# Investigating and Combating Health Insurance Fraud

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Adrienne A. Harris
Superintendent

**Table of Contents**


Introduction ........ 2

2022 Highlights ........ 2

Overview of Healthcare Fraud in New York State ........ 2

- The High Cost of Healthcare Fraud ........ 2
- Types of Healthcare Fraud ........ 3

No-Fault Fraud ........ 4

Collaborative Efforts to Combat Healthcare Fraud ........ 6

Reporting and Preventing Healthcare Fraud ........ 7

- Insurance Company Reporting ........ 7
- Consumer Reporting ........ 7
- Compliance with Section 409 of the New York Insurance Law ........ 7
- Fraud Prevention Plan Requirements ........ 7
- 2022 Healthcare Fraud Reports Received and Arrests Made ........ 8
- Public Awareness Programs ........ 8

The Year in Review ........ 9

Conclusion ........ 9

## Introduction

Adrienne A. Harris, the Superintendent of Financial Services, respectfully submits this report, pursuant to Section 409(c) of the New York Financial Services Law, summarizing the activities during 2022 of the Department of Financial Services ("DFS") in combating health insurance fraud.

## 2022 Highlights

The DFS Insurance Frauds Bureau ("IFB") has a longstanding commitment to combating insurance fraud. It is responsible for the detection and investigation of insurance and financial fraud and the referral for prosecution of persons or entities that commit those frauds. IFB is headquartered in New York City, with offices in Garden City, Albany, Syracuse, Rochester, and Buffalo.

DFS, working with its licensed entities, has a longstanding commitment to combating insurance fraud. Highlights of the Department's efforts in combating healthcare fraud in 2022 include the following:

- IFB opened 53 healthcare fraud investigations, resulting in 58 arrests;
- IFB received 30,079 reports of suspected healthcare fraud: 28,145 no-fault reports, 1,791 accident and health insurance reports, and 143 disability insurance reports,[1] and;
- Reports of suspected no-fault fraud accounted for 73% of the 38,554 suspected insurance fraud reports received, which represents a 7% increase from the previous year.

## 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, for example, estimates that losses due to healthcare fraud are in the tens of billions of dollars each year. Combating such 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**

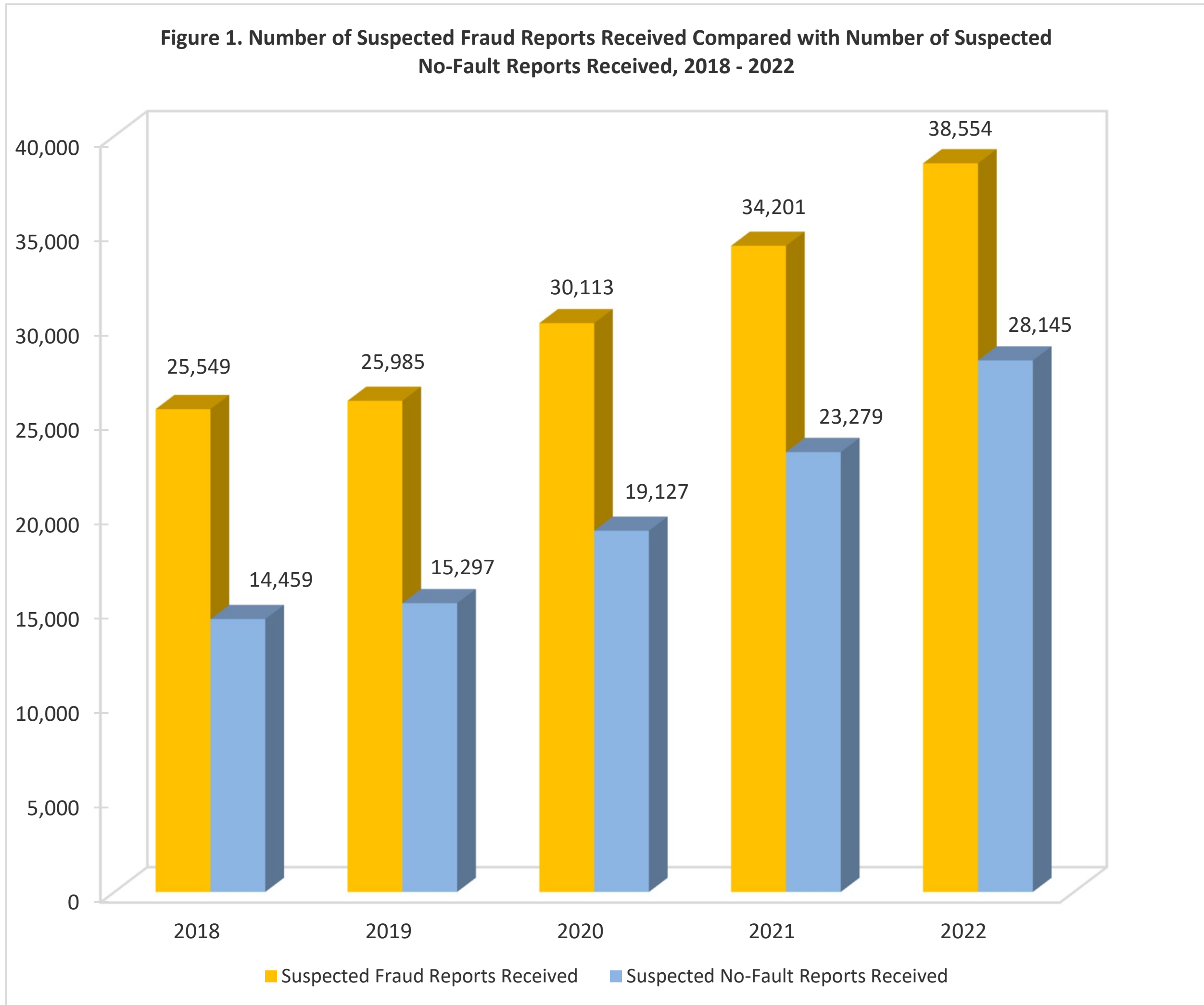
Healthcare fraud affects three major types of insurance: accident and health, private disability, and no-fault auto. The more common types of healthcare fraud include the following:

- Prescription drug diversion and misuse;
- Medical identity fraud;
- Billing for services that were never rendered or products that were not provided;
- Billing for more expensive procedures or services than were actually provided, commonly known as upcoding;
- Performing medically unnecessary treatments or 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.

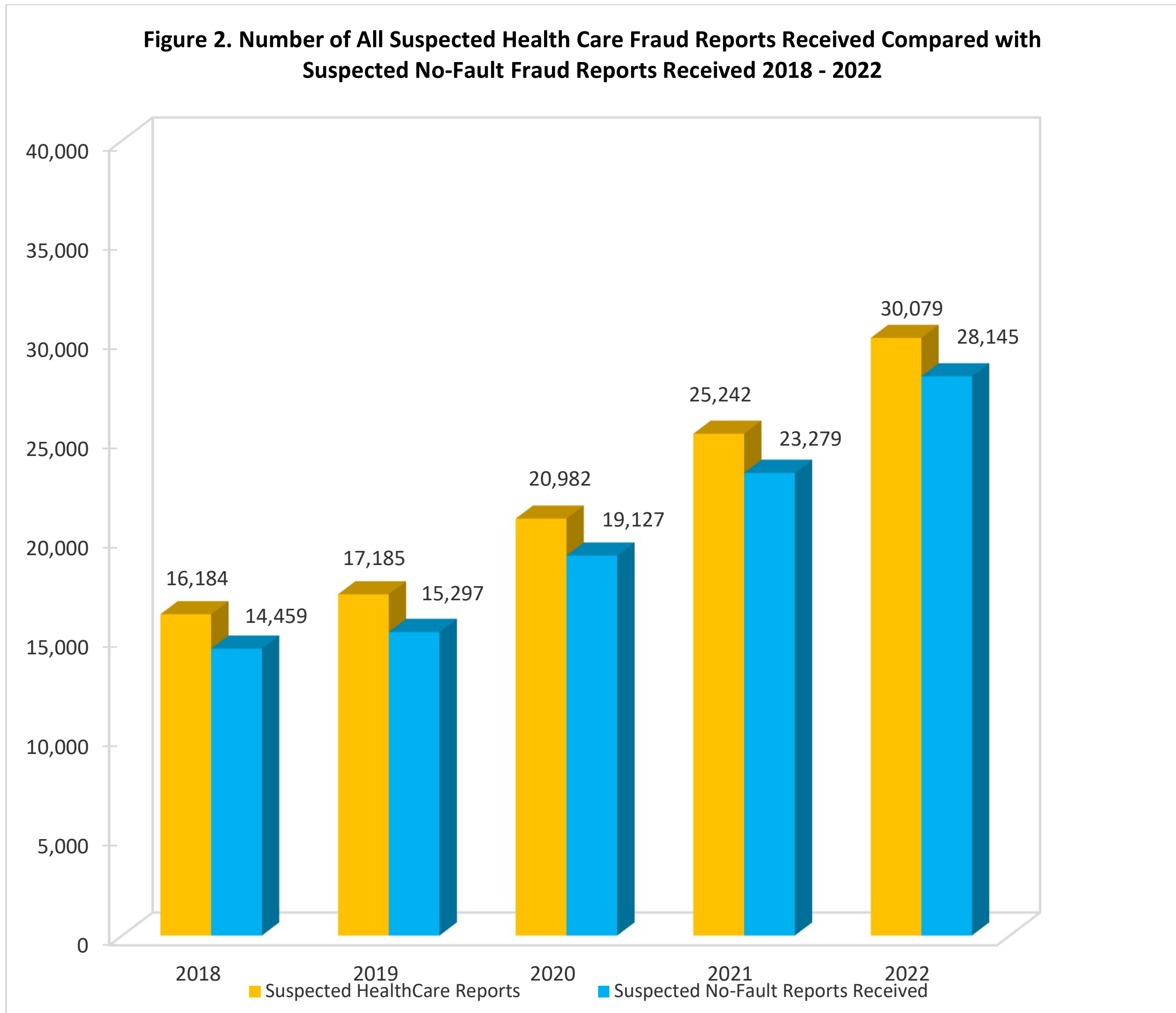
In 2022, DFS received numerous reports of suspected fraud containing allegations of medical providers billing for services not rendered and prescribing unnecessary durable medical equipment. Reports of prescription drug diversion and misuse, as well as allegations of disability fraud, remained persistent issues.

## No-Fault Fraud by the Numbers

As shown in Figure 1, suspected no-fault fraud reports accounted for 73% of all fraud reports received by DFS in 2022.



As shown in Figure 2, the number of suspected no-fault fraud reports accounted for 93% of all healthcare fraud reports received in 2022 and at least 90% of all healthcare fraud reports received since 2018.



## 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 11 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:

- New York State Department of Health Vaccine Complaint Investigation Team
- 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) Program
- Drug Enforcement Administration Tactical Diversion Task Force (Upstate/Downstate)
- Suffolk County District Attorney's Office Insurance Crime Bureau
- New York Alliance Against Insurance Fraud

IFB's participation in working groups and task forces provides the opportunity for joint investigations, intelligence gathering, effective use of resources, and the broader 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 DFS's participation in the Drug Enforcement Administration Tactical Diversion Task Force, which investigates organized drug diversion schemes.

DFS worked on various COVID-19-related matters that commenced in 2020 and lasted well into 2022. For example, IFB investigators assisted the New York State Department of Health ("DOH") with COVID-19 vaccine investigations and were assigned to work on the DOH Vaccine Complaint Investigation Team.

DFS has made several arrests related to COVID-19, including in a case involving theft of personal identifiable information that was later used to collect COVID-19 related unemployment benefits totaling more than $11,000. Most arrests DFS has made involved individuals who submitted fake and forged vaccine cards to their employers. Each of these individuals was charged with criminal possession of a forged instrument, sentenced to one year probation, and, if warranted, ordered to pay restitution of illegally obtained funds.

## 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 electronically submit reports of suspected fraud. In 2022, insurers electronically submitted approximately 98% of the 38,554 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 27 calls per month in 2022. 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 also must submit a Fraud Prevention Plan. Plans must provide for a full-time Special Investigations Unit ("SIU"), specific staffing levels within the SIU, and other anti-fraud efforts.

### Fraud Prevention Plan Requirements

Section 409 specifies what information 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 as an SIU investigator, individuals must meet certain educational and/or professional experience criteria enumerated in Section 409 and DFS's 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; and
- 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 2022, there were 63 insurer SIUs committed to investigating health fraud in New York State. These SIUs were housed within accident and health insurers, HMOs, life insurers, nonprofit medical insurers, and dental indemnity and health service corporations. In addition, 18 property and casualty insurers writing accident and health insurance had approved SIUs during 2022.

Health and life insurers reported $518 million in savings resulting from healthcare SIU investigations in 2021 (the most recent year for which data is available) and reported $48 million in recoveries from healthcare 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.

**2022 Healthcare Fraud Reports Received and Arrests Made**

DFS received 30,079 reports of suspected healthcare fraud during 2022: 1,791 involved accident and health insurance, 143 involved disability insurance, and 28,145 involved no-fault claims. DFS opened 53 healthcare fraud cases for investigation, of which 24 involved accident and health insurance, two involved disability insurance, and 22 involved no-fault insurance. DFS investigations resulted in 58 arrests in 2022.

**Public Awareness Programs**

The 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 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 the internet. Additionally, billboards target 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 23 entities with Fraud Prevention Plans on file in 2022. Thirty-nine HMOs, health insurers, or health insurer groups (an organization comprising affiliated insurers) with Fraud Prevention Plans on file participated in the New York Alliance Against Insurance Fraud program. In addition, one insurance company has an ongoing internal program to heighten awareness and reduce public tolerance for insurance fraud. 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 that IFB conducted during the past year (to the extent that information is public). The Department has numerous other confidential investigations of healthcare fraud that are pending.

- DFS investigated an employee who, while employed at a doctor's office, accessed the doctor's pre-signed prescription pads, and filled prescriptions at two pharmacies located in Niagara Falls, New York. The employee admitted to using the stolen prescriptions to obtain controlled substances for self-consumption. She filled one prescription in her own name and an additional 10 prescriptions in her son's name. She was arrested and charged with possession of a forged document and criminal possession of stolen property.
- DFS conducted a joint investigation with the Federal Bureau of Investigation that led to the arrest of a physician who was charged with misprision of felony. The investigation revealed that the physician had signed multiple fraudulent prescriptions for a pharmaceutical company's representatives for expensive compound medications. The physician signed the prescriptions after the pharmaceutical company representatives entered the compound cream medications and number of refills on the prescription form. The patients listed on the prescriptions were never seen by the physician. These fraudulent prescriptions were filled over 500 times at an average cost of $16,000 per prescription, placing the financial scope of this fraud at more than $8,000,000.
- DFS investigated a claimant who submitted 11 fraudulent claims to an insurance company for medical services that she never received. Additionally, this claimant also submitted altered medical records to support the fraudulent claims. The insurance company paid the claimant $90,005. She was arrested and charged with grand larceny and forgery.
- A nurse's assistant, working in a doctor's office in a hospital in Newburgh, New York, was part of a multi-million-dollar fraud ring. He illegally accessed the hospital database and stole patient information, which he then sold or provided to others who used the information to open businesses and bank accounts. He engaged in other fraudulent activities causing extreme financial hardship to the victims. The nurse's assistant provided a full confession and was arrested and charged with identity theft.

## Conclusion

Healthcare fraud continues to be a major focus of IFB's work, and DFS will continue to aggressively combat healthcare fraud in the year ahead.