Investigating and Combating Health Insurance Fraud

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Adrienne A. Harris
Superintendent

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

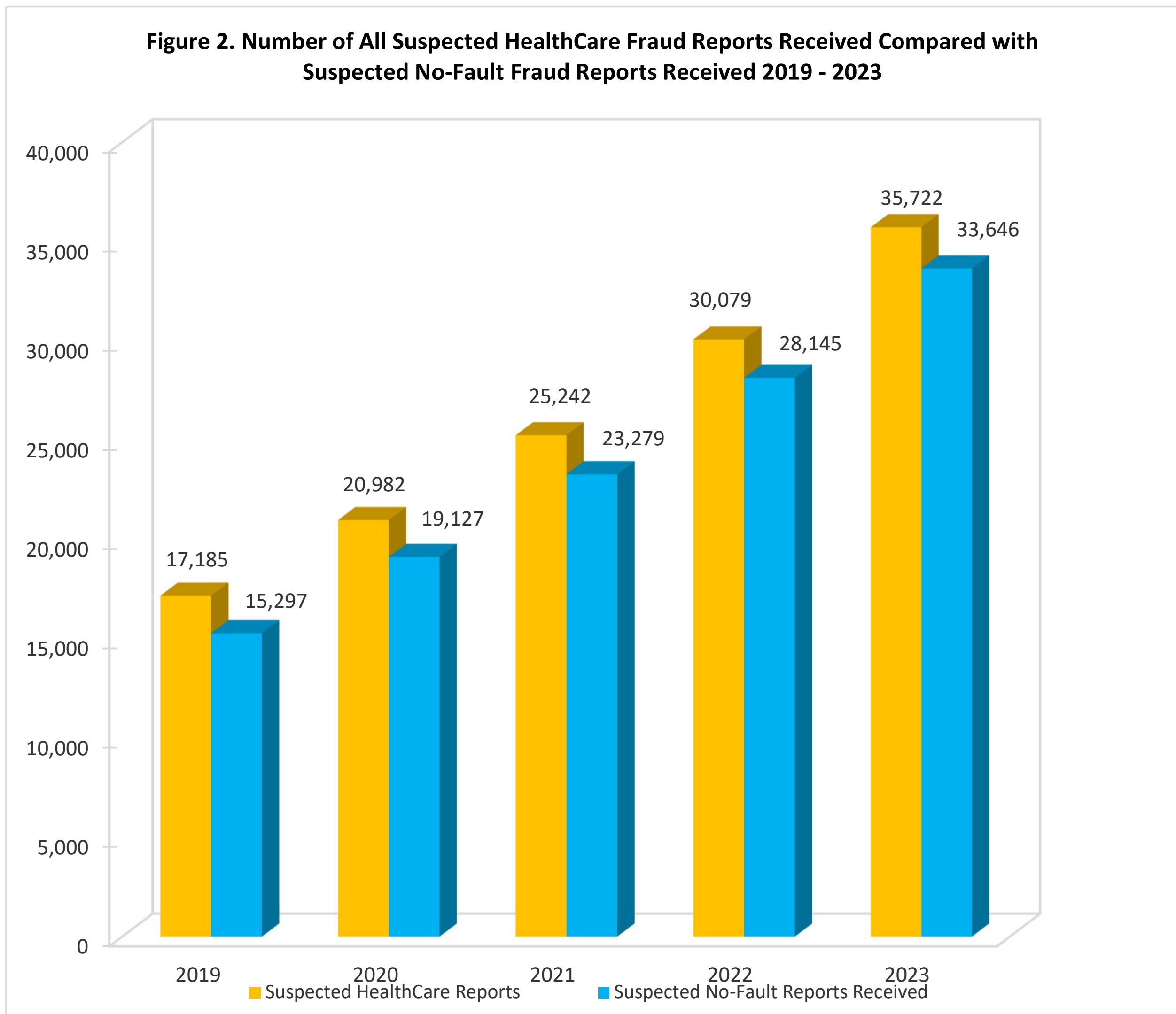
The High Cost of Healthcare Fraud

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/.

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.



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.