STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

January 15, 2000

To the Governor and the Legislature

Enclosed is the Eighteenth Annual Report of the Superintendent of Insurance on the operations of the Insurance Frauds Prevention Act and the activities of the Insurance Frauds Bureau of the Department of Insurance.

Respectfully submitted,

Neil D. Levin
Superintendent of Insurance

The 1999 Report to the Governor and the Legislature of the State of New York on the Operations of the Insurance Frauds Prevention Act (Article 4 of the Insurance Law)

Insurance Frauds Bureau
1999 Highlights

IFB chalked up a record 390 arrests in 1999. The number of criminal convictions, at 194, was almost double the previous year's total of 101.

The Bureau launched an electronic fraud reporting systems for insurers. Currently, about 25% of all reports are submitted electronically. The Bureau's goal is 100% by year-end 2000.

The Bureau approved 146 fraud prevention plans covering 420 insurers. Of these, 126 are up and running. The remaining 20 plans are required to be implemented within the first two months of 2000.

The Bureau expanded its program to increase communication and interchange with the staff of insurer Special Investigations Units. Our staff met with about 300 representatives from more than 100 insurance companies during the past year.

The Bureau issued its first Manual of Procedures in August. The Manual is designed to provide direction to Bureau staff in the performance of their day-to-day operations.

IFB sponsored two all-day fraud conferences during the year – one in May, the second in November. Representatives from the industry, law enforcement and Department staff discussed issues of mutual concern.

IFB went online in May with the launching of the Department's Frauds Resource Center. The Site provides a wealth of information for consumers, insurers and producers and is updated regularly.

IFB published a consumer brochure, "Welcome to the New York State Insurance Frauds Bureau," to acquaint the public with the operations of the Bureau and to enlist their help in the fight against insurance fraud.

IFB issued Circular Letter No. 26 on September 13 that replaced fraud reporting form IFB-1 with the more comprehensive and straightforward IFB-1 REV. 8/99.

IFB initiated an electronic case management system in June, designed to enhance the efficiency of investigators, while at the same time providing supervisors with an innovative and effective way to monitor investigator performance and case progress.

Table of Contents

I. Introduction

The Insurance Frauds Bureau (IFB) was established by an act of the Legislature in 1981 as a law enforcement agency within the New York State Insurance Department. Its primary mission is the detection, investigation and referral for prosecution of individuals and groups that commit insurance fraud. IFB staff consists of 32 investigators organized into eight specialized units: Arson, Automobile, Fraudulent Cards, General, Medical, No-Fault/Organized Fraud, Workers' Compensation and Upstate, each of which is headed by a Supervising Investigator. General oversight of the investigative staff is the responsibility of the Chief Investigator with the assistance of one Principal Investigator. The investigative staff are designated by the Superintendent as "peace officers" as defined in Section 2.10 of the New York State Criminal Procedure Law.

The Bureau also has a staff of three insurance examiners who work under the supervision of a Principal Examiner, and an Assistant Director of Research who reports to the Director and Deputy Director. In addition, six support staff members report to the Secretary to the Director. The Bureau is headquartered in New York City, with offices in Albany, Buffalo, Mineola, Oneonta, Rochester and Syracuse. A complete list of IFB staff by title and location appears in the Appendix.

II. Operational Overview

A. Administration

The Insurance Frauds Bureau has renewed its pledge for the Year 2000 to build a strong, cohesive team within the Bureau. To that end, we have established a Mentoring Program to encourage a spirit of cooperation and teamwork among the staff. Under the program, newly hired investigators are assigned to a specific investigator who acts as a mentoring supervisor. The mentor is an advisor to the new investigator, offering guidance and help during the learning process. When new investigators are assigned to one of the Bureau's specialized units, the mentor and a senior investigator provide hands-on direction. Our goal is a better trained, professional investigative team that will produce more quality investigations and higher arrest/prosecution rates.

Our teambuilding efforts also extend outside the Bureau and we have set a goal of meeting with every insurer, police department and prosecutor in the State during the coming year. We have developed a program to accomplish this objective. The Bureau held two day-long fraud conferences in 1999, each attended by about 250 members of insurer Special Investigations Units (SIUs), prosecutors and Department staff. These conferences focus on issues of mutual interest (*e.g.*, workers' compensation fraud, e-commerce, etc.) and will continue in 2000. In order for these conferences to meet the needs of insurers, we have added a feature to our Web site that allows insurers to offer suggestions for future conferences online and transmit those comments electronically to the Bureau.

Moreover, we have taken a number of additional steps to ensure that the important lines of communication between the Bureau and our customers remain open, including:

- Developing a series of training and education seminars for the industry to provide guidance on matters ranging from proper fraud reporting to the provisions of Regulation 95. During 1999, we conducted such seminars for all of CGU, State Farm and Atlantic Mutual.

- Participating in the Summer College for District Attorneys for the first time in 1999. The program is sponsored each year by the New York State District Attorneys Association to train prosecutors from across the State on innovative and effective techniques for investigating and prosecuting illicit activity. We are committed to being an active participant in this seminar every summer.

- Modernizing the Fraud Report Form to elicit more specific and accurate information. The enhanced information will help expedite the Frauds Bureau's review process and ensure a prompt investigation of each report.

- Creating a Triage Unit to screen all fraud reports so that those with the greatest potential for prosecution will be promptly assigned and an investigation will be initiated. The Triage supervisor will work closely with the industry to carry out a systematic education program on proper fraud reporting. Accurate and thorough reports will lead to prompt assignment, stronger cases and more successful prosecutions.

- Initiating a program of networking with district attorneys across the State. This program has begun to bear fruit as reflected in our year-end statistics. Counties such as the Bronx, New York, Richmond and Westchester, which were among the least productive counties in 1998 in terms of arrests, were among the most productive counties in 1999. Our persistent outreach has helped forge strong working relationships with the prosecutors in these counties, a benefit we intend to maintain and build upon. In addition, it is our intention to focus attention on some of the smaller upstate counties that have traditionally been overlooked in terms of fraud investigations. Investigators from our upstate offices will visit the prosecutors from these counties and make them aware of who we are, what we do and the many ways we can help them in their fight against insurance fraud.

- Conducting regular training sessions for law enforcement agencies, such as the New York City Police Department Auto Crime Division and the New York State Academy of Fire Science to enhance team effort in investigating insurance fraud. This program will be expanded to include many more police departments in the coming year.

Additional goals for 2000 include the following:

- ❖ Readjust resources in order to investigate and prosecute more medical fraud, including health care providers, laboratories and operators of medical mills;

- ❖ Begin the audit process for SIU compliance with the provisions of Regulation 95 and identify fraudulent acts more efficiently;

- ❖ Encourage better quality and more widespread fraud advertising;

- ❖ Evaluate insurer report information and produce the first in-depth analysis of the implementation of the Fraud Prevention Plans;

- ❖ Achieve 100% electronic fraud reporting by insurers by year end;

- ❖ Perfect a tickler system to enhance our new case tracking system;

- ❖ Create a TIPS program to encourage insider information;

- ❖ Increase staff in Rochester and Syracuse and expand facilities in Oneonta to better serve the residents in the central and western areas of upstate New York; and

B. Investigations

During 1999, the Frauds Bureau received 19,196 reports of suspected insurance fraud, down from 21,170 the previous year. Of these, 19,106 were received from licensees required to submit such reports to the Department and 90 from other sources such as consumers and anonymous tips. A total of 1,238 new investigations were opened during the year. At the same time, investigators continued work on cases pending from prior years.

These efforts led to the referral of 161 cases to prosecutorial agencies for criminal prosecution and 134 being civilly settled or referred to the Office of General Counsel for civil proceedings. Comparative multi-year statistics on fraud reports and investigations appear in the Appendix.

C. Arrests and Prosecutions

During 1999, the Insurance Frauds Bureau took part in investigations leading to the arrests of 390 individuals for insurance fraud and related crimes, outpacing last year's record of 371. This represents a 240% increase in arrests since the beginning of the Pataki Administration and reflects the strong support the Bureau has received from the Governor and the Legislature. This support has enabled us to increase our investigative staff, to create a No-Fault Unit and to strengthen our collaboration with the industry, with law enforcement and with prosecutors. In addition, we have expanded our education program for the staff of insurer Special Investigations Units to promote more thorough and accurate reporting of suspected fraud. During 1999, prosecutors obtained 194 criminal convictions and 166 individuals were sentenced in connection with IFB cases.

IFB activities resulted in stiff fines levied against 78 individuals who were sentenced to more than $4.1 million in court-ordered restitution. In 25 cases, individuals made voluntary restitution to insurance companies totaling an additional $317,417. In 52 instances, insurers were able to achieve savings totaling more than $2 million with respect to fraudulent claims under investigation by IFB.

- **No-Fault Unit**

In 1999, the Frauds Bureau established a No-Fault Unit to focus on the mounting problem of fraudulent medical claims submitted under no-fault automobile insurance coverage. The Bureau has seen reports of suspected fraudulent no-fault insurance claims increase by 218% since 1994. Nearly half (48%) of the 19,196 reports of suspected insurance fraud received by the Bureau in 1999 involved no-fault auto insurance.

Many of these reports involve organized fraud rings that operate "medical mills." These sophisticated conspiracies involve lawyers who coach clients on how to exaggerate medical conditions to provide ammunition for a lawsuit, as well as unethical doctors, physical therapists and suppliers of durable medical equipment who help document those claims with unnecessary treatment or with bills for treatment never performed. Such schemes are widespread and are among the most costly forms of insurance fraud, inflating auto insurance premiums in New York State. A single ring can cost the insurance system millions of dollars a year.

Investigations of these cases are complex and lengthy, and require a high degree of teamwork and cooperation among IFB staff, insurers, law enforcement agencies and district attorneys. In one such case, the Bureau worked with the Brooklyn District Attorney's Office to close a network of six medical mills involved in a scheme that defrauded 12 major insurance carriers of more than $5 million. In June, a 104-count indictment charged that the defendants made payoffs to "steerers" who brought individuals purportedly involved in automobile accidents to the medical mills as patients; fraudulently billed insurers for unnecessary and/or unperformed medical visits, procedures and physical therapy under the patients' no-fault auto insurance; fraudulently billed insurers for durable medical equipment using forged doctors' prescriptions; and fraudulently billed for tests such as CAT scans and MRIs based on forged and false medical reports.

Four defendants in this case subsequently pled guilty in satisfaction of the charges. However, Progressive, Allstate, GEICO and Travelers Insurance Companies have initiated a $15 million RICO (Racketeering Influenced Corrupt Organization) lawsuit against these defendants.

- **Workers' Compensation**

As part of historic reform legislation signed into law by Governor Pataki in 1996, the Frauds Bureau established a Workers' Compensation Unit which began operations in February 1997. The Unit scrutinizes every report of suspected workers' compensation fraud received from every source – the industry, the public and anonymous tips. The Unit works closely with the New York State Workers' Compensation Inspector General and his investigative staff to coordinate efforts.

In April, as a result of a joint investigation by the Insurance Frauds Bureau, the Queens District Attorney's Office, the Workers' Compensation Inspector General and the State Insurance Fund, 20 individuals were arrested on charges of bilking the State Insurance Fund and various commercial insurers of more than $300,000 in workers' compensation benefits.

The charges included falsely claiming disability, cashing benefit checks issued to deceased relatives and other fraudulent schemes. One of the largest thefts involved a woman accused of stealing over $75,000 from an insurer. She claimed on-the-job injuries in 1992 and over a five-year period collected benefits while working as a cleaning woman.

1999 Major Cases

The Frauds Bureau investigated several additional major cases during 1999 with successful results. The following are prime examples:

- **Frauds Sweep Nets 10 Arrests**
  In July, 10 New York residents were arrested on various charges of workers' compensation fraud following a sweep in western and central New York State. Those arrested included a county dog catcher, health care workers, laborers, and a sitting Town Justice. Collectively, they allegedly received a total of $138,704 in workers' compensation benefits with the potential to defraud the workers' compensation system of an additional $700,000. The arrests were the result of a joint investigation conducted by the Insurance Frauds Bureau, the Workers' Compensation Inspector General, and the State Insurance Fund.

- **Investigation Smashes Jetski Distribution Network**
  The Bureau worked with the Queens District Attorney's Office, the New York City Police Department Harbor Unit and a number of other law enforcement agencies to crack an illegal jetski distribution network. The case involved an intricate scheme to steal or obtain by insurance fraud jetskis and jetboats from the New York Metropolitan Area for resale in Puerto Rico. The case ended in December with the indictment of 55 individuals on charges of criminal enterprise, insurance fraud and other crimes. Those indicted include the owners of a lucrative jetski dealership in New York and the owners of a similar dealership in Puerto Rico. In a typical scenario, manufacturers sold the jetskis at a boat show in January, with no down payment required and no other payment due until September. The manufacturers also frequently helped arrange financing and insurance. In the fall, the owners of the New York dealership which sold the jetskis recruited people willing to claim that their jetskis had been stolen. The jetski owners benefited because it spared them the expense of storing the skis over the winter, gave them the money from their insurance policy to pay off the loan and they received a "fee" from the dealership as well. The dealership benefited because it is believed that many of these same people would purchase new jetskis the following year.

In addition, IFB staff participated in many other investigations during the year, involving various forms of insurance fraud. The following list provides a fine cross section of the types of cases investigated and prosecuted in 1999:

Workers' Compensation Insurance

- **Daughter Steals Mother's Workers' Compensation Checks**
  An investigation conducted jointly with the Frauds Bureau and the State Insurance Fund revealed that for a period of 11 years a Cheektowaga woman cashed workers' compensation checks payable to her deceased mother. During that time, she fraudulently collected more

than $70,500. The defendant was arrested and pled guilty to grand larceny in the fourth degree.

- **Long Island Man Collects Benefits While Employed**
  A Hempstead man was arrested on two counts of first degree perjury, both class D felonies, and one count of attempted grand larceny in the third degree, a class E felony. It is alleged that he made a false injury claim while working for Corda Industries of Roosevelt, Long Island. While receiving benefits, he appeared before the Workers' Compensation Board walking with a cane and lied to the Board on two separate occasions that he had not returned to work. However, he was videotaped unloading boxes from trucks, working in a variety store, walking, bending, climbing a ladder and stacking shelves, all without the use of a cane.

- **State Worker Pleads Guilty to Illegal Workers' Compensation Benefits**
  A Yonkers man employed by the New York State Office of Court Administration was arrested on charges that following his father's death in 1980 until June 1996, he cashed workers' compensation benefit checks meant for his father. The checks, issued by the State Insurance Fund, totaled more than $67,000. The defendant pled guilty to a misdemeanor and was sentenced to restitution.

- **Downstate Investigations Lead to Two Arrests**
  Two men were arrested on charges of workers' compensation fraud in separate cases in Brooklyn. One had collected more than $4,000 in benefits but was captured on videotape in the employ of an iron works company. The other was videotaped in gainful employment as a plumber, while collecting over $8,000 in benefits. Each was charged with three counts of a Class D felony and two counts of a Class A misdemeanor. The maximum penalty for a Class D felony is seven years in prison. A Class A misdemeanor carries a maximum penalty of one year.

- **Seven Arrested in Upstate Mini-Sweep**
  Seven individuals were arrested for their participation in crimes involving workers' compensation fraud. The arrests were the result of a joint investigation by the Frauds Bureau, the Workers' Compensation Inspector General's Office, the State Insurance Fund and prosecutors in a number of upstate counties. Those arrested were charged with fraudulently receiving more than $60,000 in workers' compensation benefits, with the potential to defraud the workers' compensation system of an additional $173,000.

Health Insurance

- **Physician's Assistant Files Bogus Medical Claims**
  A Manhattan physician's assistant was arrested and charged with submitting $22,000 in fraudulent medical claims to two insurance companies from 1993 to 1997. He received approximately $16,000 in benefits for treatments he either received once but not on any of the dates indicated on the claims or he did not receive at all. The defendant was sentenced to a discharge, conditioned on his making restitution to the two insurers.

- **Queens Woman Submits Fraudulent Pharmacy Receipts**
  A Queens woman was arrested for submitting claims to her insurer that included fraudulent pharmacy receipts totaling $15,000 for which she was reimbursed approximately $13,000. The defendant managed to obtain receipt pads from three different pharmacies and between December 1996 and February 1998, she generated the phony receipts. She subsequently pled guilty to petty larceny, a Class A misdemeanor, and was sentenced to three years probation and restitution to the insurer.

- **False Information Submitted on Health Insurance Applications**
  After allegedly falsifying information on health insurance applications at three different employers between 1993 and 1996, an upstate resident was arrested and charged with two counts of falsifying business records in the first degree, grand larceny in the third and fourth degree and petty larceny. The defendant received $7,900 to which he was not entitled by claiming in each case that his girlfriend and her child were his wife and daughter for coverage on a family policy. The investigation was conducted by the Frauds Bureau in conjunction with the New York State Police and the health insurer involved.

Automobile Insurance

- **Car Hidden, Then Reported Stolen**
  After reporting his car stolen, a Syracuse man filed a claim with his insurance company for $5,055. A Frauds Bureau investigation conducted with the Syracuse Police Department and the insurer involved in the case disclosed that the man allegedly hid the car in a garage on his property. He was charged with insurance fraud in the third degree.

- **Long Island Man Arrested for Double Dipping**
  When his car was stolen from an auto repair shop, a resident of Great Neck allegedly pressured the owners of the shop to pay him more that $30,000 by claiming that he had no insurance coverage. A Frauds Bureau investigation revealed that the defendant did have insurance and that he also collected $29,120 from his insurance carrier. He was charged with grand larceny in the third degree, insurance fraud in the third degree, falsifying business records in the first degree and two counts of coercion.

- **Two Charged with Issuing Fraudulent Insurance Identification Cards**
  An undercover investigation by the Frauds Bureau resulted in the arrests of two Brooklyn men for allegedly issuing fraudulent auto insurance identification cards. Each was charged with forgery in the second degree, criminal possession of a forged instrument and criminal possession of a controlled substance. A search warrant was issued after an undercover Frauds Bureau investigator purchased an insurance identification card, a set of license plates, vehicle registration and a 10-day sticker from the men at their private residence. The investigation revealed that the identification card was phony. The charges carry a penalty of up to 10 years.

- **"Stolen" Car Found Abandoned**
  The joint efforts of the Frauds Bureau and the NYPD Auto Crime Division brought about the arrest of a Queens resident charged with insurance fraud in the third degree, attempted grand

larceny in the third degree and offering a false written instrument for filing in the first degree. The defendant reported his car stolen from a shopping center parking lot and attempted to collect nearly $8,000 from his insurance company. The investigation subsequently revealed that he had abandoned the car which was later recovered by the Sanitation Department.

- **Abandoned Car Reported Stolen**
  The combined efforts of the Frauds Bureau and the NYPD Auto Larceny Unit led to the arrest of a Nassau County man on charges of insurance fraud in the third degree. The defendant reported his car stolen from a parking lot in Queens and attempted to collect $35,000 from his insurance company. However, the investigation revealed that he had allegedly abandoned the car a week earlier. The car was subsequently recovered in Brooklyn by the Sanitation Department.

- **Man Involved in "Chop Shop" Scheme**
  An investigation by the Frauds Bureau and the NYPD Auto Crime Division revealed that a Brooklyn man delivered his car to a chop shop and then fraudulently reported it stolen. He filed a claim with his insurer and collected $15,000. The defendant was arrested and charged with three counts of insurance fraud.

- **Insurance Broker Issues Phony Insurance ID Card**
  While acting as a broker, a Long Island man issued an automobile insurance identification card that stated his client had a valid policy. The broker took more than $2,400 in premium money for coverage on the client's car. However, an investigation revealed that the broker never placed the policy with the insurer. The investigation was initiated by a complaint from another insurer in connection with similar allegations. The arrest was the result of the joint efforts of the Frauds Bureau and the Suffolk County District Attorney's Office.

Life Insurance

- **Fraudulent Claim Reports Death of Nonexistent Brother**
  A joint investigation conducted by the Frauds Bureau and two life insurers resulted in the arrest of a Brooklyn man charged with attempted insurance fraud in the second degree and attempted grand larceny in the second degree. Within months after purchasing insurance policies on the life of his "brother" with two separate insurers, he submitted death benefit claims in the amounts of $1 million and $500,000, claiming his brother had died when a cruise ship sank off the coast of Haiti. The investigation revealed that not only was there no cruise ship that sank as alleged, but the defendant never had a brother.

- **Fraudulent Death Benefit Claim Filed**
  A Yonkers resident was arrested and charged with insurance fraud in the second degree for allegedly submitting a false death benefit claim in the amount of $500,000, contending that her uncle had died in the Dominican Republic. The defendant was named as beneficiary on the policy. An investigation conducted by the Frauds Bureau revealed that the uncle was alive and well and living in New York.

- **Insurance Company Employee Arrested**
  While employed as an insurance agent with a life insurer, a Buffalo resident received more than $100,000 from a client for an IRA account. However, he allegedly deposited the money into his personal account. He was arrested and charged with two counts of grand larceny in the fourth degree. The arrest was the result of an investigation conducted jointly by the Frauds Bureau, the West Seneca Police Department and the life insurer involved.

- **Upstate Man Creates 10 Phony Insurance Policies**
  Based on information provided by an insurance company, the Frauds Bureau conducted an investigation that led to the arrest of a man employed as a sales manager for that insurer. He was charged with creating 10 phony life insurance policies and collecting commissions to which he was not entitled.

Miscellaneous Insurance

- **Fraudulent Claims Involve Credit Card Purchases**
  A Brooklyn man was arrested on charges of insurance fraud in the fourth and fifth degree and scheme to defraud in the first and second degree. A joint undercover investigation by the Frauds Bureau and the Brooklyn District Attorney's Office disclosed that the defendant allegedly submitted fraudulent claims to his insurance company. The claims purported that on a number of occasions after making credit card purchases, the defendant was robbed on the street. Each claim was for $1,000 and he was paid a total of about $11,500. The defendant subsequently turned himself in to the District Attorney's Office and made full restitution to his insurer. These charges carry a penalty of up to 10 years in prison.

- **Insurance Fraud Crackdown Nets 16**
  A Westchester County sweep resulted in the arrests of 16 individuals on various charges of insurance fraud. The cases involve those who collected workers' compensation and disability benefits to which they were not entitled, a broker who failed to forward premiums to the appropriate insurer and others who submitted enhanced repair bills for insured property. The insurers involved paid out nearly $125,000 as a result of these fraudulent activities. Fifteen of the defendants face a maximum of seven years in prison if convicted; the sixteenth a maximum of four years.

- **Brooklyn Man Falsely Reports Motorcycle Stolen**
  Four months after leaving his motorcycle at a repair shop, a Brooklyn man reported to the New York City Police Department that it had been stolen. He subsequently filed a claim with his insurance company and collected over $12,000 in benefits. A joint investigation by the Frauds Bureau and the NYPD Auto Crime Division produced the arrest.

- **Insurance Company Employee Arrested for Grand Larceny**
  While employed as a collections manager, an insurance company employee was arrested on charges of grand larceny in the third degree. The defendant collected $20,000 in premiums from a management company for workers' compensation and commercial multi-peril insurance which he subsequently diverted to his own personal use. In addition, he negotiated with the management company for a reduced premium of $20,000, instead of the $27,000

which was due to the insurer. The arrest was the result of a joint effort by the Frauds Bureau, the Manhattan District Attorney's Office and the insurance company.

D. Cooperative Enforcement Efforts

1) The Western District of New York Health Care Task Force is composed of federal, state, and local law enforcement agencies including IFB. Its focus is fraudulent medical claims submitted to private insurance carriers, Medicare, and Medicaid. These fraudulent claims can be submitted by medical providers as well as by individuals.

During 1999, the Task Force completed its investigation of two doctors who pled guilty to health care fraud and saw its investigation of a local dentist culminate in a 157-count indictment on various charges of insurance fraud, including performing unnecessary dental work, billing a patient's new insurance plan for work paid for by a previous plan and getting patients to sign claim forms that did not state the services provided. In addition, an investigation into the activities of an organized émigré group initiated several years ago continued, resulting in one member of the group entering a guilty plea to filing a fraudulent claim.

2) The Frauds Bureau is an active participant in the Capital District Health Care Fraud Working Group in Albany. The group is composed of a number of federal and state agencies (*e.g.*, the U.S. Attorney's Office, the U.S. Department of Health and Human Services, the U.S. Department of Labor, the New York State Office of Professional Medical Conduct, Medicaid Fraud), as well as health insurer SIU staff from the eastern part of upstate New York.

The Northern District of New York Health Care Investigators' Group in Syracuse includes staff from the Frauds Bureau, the U.S. Attorney's Office of the Northern District of New York , the FBI, the U.S. Department of Health and Human Services, the U.S. Department of Labor, Medicaid Fraud and SIU members from health insurance companies throughout central New York.

Both groups meet quarterly to discuss general and specific fraud issues in the health insurance industry. Instances of suspected fraud are presented to the group and methods of investigation are discussed. Prosecutors discuss the elements of evidence necessary to successfully prosecute a case and information is exchanged to aid in determining trends and patterns in insurance fraud.

3) The Frauds Bureau has been a member of the Oneida County Arson Task Force/Strike Force since its inception more than three years ago. Scarce resources have limited the Frauds Bureau's role to that of providing assistance on a case-by-case basis. It should be noted that the vast majority of arson cases being investigated by the Strike Force are not arson for profit, but are more commonly generated by motives of revenge or vandalism. The Bureau has made itself readily available to assist in any way possible.

E. Civil Enforcement Program

In 1992, the Legislature enacted Section 403 of the Insurance Law which authorized the Insurance Department to impose civil penalties of up to $5,000 plus the amount of the claim on individuals who commit fraudulent insurance acts. In addition, Section 2133 of the Insurance Law permits a fine of up to $1,000 for possession of a fraudulent automobile insurance identification card and up to $5,000 for each additional card possessed. These civil penalties give the IFB the authority to impose sanctions in cases where the monetary value is not sufficient to justify criminal prosecution, or in which the extremely high burden of proof required in criminal cases cannot be met.

In 1998, a total of $313,398 in civil fines was imposed in 71 cases and $93,904 in penalties was collected. In 1999, civil fines imposed amounted to $304,011 in 78 cases, with $230,097 collected. One of the Bureau's goals for 2000 is finding a more effective system for collecting civil fines. We have been working with the Department's Office of General Counsel toward that end.

F. Fraud Prevention Plan Implementation/Public Awareness

The Bureau met a major challenge in 1999 with the review and approval of all Fraud Prevention Plans – 146 plans covering 420 companies. We conducted an extensive outreach program for insurers to provide guidance in preparing their plans. Bureau staff met with about 300 representatives from more than 100 insurance companies and fielded thousands of telephone calls requesting information and assistance.

Moreover, at the persistent encouragement of the Bureau, January 2000 will mark the kick-off of several major public awareness programs aimed at educating New York residents about the existence of insurance fraud as a crime and its costs to all of us. The National Health Care Anti-Fraud Association has put together a program for many health insurance companies licensed in New York. The NHCAA will concentrate resources on newspaper ads.

A second program is being launched by the New York Alliance Against Insurance Fraud, a group of property insurers, and will be directed toward radio advertising. Insurers that participate in these two programs are assessed for the cost based on their premium volume in New York State.

In addition, State Farm Insurance will place ads in several newspapers and outdoor bulletins will be placed in several locations, and Allstate Insurance plans television advertising. With these four major programs, the message will reach all areas of the State.

The Bureau plans to foster expansion of this public awareness campaign among insurers, with more frequent and more diverse fraud notices.

G. Circular Letters

On September 13, 1999, the Department issued Circular Letter No. 26 announcing the replacement of the Fraud Reporting Form. The new form is designed to elicit more specific information about suspected insurance fraud. The enhanced information will help expedite the Frauds Bureau's review process and ensure prompt investigation of each report.

On November 1, 1999, the Department issued Circular Letter No. 27 to advise insurers that legislation enacted by Governor Pataki made significant changes to the Penal Law and Public Health Law, strengthening efforts to combat health insurance fraud. The law also added a new subdivision to the Penal Law to define a fraudulent health care insurance act. Circular Letter No. 27 provides guidance to insurers and health maintenance organizations as to how these new provisions in the law should be understood and utilized.

Copies of both Circular Letters appear in the Appendix.

H. Uninsured and Underinsured Motorists

The Frauds Bureau has taken a number of steps to detect and curtail the incidence of operating a motor vehicle without proper insurance coverage:

- Established a Fraudulent Identification Card Unit in 1998. The Unit includes several undercover investigators and is the busiest in the Bureau. Investigations by this Unit led to 81 arrests in 1999. In one case, a notorious location in the Bronx was targeted by an undercover investigator. The investigator, after purchasing bogus cards, obtained a search warrant and recovered numerous fraudulent cards. The entire operation was shut down, thus reducing the number of uninsured and underinsured motorists on the road.

- The Unit was given the additional responsibility of providing instruction at police academies and to the staff of street crime units. The Bureau trains these officers to identify fraudulent identification cards at traffic stops.

- The Bureau worked with the insurance industry to identify commercial clients without proper insurance coverage, including rate evaders. These are usually livery vehicles operating within New York City but registered outside city limits.

- The Bureau redesigned the Fraud Report Form to include the vehicle identification number and license plate information which enables the Triage Unit to quickly assign cases to the proper investigative unit. It also allows Bureau staff to track bogus vehicles by registrants' names and addresses. In addition, the Bureau coordinated with the Department of Motor Vehicles a method that allows DMV to take appropriate action against registrants without proper insurance coverage.

- Together with other law enforcement agencies and insurers, the Frauds Bureau participates in and supports DMV's efforts to reduce the number of uninsured and underinsured drivers. The Bureau is a member of the Insurance Information and

Enforcement System Committee to design and implement a bar code system for insurance identification cards. Such bar-coded cards will provide specific information, *e.g.*, profile of the owner, address, insurance company, type of vehicle and vehicle identification number. Such a system is difficult to compromise.

- The Bureau worked with industry to maintain strict compliance with identification card inventories.

- We participated in discussions with the Automobile Insurance Plan (the Assigned Risk Plan) to identify and prevent fraudulent practices by brokers.

I. Director's Award

The Director's Award is presented every year to an individual or group that consistently stands out in the fight against insurance fraud. Two Awards were presented in 1999. Sergeant James Hand of the New York City Police Department, Deputy Commissioner – Operations, received the Award for his outstanding efforts in combating the problem of fraudulent auto insurance identification cards. Sgt. Hand, as a member of the NYPD computer management section, worked directly with the Frauds Bureau and provided invaluable assistance in several of our fraudulent card investigations. A second Award was presented to a team of police officers from the New York City Police Department Auto Crime Division. Lt. Michael Byrne, Sgt. William McCann, and Detectives Robert Magrino, Richard Smith, Chris Hesse, Joseph Clark, John Stiastny and Michael Beatty initiated a major investigation that led to the arrest of five individuals for insurance fraud. Their investigation uncovered an auto repair shop dealing in stolen cars and enhanced damages. All illegal activity has been stopped. The business is still in operation but at a significantly reduced capacity, pending the outcome of the owner's trial. The Frauds Bureau was pleased to present the Awards to these dedicated members of the New York City Police Department whose ability and cooperation are in the finest tradition of law enforcement.

III. Directions for 2000

A. Medical Insurance Fraud

The Frauds Bureau plans to develop more medical insurance fraud cases in the upcoming year, using a three-pronged approach:

1) Conduct more undercover operations. This program is already underway and has proven successful.
2) The supervisor of our new Triage Unit will work closely with insurers to develop cases of this kind. Insurer audits of medical providers and suppliers of durable medical equipment can be used to build strong cases.
3) Eventually shift investigators from the Fraudulent Auto Identification Card Unit to the Medical and No-Fault Auto Units. This shift would be entirely feasible when a new program at the Department of Motor Vehicles'(DMV) becomes operational. Under the new program, insurers would transmit insurance information electronically to DMV

where it would be stored in a database, thus eliminating the need for insurance identification cards.

B. Fraud Prevention Plan Audits

A significant challenge for 2000 will be auditing the 146 Fraud Prevention Plans to ensure compliance with the provisions of Regulation 95. Bureau staff will conduct on-site audits to monitor insurers' compliance with the provisions of the Regulation. Staff will also audit outside contractors not licensed by the Department. The audits will include a review of all major segments of the fraud plans, such as a random review of closed claims, a review of fraud detection and procedures manuals, and an examination of in-service training programs for investigative, underwriting and claims staff for identification and evaluation of suspected fraud.

For those insurers that are relatively small, we estimate that each audit would be completed in a week. For larger insurers and those with multiple sites (which may be located throughout New York State and in some cases outside the State), staff may combine efforts to complete the audits. We expect the initial audits to be completed within three years. Each plan will be audited triennially thereafter.

Initially the audits will provide guidance to insurers in developing and implementing plans that will carry out the mandate of the legislation. Going forward, the audits will ensure that any deficiencies within the plans will be promptly addressed and remedied, thus rendering the plans stronger and more effective.

In addition, the audit function would send a strong message to the insurance industry that mere submission of a Fraud Prevention Plan is not sufficient, that in addition, the requirements as specified in Regulation 95 must also be properly carried out. We believe it is necessary for the Frauds Bureau to manifest a forceful and meaningful presence in this process. If we are to be successful in detecting, investigating and ultimately preventing insurance fraud, we must ensure that the provisions of the plans are fulfilled, that the insurers' Special Investigations Units are established and staffed in compliance with the specifications of the law and that such staff perform the activities prescribed in the Regulation. On-site audits are essential if we are to achieve this goal.

The Second Amendment to Regulation 95 also requires insurers to submit to the Department by January 15 each year a report describing the companies' experience, performance and cost effectiveness in implementing their fraud plans. The reports must also include the companies' proposals for modifications to the plans to amend operations, to improve performance or to remedy observed deficiencies. These data must be evaluated by the Frauds Bureau and a report prepared and submitted to the Governor and the Legislature.

C. TIPS Program

During 1999, the Bureau conducted extensive research into the feasibility of an arrangement to offer a reward of $1,000 for information leading to the arrest and conviction of anyone committing insurance fraud. Such a TIPS program would encourage insider information which can produce strong evidence about illegal activities and the players involved.

Establishment of a TIPS program would require legislation and we have requested such legislation.

IV. Legislation

The Frauds Bureau requests and/or supports the following legislative changes:

- Modifying the reporting date for Annual Frauds Report (Section 405 of the Insurance Law) from January 15 to March 15 of each year;

- Modifying the reporting date for the Special Investigations Units annual report (Section 409 of the Insurance Law) from January 15 to February 15 of each year;

- Creating an Audit Unit within the Frauds Bureau to conduct on-site audits of insurer Fraud Prevention Plans to ensure compliance with Regulation 95;

- Establishing minimum standards for the public awareness programs that insurers are required to develop under the provisions of Regulation 95;

- Establishing a TIPS program;

- Creating a class E felony for unlicensed activity by certain previously licensed individuals and entities that are no longer licensed at the time of the violation;

- Subjecting unlicensed activity to civil penalties after notice and hearing before the Insurance Department;

- Providing for automatic revocation of licenses under Article 21 of the Insurance Law for conviction of the licensee for felony larceny or felony insurance fraud;

- Requiring that life insurance policy applications include a permanent record of identification of the insured;

- Extending immunity to persons who provide assistance to the Insurance Frauds Bureau in connection with its investigations or in connection with investigations conducted jointly by the Bureau and other law enforcement agencies;

- Facilitating the collection of fraud data by providing that the Insurance Frauds Bureau shall act as the collection resource for such data;

- Increasing civil penalties for knowing possession, transfer or use of fraudulent insurance documents;

- Defining a new series of crimes relating to insurance fraud that involve false entries upon the books of account of insurers or in reports or documents submitted to regulatory officials or embezzlement from insurers, and also of new crimes involving threats or force or the use of

threatening letters or communications to corruptly influence, obstruct or impede the proper administration of the Insurance Law;

- Prohibiting the participation of individuals in the insurance business who have been convicted of felonies involving dishonesty, breach of trust or other violations of Article 176 of the Penal Law unless such persons first obtain the written consent of the Superintendent of Insurance for such activities;

- Including the Superintendent of Insurance as a member *ex officio* of the Motor Vehicle Theft and Insurance Fraud Prevention Board and permit state agencies to be eligible for grants from the fund administered by such Board;

- Amending Section 2111 of the Insurance Law to prohibit a revoked licensee from becoming employed in any capacity by an entity subject to the provisions of Article 21 without the prior written approval of the Superintendent;

- Requiring a periodic certification of continued eligibility by recipients of workers' compensation or disability benefits;

- Increasing penalties in the Vehicle and Traffic Law to reduce the number of uninsured or unlicensed motorists driving in New York State;

- Requiring no-fault and workers' compensation insurers to provide explanations of benefits in response to claims filed for health care services under those programs; and

- Upgrading the status of Insurance Frauds Bureau investigators from peace officers to police officers, enabling them to act independently in the execution of such tasks as search and arrest warrants, court orders relating to surveillance and summary arrests.

V. Appendices

Comparative Statistics

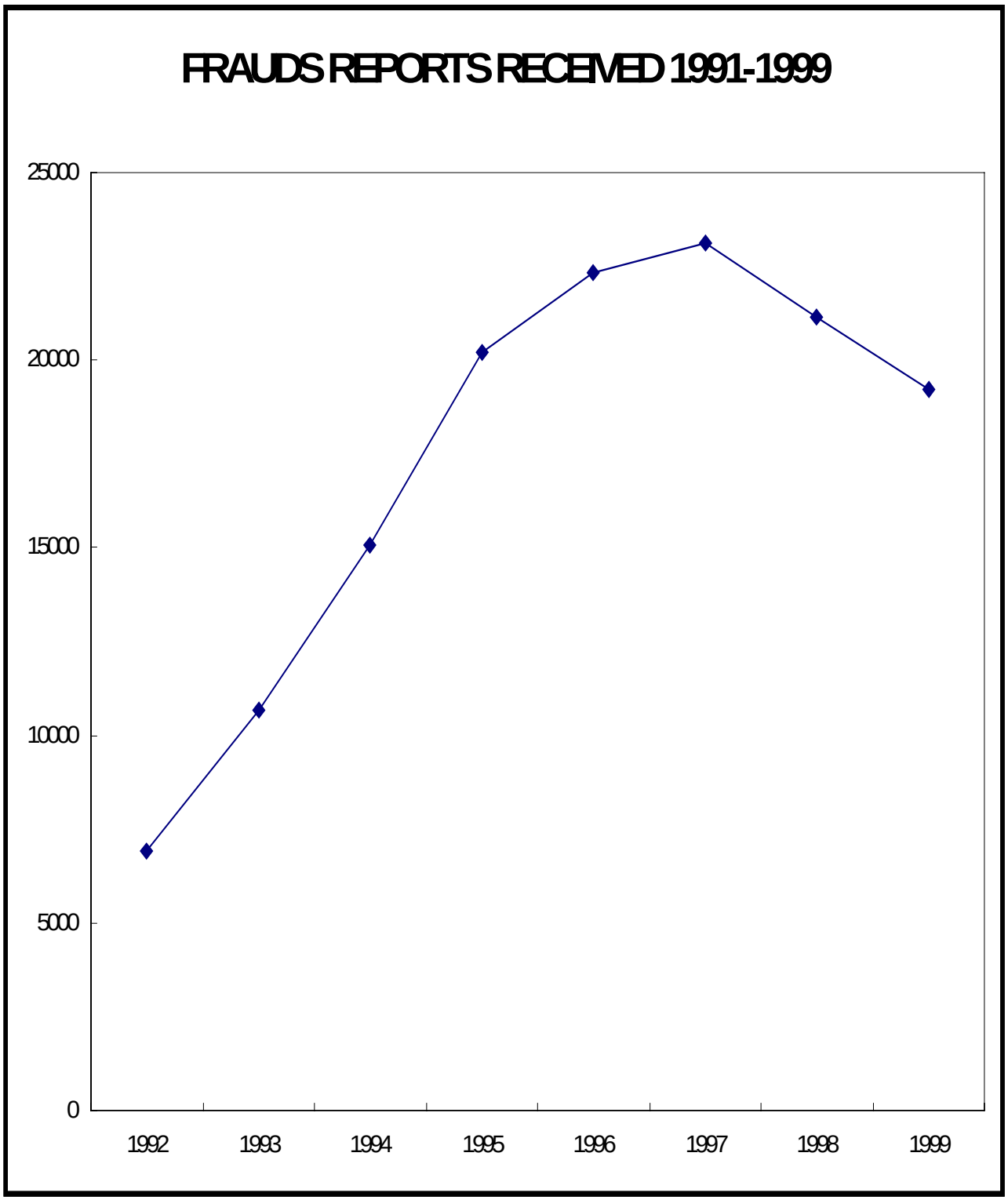
FRAUDS REPORTS RECEIVED, BY TYPE

	1994	1995	1996	1997	1998	1999
Auto Theft	1,892	2,373	2,646	2,674	2,234	2,015
Auto Fire	146	165	268	253	262	310
Theft From Auto	222	341	165	130	119	119
Auto Vandalism	200	252	447	427	281	236
Auto Collision Damage	1,708	2,078	2,134	2,025	1,517	1,097
Auto Fraudulent Bills	49	177	43	55	45	28
Auto I. D. Cards	771	648	273	402	308	253
Auto Misc.	421	933	1,080	693	526	433
Fire - Residential	171	211	164	170	150	126
Fire - Commercial	64	52	67	49	57	58
Burglary - Residential	436	310	434	272	452	453
Burglary - Commercial	66	97	88	59	115	62
Homeowners	469	928	779	808	620	340
Larceny	180	103	206	304	67	34
Lost Property	58	28	21	45	59	77

FRAUDS REPORTS RECEIVED, BY TYPE (Continued)

	1994	1995	1996	1997	1998	1999
Robbery	34	14	26	3	11	16
Bonds	8	5	11	18	9	2
Life Insurance	36	27	32	68	66	95
Disability Insurance	168	41	173	91	70	102
Workers' Compensation	585	851	758	698	661	798
Health Accident Insurance	3,854	4,712	5,841	5,457	2,637	2,359
No-Fault Auto Insurance	2,891	4,393	5,214	7,042	9,659	9,191
Ocean Marine Insurance	30	35	19	49	38	24
Reinsurance	0	0	1	0	0	0
Appraisers/Adjusters	27	8	11	27	6	10
Agents	56	65	50	63	49	50
Brokers	65	74	50	55	75	87
Ins. Company Employees	4	2	3	14	7	6
Insurance Companies	2	0	9	8	2	2
Miscellaneous	457	549	413	520	358	242
Unassigned	N/A	733	917	634	710	571
Totals	15,070	20,205	22,343	23,113	21,170	19,196

N/A – not applicable

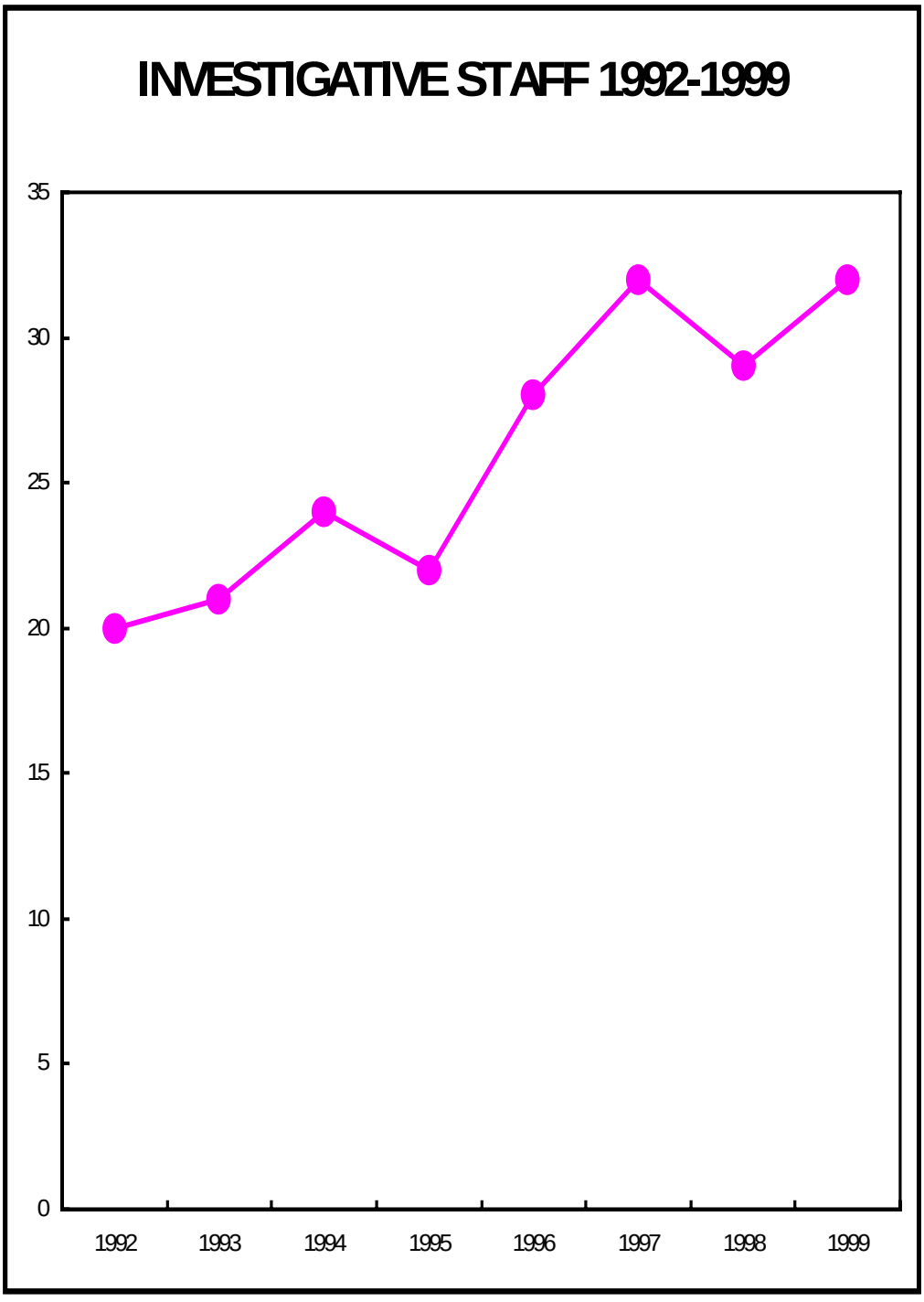

FRAUDS REPORTS RECEIVED 1991-1999
25000
20000
15000
10000
5000
0
1992
1993
1994
1995
1996
1997
1998
1999

IFB INVESTIGATIONS OPENED, BY TYPE

	1994	1995	1996	1997	1998	1999
Auto Theft	140	111	112	98	77	79
Auto Fire	14	13	12	10	12	12
Theft From Auto	18	7	9	5	12	7
Auto Vandalism	7	5	26	25	3	10
Auto Collision Damage	26	38	101	96	46	35
Auto Fraudulent Bills	7	25	9	5	4	5
Auto I.D. Cards	357	349	248	336	218	160
Auto Misc.	39	308	318	24	76	23
Fire - Residential	30	28	48	53	33	15
Fire - Commercial	21	10	30	17	15	16
Burglary - Residential	42	32	25	34	15	17
Burglary - Commercial	11	11	15	12	9	3
Homeowners	23	27	48	46	27	29
Larceny	9	7	21	22	8	6
Lost Property	2	1	1	4	5	0
Robbery	2	2	4	0	1	2
Bonds	8	4	9	11	8	0

IFB INVESTIGATIONS OPENED, BY TYPE (Continued)

	1994	1995	1996	1997	1998	1999
Life Insurance	12	6	10	11	13	17
Disability Ins.	8	12	28	41	14	18
Workers' Compensation	56	66	105	408	415	527
Health Accident Insurance	364	190	462	161	97	65
No-Fault Auto Insurance	89	82	195	295	132	127
Ocean Marine Insurance	4	4	0	9	0	5
Reinsurance	0	0	0	0	0	0
Appraisers/Adjusters	14	4	8	18	3	2
Agents	32	30	30	26	26	18
Brokers	33	33	22	19	17	9
Ins. Company Employees	4	2	2	8	3	3
Insurance Companies	2	0	8	2	0	0
Miscellaneous	58	31	28	37	28	28
Totals	1,431	1,438	1,934	1,833	1,317	1,238


INVESTIGATIVE STAFF 1992-1999
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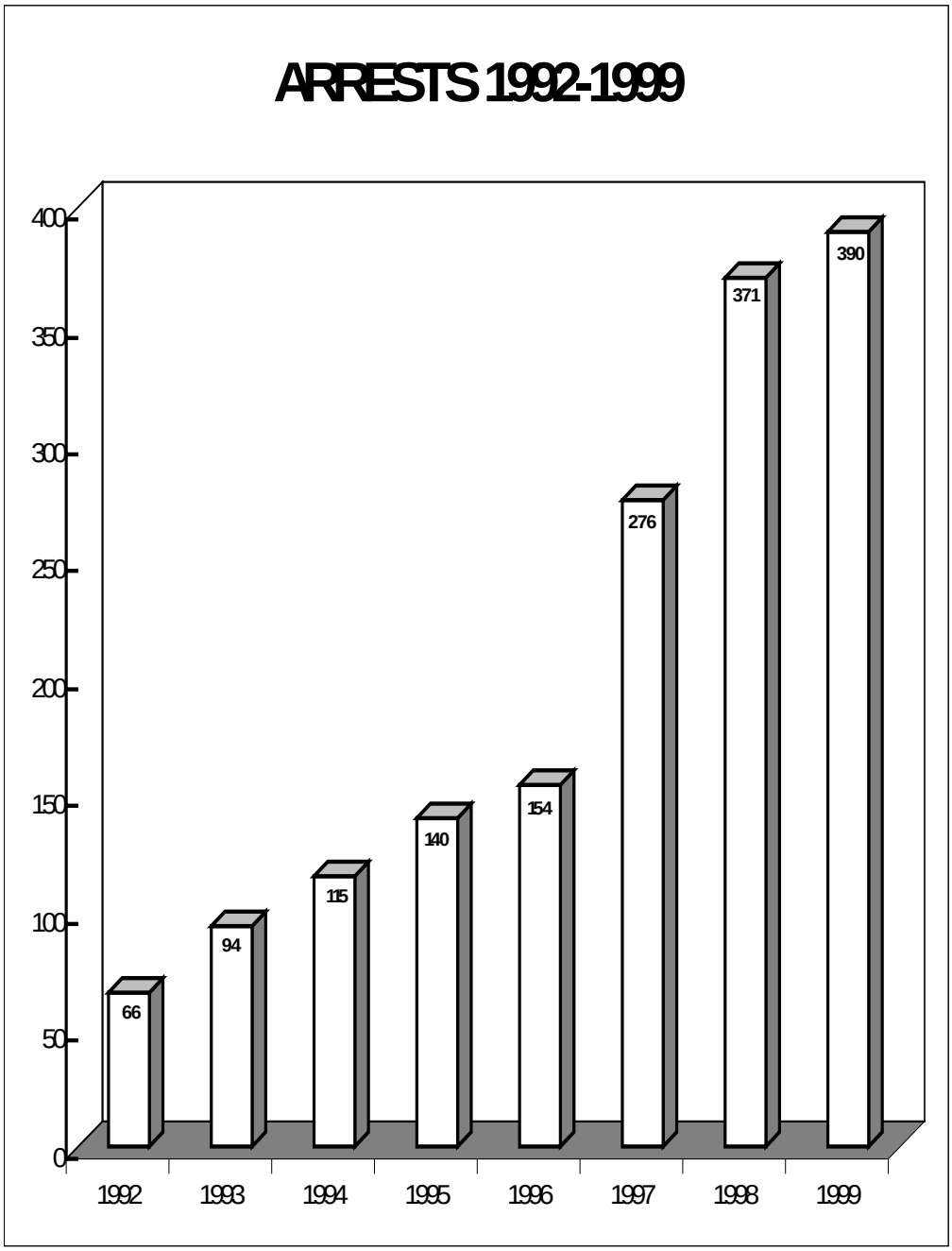
30
25
20
15
10
5
0
1992
1993
1994
1995
1996
1997
1998
1999


ARRESTS 1992-1999
400
350
300
250
200
150
100
50
0
66
94
115
140
154
276
371
390
1992
1993
1994
1995
1996
1997
1998
1999

CIVIL ENFORCEMENT PROGRAM

	1995	1996	1997	1998	1999
Fines Proposed	$1,841,349.26	$839,559.78	$728,275.00	$365,070.74	$610,041.45
Reduction After Proposal	($17,692.00)	0	0	0	0
Gross Fines Proposed	$1,823,657.26	$839,559.78	$728,275.00	$365,070.74	$610,041.45
Pending Criminal	($1,000,700.00)	0	0	0	0
Net Fines Proposed	$822,957.26	$839,559.78	$728,275.00	$365,070.74	$610.041.45
Settlements With IFB	$ 271,563.40	$265,009.41	$109,607.07	$ 93,904.12	$230,096.54
Hearing Determinations	$ 820,633.00	$728,390.23	$454,972.50	$219,494.11	$73,914.00
Total Fines Imposed	$1,092.196.40	$993,399.64	$564,579.57	$313,398.23	$304,010.54
Proposals Sent By IFB	691	553	157	118	127
Settlements With IFB	273	375	109	44	64
Cases Forwarded to OGC	206	186	181	53	70
Hearings Held	27	98	176	1	2
Determinations	20	96	108	27	35
Cases Sent To AG for collection	14	49	69	2	0

Miscellaneous Statistics

I. Referrals

To Licensing Agencies	70
To Local Prosecutors	146
To Attorney General	3
To U.S. Attorneys	8

Twelve cases referred to prosecutors by the Bureau in 1999 were declined for prosecution. All other cases are pending.

II. Technical and Monetary Contributions

During 1999, the Bureau requested and received $45,000 from various insurance companies. These funds were allocated in connection with joint investigations conducted under the supervision of local district attorneys.

III. Civil Penalties

Civil Penalties totaling $295,475.54 were imposed in 78 cases under Insurance Law Section 403 in 1999, and $8,535.00 in 13 cases under Section 2133.

Insurance Frauds Bureau
Continuing Education Program
1999

Date	Group	Location	Number of Attendees
01/20/99	Various Insurance Companies	New York City	90
01/20/99	Various Insurance Companies	New York City	35
01/21/99	Various Insurance Companies	Albany	20
01/21/99	Various Insurance Companies	Albany	20
01/29/99	NYPD Auto Crime School	New York City	21
02/01/99	Various Insurance Companies	New York City	15
02/04/99	State Insurance Fund	Buffalo	64
02/06/99	Hamberger & Weiss Law Firm	Hamburg	18
02/09/99	New York Insurance Association	Albany	100
02/16/99	Travelers P&C Insurance Company	Cohoes	10
02/19/99	NYPD Auto Crime School	New York City	32
03/05/99	National Insurance Crime Bureau	New York City	10
03/05/99	NYPD Auto Crime School	New York City	29
03/19/99	NYPD Auto Crime School	New York City	20
03/24/99	Columbian Mutual Life Insurance Co.	Vestal	20
03/29/99	NYS Academy of Fire Science	Montour Falls	30
3/29/99	Otsego County Volunteer Fire	Worcester	37
03/30/99	State Farm Mgt. Fraud Awareness Seminar	Melville	200
04/09/99	NYPD Auto Crime School	New York City	5
04/16/99	NYPD Auto Crime School	New York City	19
04/20/99	Hamberger & Weiss Law Firm	Hamburg	205
05/06/99	New York Insurance Association	Syracuse	60
05/07/99	NYPD Auto Crime School	New York City	25
05/21/99	NYPD Auto Crime School	New York City	20
05/25/99	IFB Frauds Conference	New York City	250
05/26/99	NYS Academy of Fire Science	Montour Falls	25
05/28/99	NYPD Auto Crime School	New York City	17
06/04/99	NYPD Auto Crime School	New York City	7
06/14/99	NYS Academy of Fire Science	Montour Falls	30
06/25/99	NYPD Auto Crime School	New York City	23
06/30/99	Atlantic Mutual Insurance Companies	Morristown, NJ	16
07/02/99	NYPD Auto Crime School	New York City	8
07/07/99	State Farm Special Investigations Unit	Lakeville	12
07/27/99	CGU Insurance Company	Melville	52
07/23/99	NYPD Auto Crime School	New York City	20
07/28/99	Summer College for District Attorneys	Syracuse	50
08/06/99	New York Health Insurers	New York City	40

08/09/99	Cap. Dist. Health Care Fraud Working Grp.	Albany	30
08/20/99	NYPD Auto Crime School	New York City	16
08/27/99	NYPD Auto Crime School	New York City	20
09/10/99	NOVA Insurance Group	Buffalo	16
09/15/99	CGU Insurance Company	Rochester	36
09/21/99	CPCU – Northeast Chapter	Albany	44
09/24/99	NYPD Auto Crime School	New York City	17
09/28/99	Allstate Insurance Company	Amherst	78
09/29/99	Fireman's Fund Insurance Co.	Amherst	10
09/29/99	CGU Insurance Company	West Amherst	43
09/30/99	CGU Insurance Company	West Amherst	32
10/06/99	Insurance Fraud Mgmt. Advisory Panel	Baltimore, MD	50
10/08/99	NYPD Auto Crime School	New York City	23
10/13/99	CGU Insurance Company	Albany	35
10/19/99	CGU Insurance Company	Syracuse	38
10/20/99	Chubb Insurance Group	Rochester	15
10/20/99	NYS Chapter of Special Investigative Units	Schenectady	55
10/22/99	NYPD Auto Crime School	New York City	21
10/25/99	NYS Office of Fire Prevention & Control	Montour Falls	38
10/26/99	State Farm Insurance Companies	Ballston Spa	86
10/29/99	Royal/Sunalliance Insurance Companies	Amherst	23
10/29/99	NYPD Auto Crime School	New York City	26
11/04/99	Allstate Insurance Company	Albany	64
11/05/99	NYPD Auto Crime School	New York City	13
11/9-10/99	NY Anti Car Theft & Fraud Association	Tarrytown	200
11/11/99	NYPD Auto Crime School	New York City	11
11/12/99	Allstate Insurance Company	East Syracuse	26
11/16/99	IFB Frauds Conference	New York City	200
11/17/99	CGU Insurance Company	New York City	66
11/18/99	Allstate Insurance Company	Fishkill	64
12/01/99	Allstate Insurance Company	Saratoga Springs	250
12/02/99	College of Insurance	New York City	60
12/03/99	NYPD Auto Crime School	New York City	16
12/10/99	Allstate Insurance Company	East Syracuse	43
TOTAL	**71 insurers/law enforcement agencies**		**3,420 participants**

APPROVED FRAUD PREVENTION PLANS

Insurance Companies	# of Investigators	Approval Date	Implemented
Acceptance	6	4/16/99	Within 6 mos.
Aetna	7	3/5/99	Immediately
AFLAC	5	4/16/99	Immediately
Agway	1	2/11/99	Immediately
AIG	10	12/10/99	Immediately
Allianz/Preferred	2	6/10/99	Within 6 mos.
Allmerica Financial	10	2/16/99	Immediately
Allstae Life	2	4/1/99	Immediately
Allstate	50	7/1/99	Immediately
Amalgamated Life	2	4/16/99	Immediately
American Agent	11	6/10/99	Within 6 mos.
American Bankers Life	4	5/6/99	Immediately
American Bankers P/C	8	5/28/99	Immediately
American Medical	11	7/1/99	Within 4 mos.
American Progressive(Penn Life)	1	12/15/99	1/1/00
American Transit	3	4/19/99	Immediately
AMEX Assurance	1	10/22/99	Immediately
Amica Life	10	4/16/99	Immediately
Amica Mutual	1	2/16/99	Immediately
Amwest Surety	4	2/16/99	Immediately
Atlantic Casualty	1	12/16/99	Immediately
Atlantic Mutual	2	2/16/99	Immediately
AUSA	Contracted	6/10/99	Jul-99
Blue Cross - Rochester	6	4/1/99	7/1/99
Blue Ridge	3	3/5/99	Immediately
Capital District Physicians	1	5/28/99	Within 6 mos.
Central	Contracted	12/16/99	Immediately
CGU	22	2/16/99	Immediately
Chubb Group	4	4/23/99	Immediately
Cigna (ACE USA)	3	10/15/99	Immediately
Cigna (Health Care)	18	3/5/99	Immediately
Cigna (INA LIFE)	16	4/1/99	Immediately
Clarendon	Contracted	5/28/99	Immediately
CNA	11	7/9/99	Within 6 mos.
Colonial Penn	5	4/1/99	Immediately
Combined Life	1	3/5/99	Within 6 mos.
Country Wide	5	9/10/99	Immediately
Crum & Forster	1	3/26/99	Immediately
CUNA Mutual	2	5/28/99	Within 6 mos.
Dairyland (Sentry)	3	3/19/99	Immediately

Delta Dental	1	7/26/99	10/1/99
Eagle (Robert Plan)	23	5/6/99	Immediately
Electric	2	2/16/99	Immediately
Empire	7	3/26/99	Immediately
Empire Blue Cross	24	2/16/99	4/1/99
Erie	1	3/19/99	Immediately
Eveready	Contracted	10/15/99	Within 6 mos.
Farm Family	1	3/5/99	Immediately
FICO	11	3/5/99	Within 6 mos.
Fiduciary	2	6/10/99	Within 6 mos.
Fireman's Fund	11	6/10/99	Immediately
First Ameritas	9	5/6/99	Within 6 mos.
First Fortis Life	6	7/9/99	Within 6 mos.
First Rehabilitation	3	4/16/99	Immediately
First Reliance	2	10/5/99	Within 30 days
First United American	4	10/15/99	Immediately
Freemont	1	7/1/99	Immediately
GEICO Direct	29	4/26/99	Immediately
Gerber	1	3/5/99	4/28/99
GHI	8	7/1/99	Immediately
Great American	4	6/18/99	Immediately
Great western	4	6/18/99	Within 6 mos.
Guardian	18	5/21/99	Within 6 mos.
Harleysville	5	2/16/99	Within 6 mos.
Hartford Life	6	7/26/99	Immediately
HealthCare Plan	2	6/18/99	Within 6 mos.
Highlands	Contracted	8/12/99	Immediately
HIP Health	3	3/5/99	Within 6 mos.
IDS Life	1	11/22/99	Within 6 mos.
Independent Health	2	5/21/99	Within 6 mos.
Infinity	4	4/1/99	Immediately
Integon	7	5/28/99	Within 6 mos.
Interboro	11	6/10/99	Immediately
Integrity Plus(Empire Plan)	2	4/12/99	Within 6 mos.
Integrity Plus(United H/C- Upstate NY)	13	3/5/99	4/1/99
ITT Hartford	15	7/26/99	Immediately
John Hancock	1	3/19/99	Immediately
Kaiser Permanente	3	3/19/99	4/99
Kemper	3	5/28/99	Immediately
Lancer	2	5/6/99	Immediately
Leader	2	9/27/99	Immediately
Legion	1	7/1/99	Immediately
Liberty Mutual	16	3/26/99	Within 6 mos.
Mass Mutual	5	10/15/99	Immediately
MDNY	Contracted	12/16/99	Within 3 mos.

Merchants	2	2/16/99	Immediately
Merchants & Business Men's	12	3/5/99	Immediately
MetLife	6	5/21/99	Immediately
MetLife Property	6	4/1/99	Immediately
Metroplus	5	11/1/99	Within 6 mos.
Michigan Millers	20	10/5/99	Within 6 mos.
MSI- Mutual Service Life	Contracted	11/26/99	Within 6 mos.
Mutual of Omaha	9	7/26/99	Within 6 mos.
MVP Health	2	6/18/99	Within 6 mos.
National General	9	4/1/99	Immediately
National Grange Mutual	2	5/21/99	Immediately
Nationwide	13	3/5/99	Immediately
North Star	4	4/16/99	Immediately
Northwestern Mutual	1	3/5/99	7/31/99
Nova	1	3/5/99	Immediately
NY Care Plus(BC&BS Western NY)	2	4/23/99	Immediately
NY Central Mutual	12	9/7/99	Immediately
NY Life	1	6/10/99	9/1/99
Ohio Casualty Group	4	1/7/00	Within 6 mos.
Oxford Health	7	5/28/99	Immediately
Peerless	2	9/14/99	Within 6 mos.
Phoenix Home Life	5	6/18/99	Within 6 mos.
Physicians Health Service	1	7/26/99	Within 6 mos.
Preferred Care	2	2/16/99	4/15/99
Preferred Mutual	2	5/6/99	Immediately
Principal Life	1	4/23/99	Immediately
Progressive Casualty	20	2/16/99	Immediately
Provident	11	2/16/99	Immediately
Provident Washington	Contracted	12/16/99	Within 6 mos.
Prudential	6	5/28/99	Immediately
PSM	1	3/19/99	7/1/99
Reliance	2	3/5/99	Immediately
Reliaster Life	4	4/9/99	Immediately
Response	1	9/14/99	Immediately
Royal & Sunalliance	9	4/16/99	Immediately
Safeco	2	4/23/99	Immediately
Security Mutual	2	3/5/99	Immediately
Selective	3	2/16/99	Immediately
St Paul	4	5/21/99	Immediately
Standard Security	Contracted	9/16/99	Within 6 mos.
State Farm	110	5/28/99	Within 6 mos.
State Fund	12	2/16/99	6/1/6/99
State-Wide	Contracted	11/19/99	Within 6 mos.
Sterling	1	5/10/99	Immediately
Teachers	Contracted	3/5/99	Within 6 mos.
Travelers	26	3/5/99	Immediately

Trustmark	8	6/18/99	Within 6 mos.
U.S. Life	5	5/6/99	Immediately
ULICO	1	5/28/99	Within 6 mos.
Union Fidelity	3	6/18/99	Immediately
United Health Care Integrity	3	9/3/99	Within 6 mos.
USSA	15	8/19/99	Immediately
Utica Mutual	4	5/6/99	Immediately
VYTRA	2	7/1/99	Immediately
Wausau	2	11/19/99	Immediately
Wellcare	Contracted	11/26/99	Within 6 mos.
Windsor	3	4/9/99	Immediately
Zurich U.S.	Contracted	10/22/99	Immediately

TOTAL 143 Plans

INSURANCE FRAUDS BUREAU STAFF
December 31, 1999

NEW YORK CITY OFFICE

Director

Assistant Director

Principal Investigator

7 Associate Investigators

18 Senior Investigators

14 Investigators

Principal Insurance Examiner

Senior Insurance Examiner

2 Insurance Examiners

Assistant Director of Research

Secretary I

Calculations Clerk 2

5 Keyboard Specialists

ALBANY OFFICE
4 Investigators
Insurance Examiner

BUFFALO OFFICE
Chief Investigator
2 Senior Investigators

ROCHESTER OFFICE
Senior Investigator

SYRACUSE OFFICE
Associate Investigator
Investigator

ONEONTA OFFICE
Senior Investigator

MINEOLA OFFICE
Associate Investigator
3 Senior Investigators
3 Investigators

INSURANCE FRAUDS BUREAU OFFICES

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25 Beaver Street
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Empire State Plaza
Albany, NY 12257
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Walter Mahoney State Office Bldg.
65 Court Street - Rm. 7
Buffalo, NY 14202
(716) 847-7622 or 7618
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189 North Water Street
Rochester, NY 14604
(716) 325-1857
FAX #(716) 325-1857

SYRACUSE OFFICE
620 Erie Blvd., West
Suite 105
Syracuse, NY 13204
(315) 423-1102
FAX#(315)423-1102

ONEONTA OFFICE
28 Hill Street, Room 326
Oneonta, NY 13820
(607) 433-0108
FAX #(607)433-0284

MINEOLA OFFICE
200 Old Country Road
Suite 340
Mineola, NY 11501
(516) 248-5870
FAX # (516) 248-5727

STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

Circular Letter No. 26 (1999)
September 13, 1999

TO: All Insurers and Self-Insurers

RE: Revised Insurance Department Fraud Reporting Form (IFB-1 REV. 8/99)

Section 405 of the New York Insurance Law requires insurers and self-insurers to report to the Insurance Frauds Bureau all incidents of suspected insurance fraud on a form prescribed by the Superintendent. Effective immediately, the Superintendent has replaced the original Fraud Reporting Form (IFB-1) with Form IFB-1 REV. 8/99. The new Form is designed to elicit more specific information about suspected insurance fraud. The enhanced information will help to expedite the Frauds Bureau's review process and ensure a prompt investigation of each report.

In addition to the information requested on Reporting Form IFB-1, the new Form seeks the following information:

- Question 1 requests information on whether the current report has previously been submitted.
- Question 2 lists types of loss and asks which type the report involves.
- Question 3 requests the VIN and license plate number for reports involving auto insurance fraud or fraudulent identification cards.
- Question 4 asks for the status of the claim involved (*i.e*., whether the claim has been paid), and the SIU number.
- Questions 5 and 6 request no additional information. However, these questions are now presented in an easy-to-follow format.

Insurers are advised that Reporting Form IFB-1 REV. 8/99 is effective upon receipt of this Circular Letter. A copy of the new Form is attached.

Very truly yours,

_____

Charles DeRienzo
Director
Insurance Frauds Bureau

DATE:_____

1). ***Information furnished by:***

Company Name: _____

Address: _____

_____

NAIC # _____

Previously submitted? Yes ____ Log # _____ No_____

STATE OF NEW YORK
INSURANCE DEPARTMENT
FRAUDS BUREAU
25 BEAVER STREET
NEW YORK, NY 10004

PLEASE PRINT/TYPE INFORMATION

2) Brief statement of suspect transaction. Date of loss _____ Amount of loss _____ County_____
Type of loss: Auto_____ Medical _____ Workers Comp. _____ Fraudulent cards_____ Other_____

STATEMENT

3) Identify parties to suspect transaction: Name(s) A
Address (es)
Additional information on suspect(s)

If Auto or Fraudulent cards give VIN # _____ Plate or License # _____

4) Identify your policy, claim or reference number under which the above transaction is recorded:
Claim # _____ Claim status_____
Reference #_____ Policy # _____ SIU #_____

5) Name, title, address & telephone number of individual in your company who can provide detailed information:
NAME_____ ***TITLE*** _____
ADDRESS _____***TELEPHONE #*** _____

6) Have you reported this transaction to any other law enforcement agency? Yes _____ No_____
If yes, please furnish: Agency _____
Address _____
Person contacted _____ Telephone #_____Date of report _____

Continue on reverse or attach additional sheets as necessary.

Signed: _____

Title: _____

http://www.ins.state.ny.us

IFB-1 REV 8/99

STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

Circular Letter No. 27 (1999)
November 1, 1999

TO: ALL INSURERS LICENSED TO WRITE ACCIDENT & HEALTH INSURANCE IN NEW YORK STATE, ARTICLE 43 CORPORATIONS AND HEALTH MAINTENANCE ORGANIZATIONS

RE: Chapter 2 of 1998: Fraudulent Health Insurance Acts Pursuant to §176.05(2) of the Penal Law and Healthcare Compliance Programs Pursuant to §4414 of the Public Health Law

On September 24, 1998, Governor George Pataki signed into law Chapter 2 of the Laws of 1998, which among other things, enacted significant changes to the Penal Law and Public Health Law strengthening efforts to combat health insurance fraud. This circular letter will provide guidance to insurers and health maintenance organizations (HMOs) as to how these new provisions in the law should be understood and utilized.

NOTE: Given that Chapter 2 was signed into law late in 1998, its changes to the Insurance Law and the Penal Law do not appear in the 1999 Pocket Part of McKinney's statutes. They can be found in the 1998 Session Laws. These amendments also appear in the Department's website at www.ins.state.ny.us.

Section 42 of Chapter 2 adds a new subdivision 2 to §176.05 of the Penal Law to define a fraudulent health care insurance act. A "fraudulent health care insurance act" has been committed when the following elements are present:

1. Any person,
2. knowingly and with the intent to defraud,
3. presents, causes to be presented, or prepares with the knowledge or belief that it will be presented to, or by, any insurer, or purported insurer, or self-insurer, or any agent,
4. any written statement or physical evidence as part of or in support of an application for the issuance of a health insurance policy, or any policy or contract that provides for or allows for coverage or membership or enrollment or any other service of a public or private health plan;
5. or presents a claim for payment, services or any other benefit pursuant to such policy, contract or plan which that person knows to:
6. contain materially false information concerning any fact related to an application for the issuance of a health insurance policy or contract, or to a claim for payment, services or benefits under such a policy; or
7. conceal, for the purpose of misleading, any fact related to the issuance of a

health insurance policy or contract, or to a claim for payment, services or any benefits under such a policy or plan.

A health insurance policy, contract or plan includes those issued or operated by any public or governmentally-sponsored or supported plan for health care coverage or services or for any entity otherwise authorized pursuant to the Public Health Law. An "application for the issuance of a health insurance policy" may include any physical evidence of such application. It does not include an application for a health insurance policy or contract issued as an individual accident and health policy. It does not include individual enrollee direct payment contracts offered byHMOs, including individual direct payment HMO contracts providing out of plan benefits, and which are subject to the provisions of Article 43 of the Insurance Law. Further, it does not include any other application for a health insurance policy or contract approved by the Department in the individual or direct payment market. Such aplication also does not include any application for a certificate evidencing coverage under a self-insured plan or under a group contract approved by the Department.

Violations of §176.05(2) are felonies as described in §§176.10 through 176.35. Insurers are reminded that §176.05(2) is drafted in parallel form to the original §176.05(2) of the Penal Law and is to be accorded the same weight and importance as the original §176.05 Penal Law, except where it actually expands the scope of §176.05. The reporting requirements pursuant to Article 4 of the Insurance Law for insurers are also applicable to transactions which are suspected violations of §176.05(2).

Section 43 of Chapter 2 amended the Public Health Law to add a new §4414 regarding the establishment of health care compliance programs. Section 4414 requires that the Department Health, after consulting with the Department of Insurance, promulgate regulations to establish standards and criteria for compliance programs to be implemented by entities providing coverage or coverage and services under any public or governmentally-sponsored or supported plan for health care coverage or services. The regulations are required to have provisions for the design and implementation of programs or processes to prevent, detect and address instances of health care insurance fraud and abuse. The regulations are required to take into account the nature of an entity’s business and the size of its enrolled population.

Section 4414 requires the Department of Health and the Department of Insurance to accept programs and processes implemented by entities pursuant to §409 Insurance Law, fraud prevention plans, as satisfying the obligations of §4414 and the regulations promulgated thereunder when such programs and processes incorporate the objectives contemplated by §4414.

Any questions regarding this circular letter should be directed to:

Charles DeRienzo
Director
Insurance Frauds Bureau
New York State Insurance Department
25 Beaver Street
New York, NY 10004
cderienz@ins.state.ny.us (email)

SIGNED:

Charles DeRienzo
Director
Insurance Frauds Bureau