs and insurers of health products. The National Health Care Anti-Fraud Association conducted public awareness programs for HMOs and insurers of health products on behalf of 20 entities with Fraud Prevention Plans on file in 2020. There were 40 HMOs, health insurers, or health insurer groups (an organization comprising affiliated insurers) with Fraud Prevention Plans on file that participated in the New York Alliance Against Insurance Fraud program. In addition, two insurance companies have ongoing programs to heighten awareness and reduce public tolerance for insurance fraud. As a result, these anti-fraud messages reach millions of New Yorkers each year.

The Year in Review

Summarized below are some of the major healthcare fraud investigations conducted by the Bureau during the past year, to the extent that information is public. The Department has pending numerous other, confidential, investigations of healthcare fraud.

- DFS, as a part of the Healthcare Fraud Task Force of the Northern District of New York, investigated a pharmacy in Morrisville, NY that was formerly owned and operated by the subject pharmacist. The pharmacist submitted fraudulent claims to private insurance companies, Medicaid, and Medicare for more expensive brand name drugs, while dispensing cheaper generic drugs to customers. Between 2010 and 2015, the pharmacist

overbilled insurers in the amount of \$110,962. In 2020, the pharmacist signed a plea agreement with the US Attorney's Office, Northern District of New York, in which she agreed to plead guilty to one count of healthcare fraud pursuant to U.S.C. Title 18 – Section 1347.

- DFS, working in coordination with the New York City Police Department, investigated a husband and wife team suspected of “jump-ins.” The two subjects were owners of a parked vehicle hit by a drunk driver during the middle of the night, while the suspects were in their home. The drunk driver fled the scene of the accident prior to police arrival. In the owner's initial report to the insurance company made pursuant to a recorded call, he stated that he and his wife were not in the vehicle at the time of the accident. The investigation revealed that the two suspects had filed false documents, claiming to have been treated at a medical facility and filed a lawsuit for injuries purportedly received in said accident. The total fraudulent billing related to the accident exceeded \$40,000. In August 2020, both subjects were taken into custody in Queens, NY and charged with insurance fraud and falsifying business records.
- In 2020, DFS, working with the Federal Bureau of Investigation, and the Internal Revenue Service, investigated Prime Aid Pharmacies (“Prime Aid”), a specialty pharmacy. The investigation found that Prime Aid's employees paid bribes and kickbacks to doctors and doctors' employees, inducing them to steer prescriptions to Prime Aid to obtain a higher prescriptions volume. The kickbacks included expensive meals and payments by cash, check, and wire transfers. Prime Aid employees falsified records prior to submission, while a Prime Aid owner forged the shipping records of a private commercial shipping company to make it appear that medications were shipped to patients when, in fact, they were not. Prime Aid also engaged in the pervasive fraudulent practice of billing health providers for medications that were never provided to patients. The Company systematically billed for refills for those same medications without ever dispensing them to patients. Prime Aid received over \$65 million in reimbursement payments from Medicare, Medicaid, and private insurers for medications the pharmacy had not only failed to deliver to patients, but also had never ordered or had in stock. This scheme resulted in Medicare, Medicaid, and private insurers being defrauded into paying over \$34 million in reimbursement payments. As a result of this investigation, seven individuals, owners and managers were arrested.
- DFS, working jointly with the Drug Enforcement Administration (DEA), gathered information proving that a doctor was involved in the illegal distribution of oxycodone and related healthcare fraud. The investigation resulted in evidence that proved there had been no legitimate medical need for the pills, and that frequently, no medical examinations had occurred. The investigation also revealed that fraudulent billing had occurred. In July 2019, the DEA executed a search warrant for the doctor's office, located in Bay Ridge, Brooklyn. The doctor was subsequently arrested and interviewed, during which he made a full and extensive admission and surrendered his DEA registration. In May 2020, a reverse proffer was conducted with the doctor. Once the doctor was presented with the overwhelming evidence against him -- including 450,000 plus oxycodone pills and healthcare fraud, combined with a potential sentence of 181-365

months of incarceration – the doctor agreed to plead guilty. The case is being prosecuted in the Southern District of New York.

Conclusion

Healthcare fraud continues as a major focus of the DFS Insurance Frauds Bureau's work. DFS will continue to aggressively combat healthcare fraud in the year ahead.