



Investigating and Combating Health Insurance Fraud

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Adrienne A. Harris
Superintendent

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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 2023 of the Department of Financial Services (“DFS”) in combating health insurance fraud.

2023 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.

Highlights of the Department’s efforts in combating healthcare fraud in 2023 include the following:

- IFB opened 77 healthcare fraud investigations, resulting in 24 arrests;
- IFB received 35,722 reports of suspected healthcare fraud: 33,646 no-fault reports, 1,913 accident and health insurance reports, and 163 disability insurance reports;¹ and
- Reports of suspected no-fault fraud accounted for 75% of the 44,998 suspected insurance fraud reports received, which represents a 2% 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.² 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.

² National Health Care Anti-Fraud Association, “The Challenge of Health Care Fraud,” <https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/>.

Types of Healthcare Fraud

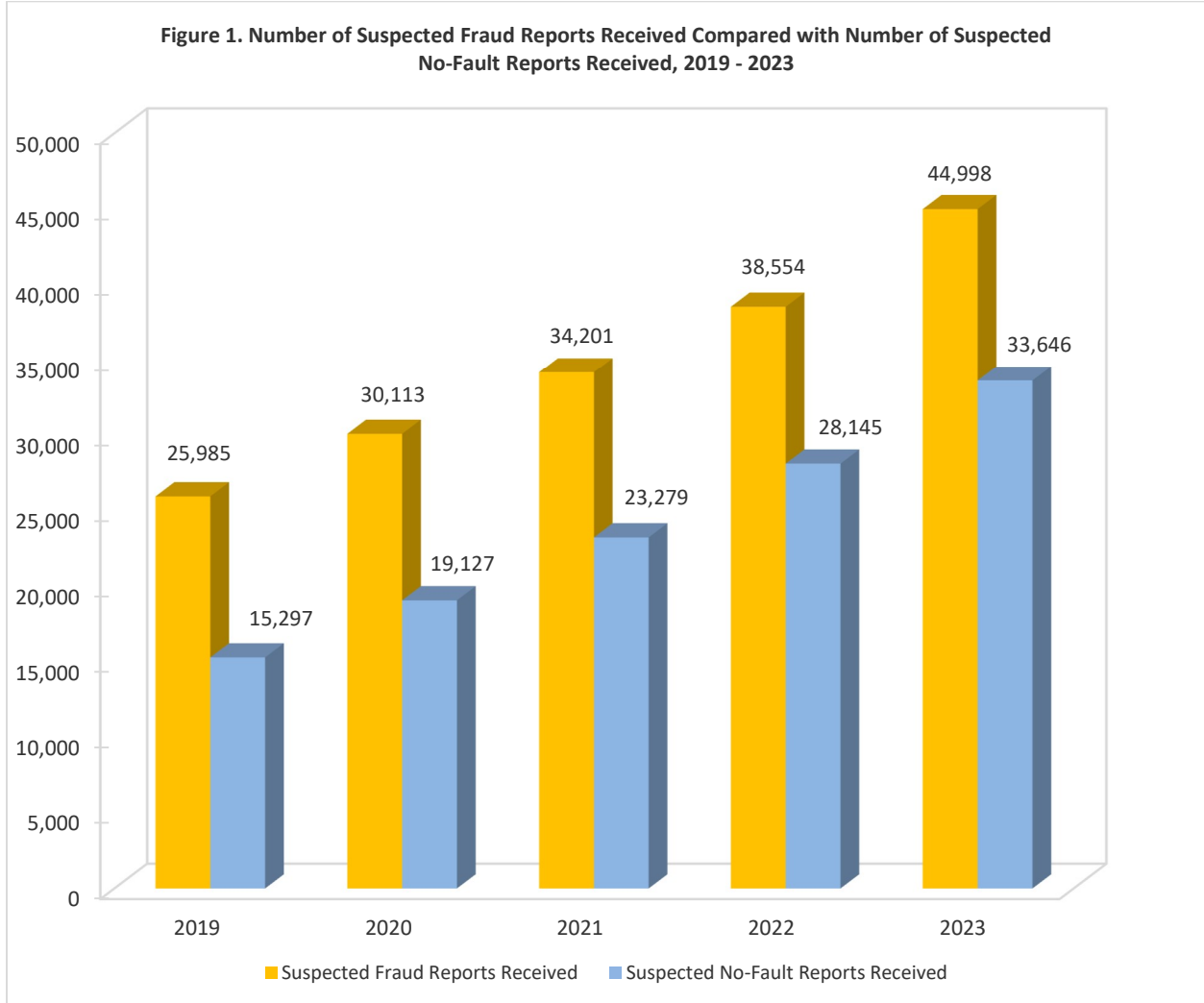
Healthcare fraud affects three major types of insurance: accident and health, private disability, and no-fault auto. The more common types of healthcare fraud include the following:

- 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.

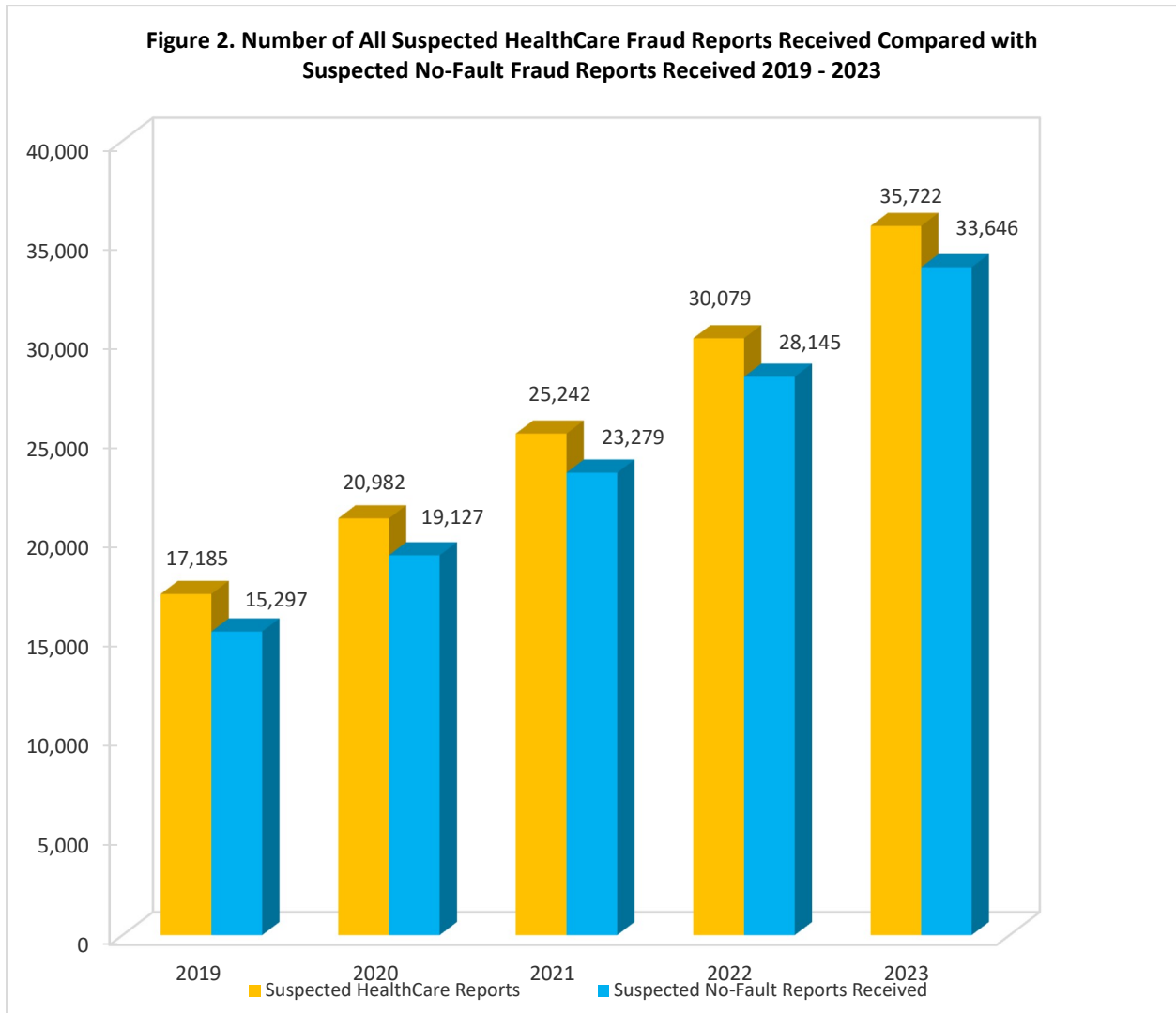
In 2023, DFS received numerous reports of suspected fraud containing allegations of medical providers billing for services not rendered and prescribing unnecessary durable medical equipment. Reports of prescription drug diversion and misuse, as well as allegations of disability fraud, remained persistent issues.

No-Fault Fraud by the Numbers

As shown in Figure 1, suspected no-fault fraud reports accounted for 75% of all fraud reports received by DFS in 2023.



As shown in Figure 2, the number of suspected no-fault fraud reports accounted for 94% of all healthcare fraud reports received in 2023 and at least 92% of all healthcare fraud reports received since 2019.



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 are 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 2023. 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 10 arrests related to COVID-19 to date. Most of the 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 2023, insurers electronically submitted approximately 98% of the 44,998 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 75 calls per month in 2023. 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 2023, there were 62 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, 19 property and casualty insurers writing accident and health insurance had approved SIUs during 2023.

Health and life insurers reported \$447.7 million in savings resulting from healthcare SIU investigations in 2022 (the most recent year for which data is available) and reported \$25.7 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.

2023 Healthcare Fraud Reports Received and Arrests Made

DFS received 35,722 reports of suspected healthcare fraud during 2023: 1,913 involved accident and health insurance, 163 involved disability insurance, and 33,646 involved no-fault claims. DFS opened 77 healthcare fraud cases for investigation, of which 19 involved accident and health insurance, nine involved disability insurance, and 49 involved no-fault insurance. DFS investigations resulted in 24 arrests in 2023.

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 2023. 39 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

Major Healthcare Investigation Highlights in 2023

Summarized below are additional major healthcare fraud investigations that the Bureau conducted during the past year (to the extent that information is public). The Bureau has numerous other confidential investigations of healthcare fraud that are pending.

- DFS, working with the New York State Department of Labor, Suffolk County District Attorney's Office, and DOH, investigated the unlawful practices of employees at a pediatrics healthcare service based in Lindenhurst. The investigation determined that the nurse practitioner who owned and operated the pediatrics healthcare service, along with two employees, another nurse practitioner, and an office receptionist used their positions to obtain COVID-19 vaccines, vaccination cards, and medical syringes from the DOH. The investigation concluded that the scheme involved approximately 300 licensed medical professionals who may have purchased the fake vaccine cards and that the nurse practitioners forged the COVID-19 vaccination cards. During the course of the investigation, the nurse practitioners furnished an undercover detective with a fake vaccination card and attested that they had administered vaccines to him on one or more occasions when, in fact, the vaccines were never administered. The nurse practitioners then entered the false vaccination information into the New York State Immunization Information System (NYSIIS), charging \$220 for each false entry per adult and \$85 per child. Law enforcement officers executed a search warrant at the home of a healthcare service owner located in Amityville, New York, seizing approximately \$900,000 in U.S. currency and a ledger that documented profits of more than \$1.5 million from the alleged illegal activity. The healthcare service owner and the two employees were charged with one count of forgery in the second degree, and the healthcare service owner was charged with an additional count of offering a false instrument for filing in the first degree (i.e., Class E felony).
- DFS, working with the Federal Bureau of Investigation, investigated a New York State-licensed broker from Fayetteville, New York, who was suspected of committing conspiratorial fraud related to Medicare insurance benefits. The investigation revealed that the broker facilitated several beneficiaries' enrollments in a Medicare-based insurance plan to obtain payments for medically unnecessary medication and durable medical equipment. The broker had exclusive relationships with multiple pharmacies around the country that paid him directly when the prescriptions for specific medications were filled. The investigation revealed that the broker's fraudulent actions caused losses of approximately \$4 million dollars to various insurance companies in the western New York area. On July 13, 2023, the broker was arrested on a federal arrest warrant at his home in Fayetteville. Arrests related to this crime include at least three co-conspirators employed by a Fayetteville brokerage firm and a doctor from Union City, New Jersey, who falsified prescriptions worth more than \$3.1 million.
- In January 2018, DFS determined that an individual residing in Angola, New York, submitted fraudulent medical bills to their insurance company, resulting in illegitimate

payments from her hospital insurance plan. The investigation revealed that this individual filed 123 invalid claims on her accident policy to gain financial benefits from her insurance company. The medical offices, where she claimed to have been treated, verified that she was not seen on any of the dates listed on claims submitted to the insurance company. The investigation determined that this individual submitted 123 fraudulent claims on 273 separate dates in the amount of \$17,690. On November 8, 2023, she was arrested and charged with grand larceny and insurance fraud.

- DFS, working with the Office of the Inspector General for the U.S. Department of Labor, discovered that an individual based in Buffalo, New York created fraudulent medical records in order to steal funds from his employee union health care fund. In February 2022, investigators received a complaint from this individual's former girlfriend alleging that the subject submitted false invoices for reimbursement of thousands of dollars in medical expenses for several years. Investigators obtained records from his union consisting of invoices for reimbursement of funds from member medical expense accounts and determined that a significant number of the claims appeared to be "suspicious invoices." After being interviewed, a union employee informed investigators that the fund administrator had directed her to never confirm the authenticity of the invoices, regardless of their apparent inauthenticity, if less than one year old. Multiple medical providers whose names appeared on the questionable invoices also were interviewed, and they confirmed that the invoices were false, resulting in losses greater than \$200,000. On June 8, 2023, the defendant was arrested and charged with theft or embezzlement in connection with healthcare, in violation of 18 U.S.C. § 669. One participant has been arrested thus far, with additional arrests pending.
- In 2023, DFS continued its efforts to combat COVID-19 vaccination card fraudsters seeking to circumvent various COVID-19 measures designed to maintain the public health. DFS investigators continued to assist the DOH with COVID-19 vaccine investigations and remained assigned to work on the DOH Vaccine Complaint Investigation Team. DFS made 10 arrests and assisted DOH and other law enforcement agencies in making arrests related to COVID-19, resulting in the adjudication of 10 defendants in the upstate and downstate regions. DFS and DOH arrests also involved individuals who submitted fake and forged vaccination cards to their employers. Each of these individuals was charged with criminal possession of a forged instrument or with theft or embezzlement of healthcare benefits.