



# Investigating and Combating Health Insurance Fraud

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Acting Superintendent

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## **Introduction**

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Kaitlin Asrow, the Acting Superintendent of Financial Services, respectfully submits this report, pursuant to Section 409(c) of the New York Financial Services Law, summarizing the Department of Financial Services' ("DFS" or the "Department") efforts in combating health insurance fraud in 2025.

The DFS Insurance Frauds Bureau ("IFB") has a longstanding commitment to combating insurance fraud in New York State. IFB conducts complex and impactful statewide investigations, implicating insurance fraud and adjacent financial fraud schemes by leveraging its one-of-a-kind insurance fraud intelligence database and by partnering with key state and federal law enforcement authorities.

## **2025 Highlights**

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In 2025, DFS transformed its approach to combating insurance fraud by rebuilding and modernizing IFB. The Department hired new, experienced leadership and subject-matter experts, while also investing in modern technology solutions, securing essential resources, and strengthening partnerships with law enforcement statewide.

- In 2025, IFB received 39,676 suspected healthcare fraud reports, of which 36,835 reports were related to no-fault automobile insurance fraud, 2,651 reports were related to accident and health insurance fraud, and 190 reports were related to disability insurance fraud. IFB opened 73 healthcare fraud investigations, resulting in 40 arrests.
- Insurers reported approximately \$3.5 billion in savings and approximately \$40.3 million in recoveries, resulting from investigations conducted by a statutorily required special investigations unit ("SIU") in 2024, the most recent year for which data is available.

## **Overview of Healthcare Fraud in New York State**

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### **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 \$30 to \$300 billion

each year.<sup>1</sup> Combating such fraud and abuse helps reduce the escalating costs of healthcare in New York and the United States.

## **Types of Healthcare Fraud**

Healthcare fraud affects accident and health, private disability, and no-fault auto insurance lines. Combating fraud and abuse helps reduce the escalating costs of healthcare in New York and the United States. 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.

## **Reporting Healthcare Fraud**

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### **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

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<sup>1</sup> 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>.

Fraud Case Management System (“FCMS”), allows insurers to electronically submit reports of suspected fraud.

### Consumer Reporting

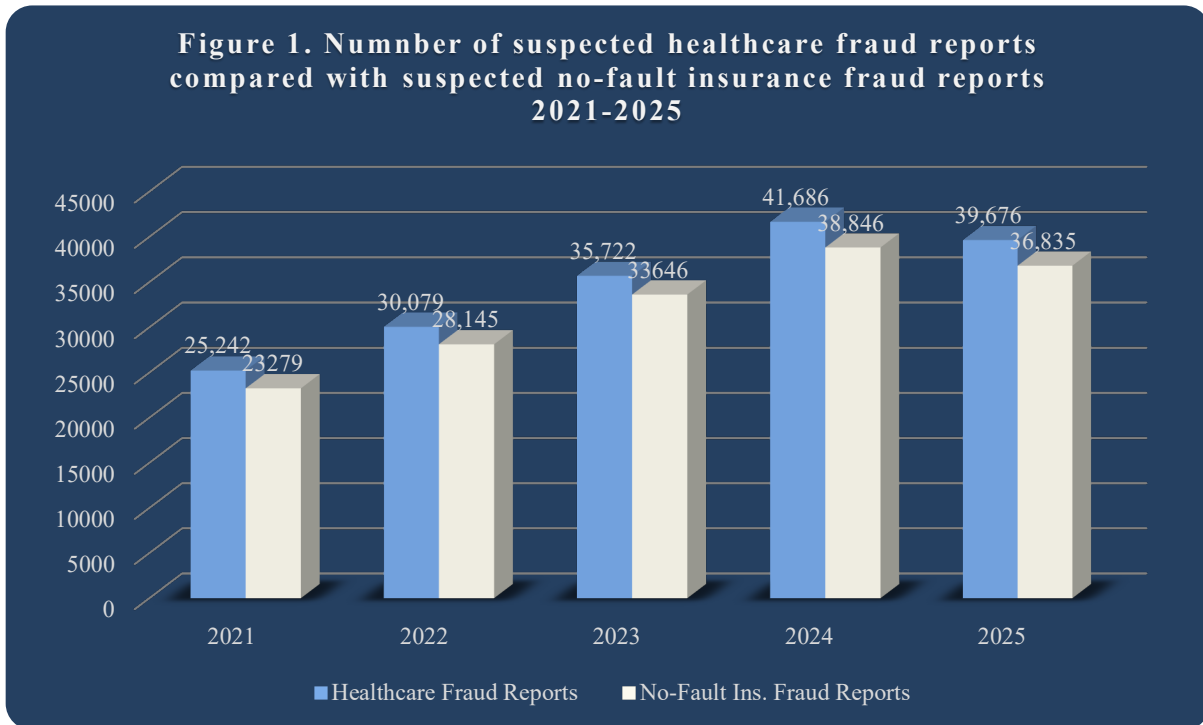
DFS encourages consumers to report suspected insurance fraud through its toll-free hotline at (888) FRAUDNY (888) 372-8369 or through its [online Fraud Reporting web form](#). In 2025, IFB received an average of 17 calls per month concerning suspected insurance fraud.

### Healthcare Fraud Referral Statistics

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In 2025, IFB received 51,419 reports of suspected insurance fraud, of which 39,676 were reports of suspected healthcare fraud. Healthcare fraud reports accounted for approximately 77% of all fraud reports received by IFB in 2025. The vast majority of these reports were from licensees required to submit reports of suspected fraud to IFB. The remaining reports were from other sources, including non-profit organizations, businesses, consumers, and anonymous tips.

In 2025, IFB received 36,835 no-fault fraud reports, accounting for approximately 93% of all healthcare fraud reports received by the Department. The remaining healthcare fraud reports included 2,651 involving accident and health insurance and 190 reports involving disability insurance.



## **Collaborative Efforts to Combat Healthcare Fraud**

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IFB investigators work closely with the insurance industry and law enforcement agencies at the federal, state, and local levels to combat healthcare fraud schemes.

IFB opened 73 healthcare fraud cases for investigation in 2025. Further, IFB investigations resulted in 40 arrests in 2025.

IFB is a member of eight 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:

- High Intensity Drug Trafficking Area Program
- Nassau County District Attorney’s Office Revenue, Auto, Insurance, and Labor Crime Unit
- National Insurance Crime Bureau Working Group
- New York Alliance Against Insurance Fraud
- New York Anti-Car Theft and Fraud Association
- Rochester Health Care Fraud Working Group
- Suffolk County District Attorney’s Office Financial Crimes Bureau
- Western New York Health Care Fraud Task Force

IFB’s participation in working groups and task forces provides the opportunity for joint investigations, intelligence gathering, effective use of resources, and a broader study of trends. Several IFB investigators have been assigned to groups and task forces and partnered with other members investigating cases involving healthcare fraud.

## **Preventing Healthcare Fraud**

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### **Compliance with Section 409 of the New York Insurance Law**

Section 409 of the New York Insurance Law (“Section 409”) 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 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 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 in 11 NYCRR 86.1 (“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 2025, there were 59 insurer SIUs operating in New York. These SIUs were housed within accident and health insurers, HMOs, life insurers, nonprofit medical insurers, and dental indemnity and health service corporations.

Section 409 of the Insurance Law also requires insurers to file a Fraud Prevention Plan report on an annual basis describing insurers’ experience, performance, and cost effectiveness in implementing the plan. In their electronically filed annual SIU reports, accident and health insurers, HMOs, life insurers, nonprofit medical insurers, and dental indemnity and health service corporations reported approximately \$3 billion in savings and approximately \$30.6 million in recoveries resulting from investigations conducted by SIUs in 2024 (the most recent year for which data is available).

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.

## **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 is comprised of 80 members, most of which are HMOs and health products insurers, and the New York Alliance Against Insurance Fraud is comprised of 110 accident/health and property/casualty insurers. The public awareness programs and anti-fraud messages produced by these organizations reach millions of New Yorkers each year.

## **The Year in Review**

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### **Healthcare Investigation Highlights in 2025**

Summarized below are noteworthy healthcare fraud investigations that IFB conducted in 2025, to the extent that information is public. IFB investigated these cases in partnership with federal, state, and local agencies; insurance investigative units; and non-profit groups such as the National Health Care Anti-Fraud Association and National Insurance Crime Bureau. IFB has numerous other confidential investigations of healthcare fraud that are pending.

### **Fraud Committed by Medical Providers**

IFB partnered with the Federal Bureau of Investigation, the Internal Revenue Service, the U.S. Department of Health and Human Services, and the U.S. Department of Labor Office of the Inspector General in an investigation concerning fabricated health provider insurance claims.

The joint criminal investigation determined that a medical provider fabricated thousands of insurance claims for an at-home medical practice by combining legitimate information from unwary patients and beneficiaries with false addresses and phone numbers on claim forms. The tactic prevented the patients and beneficiaries from receiving insurance notices (e.g., explanation of benefits forms) that would have alerted them to the scheme. The patients and beneficiaries later informed investigators that they never met the medical provider or only knew of the medical provider sparingly, because the provider had a practice at the medical facility they visited. To date, investigators identified approximately \$2.8 million in fraudulent claims and the investigation remains ongoing. The medical provider was arrested and charged in the United States District Court with healthcare fraud.

## **Fraud Involving Staged Automobile Accidents**

IFB partnered with the New York City Police Department on several staged motor vehicle accident investigations throughout 2025. Notably, IFB partnered with the Queens County District Attorney's Office and the New York City Police Department's Fraudulent Collision Investigation Squad on an investigation that uncovered a conspiracy among several individuals to stage numerous motor vehicle accidents in and around Queens County for fraudulent insurance payouts.

The investigation determined that during one incident in October 2024, a conspirator promised a group of individuals several thousand dollars for their participation in a staged car accident. The conspirator met with the group in Brooklyn, New York, and provided detailed instructions in staging car collisions. Thereafter, the individuals traveled to Queens County and using four cars, targeted an unsuspecting vehicle and intentionally caused a collision. The incident was recorded by front and rear dashboard cameras mounted in the victim's vehicle. Investigators later arrested four individuals for conspiracy to stage several motor vehicle accidents and engage in insurance fraud. The individuals were also charged with reckless endangerment for creating public safety hazards.

## **Fraud Involving Workers' Compensation**

IFB and the New York State Police investigated a workers' compensation fraud matter stemming from a purported upper body injury sustained by a transportation company employee. The employee claimed permanent disability and was unable to work. Consequently, the employee collected approximately \$20,000 in benefits.

However, the investigators determined that at the same time the employee claimed disability, he was employed at a different transportation company performing similar work consistently for over one year. The investigators determined that the employee made false statements about their injury and concealed their employment, causing the employee to receive unauthorized benefits. The investigation culminated in the arrest of the employee for false statements and falsifying business records.