



STATE OF NEW YORK
INSURANCE DEPARTMENT
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David A. Paterson
Governor

James J. Wrynn
Superintendent

February 26, 2010

To: the Governor, the State Comptroller, the Attorney General, the President Pro Tem of the Senate, the Speaker of the Assembly, the Chair of the Senate Finance Committee, the Chair of the Senate Health Committee, the Chair of the Assembly Ways & Means Committee, and the Chair of the Assembly Health Committee

I am pleased to submit the Annual Report of the Superintendent of Insurance on the efforts of the Insurance Frauds Bureau to investigate and combat health care fraud during 2009. During the past year, the Frauds Bureau worked closely with federal, state, and local law enforcement agencies to investigate and prosecute fraud in the health care sector.

Frauds Bureau investigations led to 157 arrests for health care fraud in 2009. This report highlights a number of major investigations undertaken this past year, including an investigation conducted jointly with the FBI of a podiatrist in Monroe County who provided routine treatments to elderly patients and billed Medicare as if he performed complicated surgical procedures. The amount of the fraud is estimated at more than \$750,000. The podiatrist was arrested and charged with mail and wire fraud. He faces ten years in prison if convicted.

The Frauds Bureau, in conjunction with audits conducted by the New York State Comptroller's Office, continued to recoup refunds for New York State from health care providers who submitted inflated bills to United Healthcare, which administers the Empire Plan, the primary health insurance plan for State employees. To date, New York State has received almost \$12 million in refunds and over \$124,000 in fines from the providers.

In the coming year, the Frauds Bureau will continue its longstanding tradition of working closely with the law enforcement community and the insurance industry to aggressively combat healthcare fraud.

Sincerely,

James J. Wrynn
Superintendent of Insurance

The Annual Report
of the Superintendent of Insurance
on the Activities of the
Insurance Department
to Investigate and Combat
Health Insurance Fraud
in Accordance with Section 410
of the New York State
Insurance Law

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*I. Health Care Fraud
2009 Highlights*

- **The Frauds Bureau investigates and combats health care fraud, which includes three major types of insurance: health, private disability and no-fault.**
- **Health care fraud investigations conducted by the Frauds Bureau resulted in 157 arrests in 2009.**
- **The National Health Care Anti-Fraud Association “conservatively” estimates the cost of health care fraud to be a sizable \$60 billion to \$70 billion a year.**
- **The Frauds Bureau is a member of the Medicare Fraud Strike Force, a group of federal, state and local law enforcement agencies that investigates individuals and health care providers suspected of fraudulently billing the Medicare program.**
- **There were 15,163 reports of suspected health care fraud received by the Frauds Bureau during 2009 – 1,488 involved accident and health insurance, 242 involved disability insurance and 13,433 involved no-fault.**
- **Reports of suspected no-fault fraud increased by nearly 9 percent from 2008 and accounted for 54% of all fraud reports received during 2009.**
- **The Frauds Bureau is a member of the FBI New York Health Care Fraud Task Force, a multi-agency group established in 2007 to address health care fraud in the New York metropolitan area.**
- **New York State has received nearly \$12 million in refunds and \$124,000 in fines from a number of health care providers who submitted inflated bills to United Healthcare, administrator of the Empire Plan. The bills did not reflect the fact that the out-of-network providers were systematically waiving co-insurance payments that were required to be paid by patients.**

II. The Insurance Frauds Bureau

A. Health Care Fraud

The Frauds Bureau investigates insurance fraud, including health care fraud, throughout New York State. The Bureau is headquartered in New York City, with an office in Mineola and five offices across the upstate region: Albany, Syracuse, Rochester, Buffalo and Oneonta. A full list of office locations, including addresses and telephone/fax numbers, appears on page 16 of this Report.

B. Types of Health Care Fraud

Frauds Bureau investigators work closely with the insurance industry and law enforcement agencies on the federal, state and local levels to combat health care fraud schemes. Such schemes increase health insurance premiums for all consumers.

The following are some of the more common types of health care fraud.

- Billing for services that were not rendered;
- Billing for more expensive procedures than were actually provided, a practice known as upcoding;
- Performing medically unnecessary treatments and expensive diagnostic tests;
- Filing claims for nonexistent injuries;
- Filing false or exaggerated medical disability claims;
- Misrepresenting noncovered treatments as medically necessary covered treatments, e.g., cosmetic nose surgery billed as deviated septum repairs;
- Unbundling, i.e., billing as if each step of a procedure were a separate procedure;
- Accepting kickbacks for patient referrals.

A review of health care fraud reports received by the Bureau in 2009 showed an increase in upcoding, billing for services not provided, and billing for unnecessary medical testing such as electromyographies (EMGs).

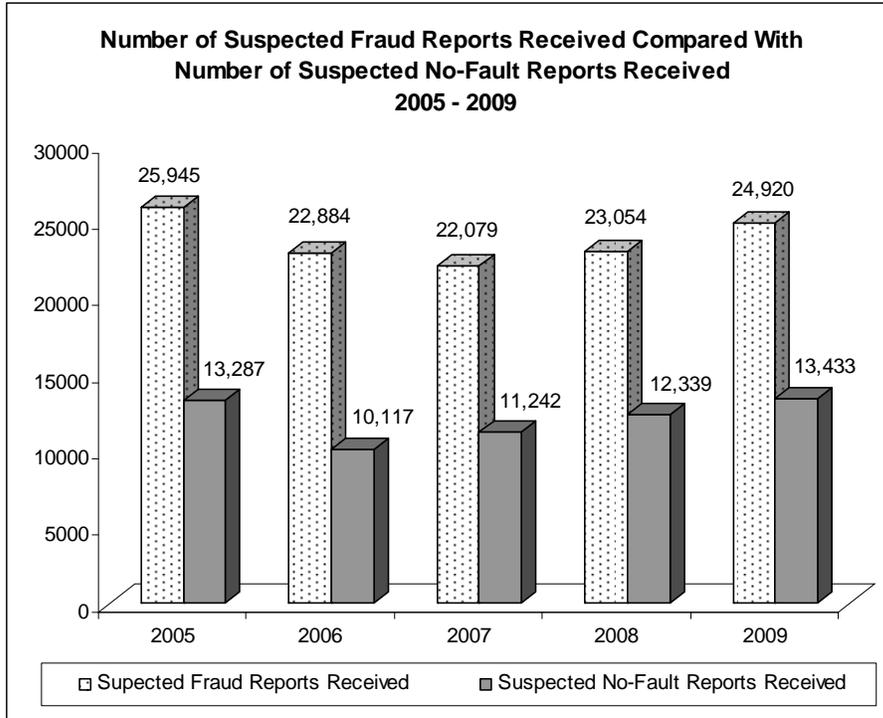
C. The Costs of Health Care Fraud

Experts vary in their estimates of the cost of health care fraud, but all agree it is in the billions of dollars. The National Health Care Anti-Fraud Association “conservatively” estimates that fraud is at 3 percent of the nation’s health care spending. That estimate comes from Association members, which include health insurers and federal, state and local agencies involved in investigating insurance fraud. Though the Association admits the estimate is low, 3 percent amounts to a sizable \$60 billion to \$70 billion a year lost to fraud.

D. No-Fault Fraud on the Rise

After several years of decline, the number of suspected no-fault fraud reports began to rise in 2007 and that trend continued through 2009. Suspected no-fault claims totaled 13,433 in 2009, an increase of almost 9 percent from 2008, and accounted for 54 percent of all fraud reports received during 2009.

Graph 1



Data in a recent analysis by the Insurance Information Institute (I.I.I.) showed that the average no-fault claim cost in New York was \$8,690 in 2009, surpassing the average of \$5,615 in late 2004 by a significant 55 percent. I.I.I. reports that New York's no-fault claim costs are the second highest in the country and are 109 percent higher than the U.S. average of \$4,152. As an inevitable consequence, auto insurance rates for New York drivers are increasing as well.

E. Proposed Revisions to Department Regulation 68

No-fault fraud is often perpetrated by highly organized criminal entities that can include corrupt medical clinics and corrupt attorneys, acting with staged accident/solicitation rings to submit fraudulent no-fault and bodily injury claims.

In an effort to combat no-fault fraud and abuse and to help keep New Yorkers' automobile insurance premiums from skyrocketing, Superintendent James J. Wrynn has proposed revisions to Department Regulation 68, which implements no-fault auto insurance. The proposed revisions include:

- Modifying prescribed forms to require more information to ensure that claims paid are medically necessary and reduce the need for additional verification by the insurer, thereby expediting claims processing and legitimate payment to consumers. Insurers would have greater latitude to deny health services that are not provided or are not billed in compliance with the applicable fee schedule, thus reducing payment of fraudulent claims and instances of over-billing.
- Simplifying procedures required for insurers to suspend all payments for claims submitted by the owner or owners of medical clinics suspected of fraud while an investigation of the clinics' licensing status is underway.
- Insurers would have to schedule medical examinations they request so as not to overly burden the insured. For example, examinations may not be scheduled in geographically inconvenient locations and multiple exams may not be scheduled on the same day.
- Raising the maximum attorney fee from \$850 to \$2,500 to reflect inflation and to reduce the incentive for claimants and providers to file small claims separately, and eliminate the minimum attorney fee to encourage the consolidation of claims in arbitration and litigation.

Combating no-fault fraud remains an important part of mitigating the increase in auto insurance costs. The Frauds Bureau's No-Fault/Medical Unit is dedicated to rooting out no-fault fraud as well as other forms of health insurance fraud.

III. Combating Health Care Fraud – Collaborative Efforts

A. FBI New York Health Care Fraud Task Force

The Frauds Bureau is a member of the FBI New York Health Care Fraud Task Force, a multi-agency group established in 2007 to address health care fraud in the New York metropolitan area. The mission of the Task Force is to identify, investigate and prosecute health care fraud. The FBI is the lead agency for the Task Force, whose members include agents and detectives from the FBI, the NYPD, investigators from the Frauds Bureau, and other federal, state and local law enforcement agencies, as well as the insurance industry. Members of the Task Force meet on a regular basis to discuss joint investigations, study trends and plan strategies.

B. Medicare Fraud Strike Force

The Medicare Fraud Strike Force supplements the criminal health care fraud enforcement activities of the U.S. Attorneys' Offices by targeting chronic fraud as well as emerging or migrating schemes perpetrated by criminals operating as health care providers or suppliers. The Strike Force members include the Department of Justice Criminal Division's Fraud Section, law enforcement partners in the Department of Health and Human Services (HHS), the New York Insurance Frauds Bureau and other state and local law enforcement agencies.

In May 2009, the Strike Force expanded its operations into Brooklyn, NY, Tampa, FL, and Baton Rouge, LA, in a targeted criminal, civil and administrative effort against individuals and health care companies that fraudulently bill the Medicare program. The Frauds Bureau began its participation in the Strike Force with the expansion into Brooklyn.

From the inception of operations in March 2007 to the May 2009 expansion, the Strike Force obtained indictments of more than 460 individuals and organizations that falsely billed the Medicare program for more than \$1 billion. Moreover, the HHS Centers for Medicare & Medicaid Services is working together with its Office of the Inspector General to take steps to increase accountability and decrease the presence of fraudulent providers.

C. Other Group Participation

The Frauds Bureau actively participates in several other task forces and working groups designed to foster cooperation among the many agencies involved in fighting health care fraud. Participation provides the opportunity to share information and hone investigative skills. Among those groups whose members investigate health care fraud are the Central New York Health Care Fraud Working Group and the Western New York Health Care Fraud Task Force.

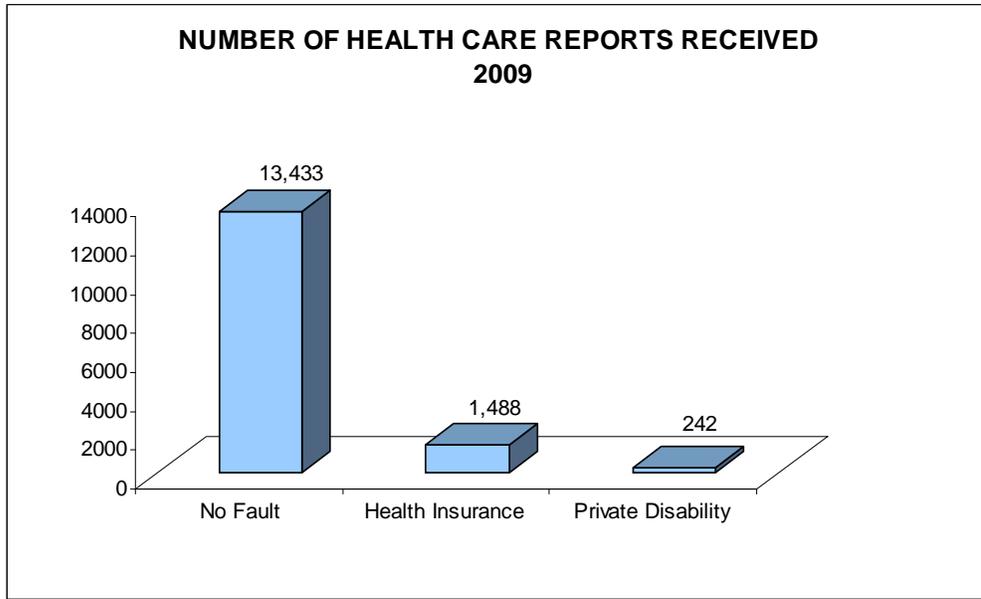
IV. Reporting and Preventing Insurance Fraud

A. Insurance Company Reporting

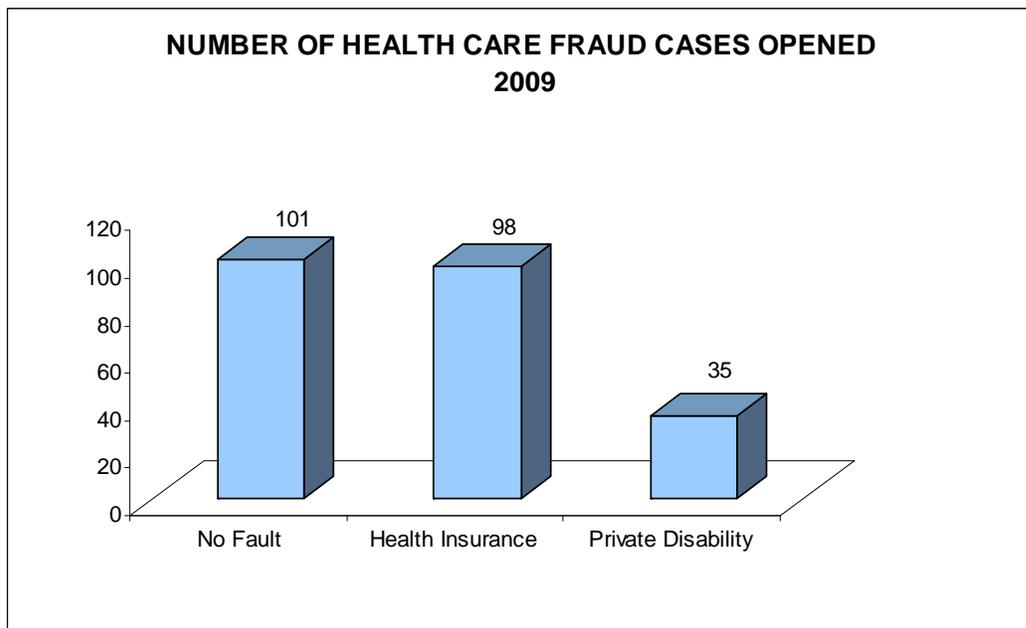
Insurers are required by Section 405 of the Insurance Law to report suspected fraud to the Frauds Bureau. The Bureau has a Web-Based Case Management System, known as FCMS, that allows insurers to submit reports of suspected fraud electronically. The system has been fully operational since the first quarter of 2007. In 2009, approximately 90% of the 24,920 fraud reports received by the Bureau were transmitted electronically and received remotely from insurers. Insurers have access to FCMS through the Department portal using secure accounts.

There were 15,163 reports of suspected health care fraud received by the Frauds Bureau during 2009 – 1,488 involved accident and health insurance, 242 involved disability insurance and 13,433 involved no-fault. A total of 234 new health care fraud cases were opened for investigation in 2009. (It should be noted that frequently one case can be linked to multiple fraud reports.) At the same time, investigations continued in numerous cases that were opened in prior years. All told, Frauds Bureau health care fraud investigations resulted in 157 arrests in 2009.

Graph 2



Graph 3



B. Compliance with Section 409 of the Insurance Law

Section 409 of the New York Insurance Law requires insurers that write at least 3,000 policies (or individuals if written on a group business) of auto, workers' compensation or accident and health insurance in New York State to submit to the Department a Fraud Prevention Plan for the detection, investigation and prevention of insurance fraud. The Plans must provide for a full-time Special Investigations Unit (SIU), as well as specific staffing levels within the SIU.

There were 60 approved insurer SIUs dedicated to investigating health care fraud in New York State in 2009. These SIUs comprised accident and health insurers, HMOs, life insurers and nonprofit medical and dental indemnity or health service corporations. In addition, there were 11 property and casualty insurers with approved SIUs writing accident and health insurance during 2009.

Accident and health insurers reported \$92.1 million in savings resulting from SIU investigations in 2008 (the most recent year for which data are available). In addition, the 11 property and casualty insurers writing accident and health insurance reported \$362,000 in savings. Accident and health insurers reported \$14.6 million in recoveries resulting from SIU investigations in 2008.

The Frauds Bureau monitors insurer compliance with Section 409 via the analysis of data included in the Annual SIU Reports which are required by Section 409(g). Annual SIU Reports are due to the Department by March 15 of each year and must be filed electronically. In addition, the Bureau may perform market conduct field examinations of insurer SIUs to ensure compliance with Section 409.

C. Public Awareness Programs

Section 409 requires insurers to develop public awareness programs focused on the cost and frequency of insurance fraud and the methods by which the public can assist in preventing fraud. Insurer public awareness programs must be geared to reach a wider audience than an insurer's policyholders and applicants. Toward that end, the New York Alliance Against Insurance Fraud and the National Health Care Anti-Fraud Association carry out advertising campaigns using newspapers, radio and television to target insurance consumers. The National Health Care Anti-Fraud Association conducted the public awareness programs for 22 health insurer groups with Fraud Prevention Plans on file with the New York State Insurance Department. The New York Alliance performed the public awareness programs for 108 insurers or insurer groups with Plans on file with the Insurance Department. In addition, several individual 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.

D. Consumer Reporting

Consumers are encouraged to report suspected fraud to the Bureau. To facilitate reporting, the Bureau maintains a toll-free hotline (1-888-FRAUDNY) for consumers to report their suspicions. Once a report is received, a Bureau investigator will contact the caller for details and the matter will be kept confidential. The Bureau recorded on average 28 calls a week during 2009. The Web site also includes a link to a fraud report form and instructions for consumers to report fraud by mail or fax.

V. *The Year in Review*

A. Major Cases

Numerous health care fraud investigations were conducted during the past year. Below are summaries of some of these major cases.

Convicted

- After a six-week trial in Brooklyn Supreme Court, Dr. Alexander Rozenberg and his clinic, AR Medical Art, were convicted on 2/20/09 of numerous charges. The doctor was found guilty of insurance fraud in the 5th degree and falsifying business records in the 1st degree. The clinic was found guilty of scheme to defraud in the 1st degree, insurance fraud in the 5th degree and falsifying business records in the 1st degree. Evidence showed that Rozenberg and his clinic purported to treat people injured in real and staged accidents in a complex scheme to defraud no-fault insurers. “Steerers” referred accident victims to the clinic where Rozenberg falsely diagnosed injuries, provided unnecessary medical treatments and prescribed costly medical equipment. The convictions were the result of a 20-month joint investigation by the Attorney General’s Office, the Frauds Bureau and the NYPD’s Fraudulent Accident Investigation Squad in which 25 defendants were charged. Twenty-three have pleaded guilty to criminal charges in connection with their involvement in the scheme. The case against the 25th defendant was dismissed.

Not in the Army

- The defendant in this case reported to the police that he was the driver of a vehicle involved in a one-car accident on 7/26/07. He subsequently filed a claim for lost-wage benefits with GMAC Insurance Company under his no-fault insurance coverage, stating that as a result of the accident he was unable to continue his employment with the Utica Salvation Army. As part of the fraudulent claim, he allegedly submitted forged/altered prescriptions and a forged affidavit in the name of the supervisor of the Utica Salvation Army falsely claiming that he was an employee. However, an investigation by the Frauds Bureau and the Utica Police

Department revealed that he had never been employed by the Salvation Army. As a result of the fraud, he was arrested on a number of charges including insurance fraud.

Who's the Boss?

- An Orange County man was accused of filing false statements with AFLAC Insurance Company and forging his boss's signature on claim forms in order to continue to collect disability payments after recovering from a foot injury and returning to work. As a result of the fraud, he collected \$11,360 in benefits to which he was not entitled. An investigation by the Frauds Bureau led to his arrest on 3/17/09. He was charged with insurance fraud in the 3rd degree, forgery in the 2nd degree, identity theft in the 1st degree and falsifying business records in the 1st degree.

Phony Claims

- Two office workers employed by a doctor in Yonkers, NY, allegedly devised a scheme in which they filed claims for medical treatments – typically \$75 office visits – that were never rendered. They filled out 70 phony claim forms in their own names and the names of family members and submitted the claims to Combined Life Insurance Company for payment. As a result, they fraudulently collected payments totaling \$8,700. An investigation by the Frauds Bureau revealed that the insurer had made written inquiries to the doctor about the purported treatments. The inquiries were intercepted by the defendants who then submitted forged documents in the doctor's name to the insurer. The investigation was begun when a claims adjuster noticed the same handwriting on claims submitted for different people. Investigators discovered that fraudulent claims were filed over a two-year period from 2006 to 2008. The doctor fired the two employees after the scheme was uncovered in September 2008. They were arrested on 3/12/09 and charged with identity theft, insurance fraud, falsifying business records and possession of a forged instrument.

Incarceration & Restitution

- Jeffrey C. Seifts, a former insurance agent from Poughkeepsie, NY, was sentenced on 3/19/09 to a year in federal prison and ordered to make \$133,000 in restitution to retirees, small business owners and others in the upstate area. He was accused of running a phony insurance scheme that victimized 240 people in Dutchess, Ulster and Columbia Counties. His arrest stemmed from an investigation initiated in 2003 when the Insurance Department was contacted by a Dutchess County woman who incurred \$50,000 in medical expenses resulting from complications during a pregnancy. She told the Department's Consumer Services Bureau she was unable to have the expenses paid through the insurance she purchased from Seifts and was subsequently forced to file for bankruptcy. At the same time, MVP Health Care, a health maintenance organization in

Schenectady, reported suspected irregularities in numerous applications it had received from Seifts. Investigators from the Frauds Bureau and the U. S. Postal Inspection Service found that applications from four different people contained the same handwriting and that suspicious alterations appeared to have been made on several applications. In addition, a large number of applicants were identified as “management” employees for the same organization, Professional Employees Management Corporation (PEMC), a company later determined to be fictitious. The suspect solicited business from customers on the basis that they could obtain less costly insurance through the small group plan he purportedly operated. However, a review of the suspect’s records revealed that his customers were actually paying more than they would have paid through other insurance plans and that they were overcharged by a total of \$76,747. In addition, Seifts was charging customers a \$12 monthly union fee. These customers were not members of a union nor was the money turned over to any union. While some people who purchased insurance did receive coverage for their medical expenses, Seifts failed to forward \$60,645 in premiums to MVP Health Care. Moreover, he collected \$13,232 in unauthorized fees. Seifts was arrested in July 2007 and in October 2008 pleaded guilty to theft from a health benefit plan. His corporation, JC Seifts & Company, Inc., pleaded guilty to mail fraud. The Department revoked his license to sell insurance in 2005.

That’s a Lot of Claims

- Between February 2005 and February 2008, the defendant in this case submitted 113 claims to United Healthcare Insurance Company for medical services he and his estranged wife allegedly received at a local family health care practice. He stated on the claims that they received medical treatments for which they paid \$370 per visit. However, an investigation by the Frauds Bureau and the State Police revealed that neither the defendant nor his wife received any medical services at the health care facility in question. Over the three-year period, the defendant fraudulently collected \$233,138 in reimbursements from United Healthcare. He was arrested on 4/29/09 and charged with insurance fraud, grand larceny and forgery.

Three Claims Paid

- A year-long investigation by the Frauds Bureau and Aetna Insurance Company’s SIU resulted in the arrest of an upstate clerical worker accused of filing claims for dental treatments that she never received or minor treatments for which she was not charged. The defendant filed five claims for a total of \$6,806. Aetna paid out \$3,559 on the first three claims before the insurer became suspicious and contacted the Frauds Bureau. Evidence was subsequently found indicating that all five claims were fraudulent.

Not Disabled

- An investigation by the Frauds Bureau led to the arrest of an upstate woman charged with cashing five disability checks totaling \$5,600 issued to her sister. The defendant was the caregiver for her disabled sister and had power of attorney. However, she failed to inform American International Group that her sister died on 3/17/07 and she continued to cash the checks meant for her sister. She was arrested on 6/25/09 and charged with insurance fraud in the 3rd degree and falsifying business records in the 1st degree.

Health Care Fraud & Tax Evasion

- An investigation by the Frauds Bureau and the Internal Revenue Service resulted in the 6/19/09 arrest of a Bay Shore, Long Island, doctor who filed \$800,000 in allegedly fraudulent claims with numerous health care programs, including Medicare, for services that were never provided. Court papers also alleged that he evaded almost \$1.3 million in income taxes from 2001 to 2003. He was charged with health care fraud, conspiracy to commit health care fraud and income tax evasion.

Stealing Grandma's Checks

- An investigation by the Frauds Bureau and the Hartford Insurance Company's SIU led to the 8/27/09 arrest of a Buffalo man who, investigators charged, cashed disability checks issued by Hartford to his grandmother. His grandmother had died on 10/24/07 and between that date and 9/17/08, he cashed 24 checks, collecting \$5,760 to which he was not entitled. He cashed the checks at a local bank where he had taken his grandmother when she was alive, informing bank employees that she had become too sick to come in person. He was charged with grand larceny and criminal possession of a forged instrument.

Someone Else's Coverage

- A Bronx man with no medical insurance allegedly used the identity he stole from an acquaintance to obtain \$70,000 in medical treatment and sue a landlord for injuries he suffered when he fell from a fire escape trying to get into his mother's locked apartment in January 2007. An investigation by the Frauds Bureau revealed that the suspect received emergency care and follow-up medical treatment for leg injuries under the identity he assumed without that person's knowledge. He was also charged with using the stolen identity to file a negligence lawsuit against the landlord. He claimed he suffered his injuries when he fell on an interior stairway. The landlord's insurer, Technology Insurance Company, contacted the Frauds Bureau after discovering discrepancies in the lawsuit. That led investigators to look into the health insurance claims the suspect filed with Fidelis Healthcare, his former acquaintance's health insurer. He was arrested on

9/2/09 and charged with identity theft, insurance fraud and falsifying business records.

Over-Billing

- In a case investigated by the Frauds Bureau, the FBI and the U.S. Attorney's Office, a Monroe County podiatrist was arrested on 10/28/09 and charged with health care fraud and mail fraud. He treated elderly patients at nursing homes and retirement homes, usually clipping their toenails and performing other routine procedures that are not covered services. Then he billed Medicare for complicated surgical procedures. The investigation uncovered many discrepancies in the doctor's billing records and medical charts that indicated a pattern of fraudulent billing. The amount of the alleged fraud is estimated at more than \$750,000. If convicted, he faces ten years in prison, a \$250,000 fine and restitution of the \$750,000 in fraudulent claims he filed with Medicare.

Staged Accident Scam

- The defendant in this case was arrested on 11/19/09 for his part in a staged accident ring, bringing to 11 the number of suspects arrested thus far in this case. An investigation by the Frauds Bureau, the NYPD's Fraudulent Accident Investigation Squad and the U.S. Postal Inspection Service revealed that this defendant was a passenger in a car that caused a staged accident. He subsequently sought and received medical treatment for nonexistent injuries under the no-fault portion of his auto insurance coverage. He was charged with insurance fraud. This is an ongoing investigation and additional arrests are anticipated.

Unauthorized Practice

- An investigation by the Frauds Bureau resulted in the 11/16/09 arrest of a man accused of falsely representing himself as a doctor and treating several patients at a Staten Island medical facility. He purportedly used the tax ID numbers of licensed physicians associated with the clinic for billing purposes. This was allegedly done with the knowledge of those physicians, who were sometimes present during treatment. One of the physicians involved in the scheme was also arrested on 11/16/09 and a second physician was arrested on 12/3/09. The unlicensed man was charged with insurance fraud and scheme to defraud. In addition, all three defendants were charged with unauthorized practice of a profession. The investigation was conducted jointly by the Frauds Bureau and the NYPD.

Corrupt Chiropractor

- An investigation by the Frauds Bureau, the Queens DA's Office and Empire Blue Cross and Blue Shield led to the 12/15/09 arrest of a Queens chiropractor charged with insurance fraud after investigators found evidence that he convinced a

“patient” to fabricate injuries and then billed Empire Blue Cross and Blue Shield more than \$26,000 for medical treatments over a three-month period. He allegedly paid a \$1,000 kickback to the “patient” who was actually an undercover investigator. According to the charges, the defendant met the undercover at his office on 9/16/08, where he instructed the undercover to fabricate back and knee injuries in order to obtain insurance payments. The defendant was charged with grand larceny, insurance fraud and falsifying business records.

B. Waiver of Co-Insurance

New York State has received almost \$12 million in refunds and \$124,000 in fines from a number of health care providers that inappropriately billed United Healthcare, which administers the Empire Plan, the primary health insurance plan for State employees. The bills submitted by the providers did not reflect the fact that the out-of-network providers were systematically waiving co-insurance payments that were required to be paid by Empire Plan members. Because payments should reflect the actual charge, the bills were improperly inflated by the amount waived. Following reports by the New York State Comptroller that the providers were waiving the required co-insurance payments, the New York State Insurance Department conducted its own investigation and as a result received signed stipulations from a number of the providers. In those stipulations, the providers agreed to pay civil fines and to reimburse United Healthcare for the overpayment of claims. The stipulations also state that the providers will discontinue the practice of waiving co-insurance payments for Empire Plan patients. The Department is negotiating fines and reimbursements with a number of other providers involved in this investigation.

C. 2009 Training

Frauds Bureau investigators participated in training seminars and continuing education courses during the year in order to keep current with trends and developments in fraud fighting.

Bureau investigators attended a workshop sponsored by the New York Regional Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in March. The subject of the workshop was Multiple Employer Welfare Arrangements (MEWAs). The presentation included an overview of collective bargaining and focused on how to identify unions and associations that are bogus. A legitimate MEWA is a vehicle for marketing health and welfare benefits to employers for their employees. MEWAs are designed to give small employers access to low-cost health coverage on terms similar to those available to large employers. EBSA has devoted significant resources to investigating and litigating issues connected with abusive MEWAs created by unscrupulous promoters who sell the promise of inexpensive health benefit insurance but default on their obligations. The Frauds Bureau continues to work with the Department of Labor to prosecute cases involving these types of crimes.

In October, investigators met with staff members of the pharmacy benefit manager for the Empire Plan, the primary health insurance plan for New York State employees, to learn about its operations and tour its facility. Inappropriate billing practices, prescription altering, dispensing expired or adulterated prescription drugs, and bait-and-switch pricing were among the topics discussed at the meeting. The company has compliance and ethics toll-free lines available around the clock to enable individuals, pharmacies and other providers to confidentially report any potential acts of fraud, waste or abuse on an anonymous basis.

In addition, the Bureau's Training Officer and other members of the investigative staff provided training for local police and fire units, prosecutors, insurers and community groups throughout the year. The Bureau provided training to 35 groups that included 1,597 participants during 2009, as detailed in the following table:

**Insurance Frauds Bureau
Training Program
Insurers, Law Enforcement and Community Groups
2009**

Date	Group	Location	Number of Attendees
01/29/09	New York State Insurance Fund	Albany, NY	25
02/05/09	Worcester Central School	Worcester, NY	15
02/11/09	Great American Insurance Company	New York, NY	14
02/24/09	National Insurance Crime Bureau	Melville, NY	68
03/06/09	Capital District Auto Crimes Task Force	Albany, NY	30
03/12/09	ING Insurance Company	Windsor, CT	19
03/16/09	New York State Fire Academy	Montour Falls, NY	30
03/30/09	NYPD Police Academy (Recruits)	New York, NY	250
03/31/09	Westchester County Police Academy (Recruits)	Valhalla, NY	14
04/01/09	Finger Lakes Insurance Claim Council	Chittenango, NY	30
04/14/09	American Assn. of Retired Persons	New York, NY	62
04/21/09	Office of Medicaid Fraud Inspector General	Albany, NY	25
05/13/09	AIG Insurance Company	Latham, NY	50
05/13/09	Public Employer Risk Management Assn.	Latham, NY	50
05/14/09	American Assn of Retired Persons	Staten Island, NY	65
05/15/09	American Assn of Retired Persons	Bronx, NY	53
05/20/09	National Assn of Insurance Commissioners (Interns)	New York, NY	2
06/08/09	NYS Office of Fire Prevention & Control	Montour Falls, NY	19
06/16/09	MVP Healthcare Insurance Company	Schenectady, NY	25
06/30/09	Greenwich Village Community Center	New York, NY	10
07/10/09	Lenox Hill Senior Center	New York, NY	25

07/13/09	Goddard Riverside Senior Center	New York, NY	75
07/29/09	Carter Burden Senior Center	New York, NY	65
08/03/09	Stein Senior Center	New York, NY	19
08/06/09	Caring Community Center	New York, NY	32
08/19/09	NYPD Auto Crime Division	Queens, NY	23
08/19/09	Hudson Senior Center	New York, NY	41
08/20/09	Swiss Re Insurance Company	Armonk, NY	45
08/26/09	Glen Cove Senior Center	Glen Cove, NY	65
09/28/09	NYS Office of Fire Prevention & Control	Montour Falls, NY	30
10/05/09	Westchester County Police Academy (Recruits)	Valhalla, NY	49
11/04/09	National Assn of Insurance Commissioners (Intern)	New York, NY	1
120/1/09	National Assn of Insurance Commissioners (Intern)	New York, NY	1
12/16/09	Jewish Assn for Services for the Aged	New York, NY	40
12/17/09	NYPD Police Academy (Recruits)	New York, NY	230
TOTALS	GROUPS 35	PARTICIPANTS	1,597

D. Insurance Frauds Bureau Offices

NEW YORK OFFICE

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BUFFALO OFFICE

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SYRACUSE OFFICE

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ONEONTA OFFICE

Homer Folks Facility
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