



NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

March 15, 2014

Dear Governor Cuomo, Comptroller DiNapoli, Attorney General Schneiderman, Temporary President and Majority Coalition Leader Skelos, Temporary President and Majority Coalition Leader Klein, Speaker Silver, Chairman DeFrancisco, Chairman Hannon, Chairman Farrell, and Chairman Gottfried:

On behalf of the Department of Financial Services, I hereby submit this report required by Section 409(c) of the Financial Services Law summarizing the Department's activities to investigate and combat health insurance fraud.

This report highlights the importance of fighting no-fault fraud, which costs New Yorkers hundreds of millions of dollars in insurance costs. The number of suspected no-fault fraud reports received by the Department decreased by 5 percent from 2012 to 2013. Reports of no-fault fraud totaled 91 percent of health insurance fraud reports and more than half of reports of fraud of all types, making no-fault fraud again the biggest single fraud issue faced by the Department.

DFS has continued to carry out Governor Cuomo's statewide initiative to stop deceptive doctors and shut down medical mills that plague New York's no-fault insurance payment system. In 2013, the Department's investigations led to the ban of 18 doctors and other health care providers from billing insurance companies under the no-fault system. The Department will continue to investigate and utilize the procedures set out in New York Insurance Law § 5109 and Regulation 68-E to de-authorize unscrupulous providers and protect New York consumers from rising automobile insurance premiums inflated as a result of fraud.

This report also highlights some of the major investigations undertaken during 2013, including many investigations conducted jointly with fellow law enforcement agencies. These investigations resulted in the arrests and prosecutions of individuals whose schemes were responsible for millions of dollars of fraudulent claims to insurance companies. Overall, investigations by the Department led to 170 arrests for health care fraud in 2013.

The Department will continue to aggressively combat health care fraud in the coming year.

Respectfully submitted,

Benjamin M. Lawsky
Superintendent of Financial Services



**Annual Report:
Investigating and Combating
Health Insurance Fraud**

As required by § 409(c) of the Financial Services Law

March 15, 2014
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Superintendent

New York State Department of Financial Services

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Introduction

This report, required under Section 409(c) of the Financial Services Law, summarizes the 2013 activities of the Department of Financial Services in combating health insurance fraud including information regarding referrals received, investigations initiated, investigations completed, and any other material necessary or desirable to evaluate the department's efforts.

2013 Highlights

The Department's Insurance Frauds Bureau (Bureau) investigates and combats health care fraud, which includes three major types of insurance: accident and health, private disability and no-fault. The Bureau is headquartered in New York City, with an office in Mineola and five offices across upstate New York: Albany, Syracuse, Rochester, Buffalo and Oneonta. It has a longstanding commitment to combating insurance fraud and strives to serve the people of New York State. Department highlights for combatting health care fraud in 2013 are below:

- In 2013, a total of 56 health care fraud investigations were opened in 2013 and 170 arrests were made.
- The Department received 14,543 reports of suspected health care fraud: 13,198 involved no-fault, 1,163 involved accident and health insurance and 182 involved disability insurance.
- Reports of suspected no-fault fraud accounted for 58% of fraud reports received during 2013.
- Investigations conducted led to the deauthorization of 18 doctors and other health care providers from billing insurance carriers under New York's no-fault law.
- The combined Upstate/Downstate Office of the Drug Enforcement Administration Tactical Diversion Task Force, of which the Department is a member, made 66 arrests during the year. The Task Force investigates organized drug diversion schemes, "doctor shopping" and forgery of controlled-substance prescriptions.

Overview of Health Care Fraud in New York State

The High Cost of Health Care Fraud

Health care fraud is a costly and pervasive drain on the national health care system. Though experts vary in their estimates, all agree that the costs of health care fraud are exorbitant. According to the National Health Care Anti-Fraud Association (NHCAA), the U.S. spends more than \$2 trillion on health care annually, with over 4 billion health insurance claims processed. The NHCAA reports that financial losses due to health care fraud are in the tens of billions of dollars each year. Combating fraud and abuse helps rein in the escalating costs of health care in the United States.

2013 Health Care Fraud Reports Received and Arrests Made

The Department received 14,543 reports of suspected health care fraud during 2013 – 1,163 involved accident and health insurance, 182 involved disability insurance and 13,198 involved no-fault. A total of 56 new health care fraud cases were opened for investigation. Of those, 32 involved accident and health, 2 involved disability and 22 involved no-fault. (It should be noted that multiple fraud reports frequently can be linked to one case.) Health care fraud investigations by the Department resulted in 170 arrests in 2013.

Types of Health Care Fraud

Health care fraud involves three major types of insurance: accident and health, private disability and no-fault. The following are some of the more common types of health care fraud.

- Prescription drug diversion and misuse.
- Medical identity fraud.
- Billing for services that were never rendered and products that were not provided.
- Billing for more expensive procedures or services than were actually provided, commonly known as upcoding.
- Performing medically unnecessary treatments and expensive diagnostic tests for the purpose of generating insurance payments.
- Misrepresenting noncovered treatments as medically necessary covered treatments, e.g., cosmetic nose surgery billed as deviated septum repair, for the purpose of obtaining insurance payments.
- Unbundling – billing as if each step of a procedure were a separate procedure.
- Staging or causing auto accidents.
- Filing no-fault claims for nonexistent injuries.
- Filing false or exaggerated medical disability claims.
- Staging fake slip-and-fall accidents.
- Accepting kickbacks for patient referrals.

In 2013, the health care fraud reports received included numerous allegations of medically unnecessary treatments and expensive diagnostic tests. Additionally, reports of prescription drug diversion and misuse have increased.

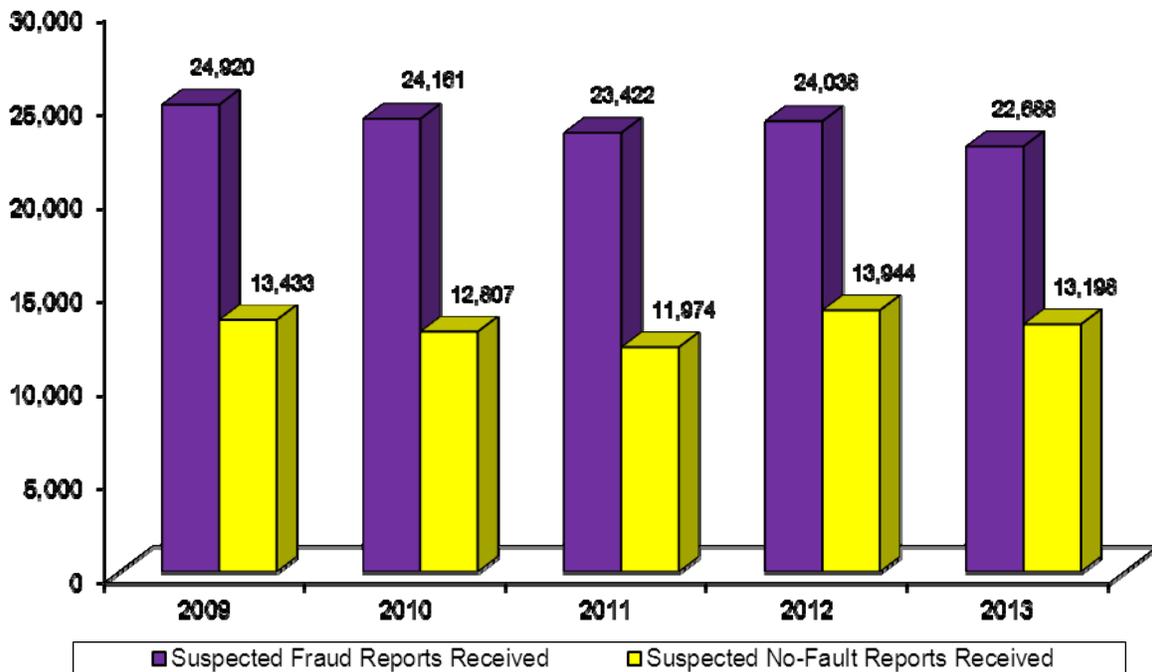
No-Fault Fraud

No-fault fraud accounts for the majority of health care fraud reported and combating no-fault fraud is one of the Department's highest priorities. To combat no-fault fraud, in 2012 the Department updated the regulation promulgated pursuant to New York Insurance Law § 51, which governs the no-fault system. In 2013, the Department's investigations led to the ban of 18 doctors and other health care providers from billing insurance companies under the no-fault system. The Department maintained its aggressive approach to combating this fraud throughout the year with investigations that are ongoing. The Department will continue to utilize the procedures set out in New York Insurance Law § 5109 and Regulation 68-E to deauthorize unscrupulous providers and protect New York consumers from rising automobile insurance premiums inflated as a result of fraud.

No-Fault Fraud by the Numbers

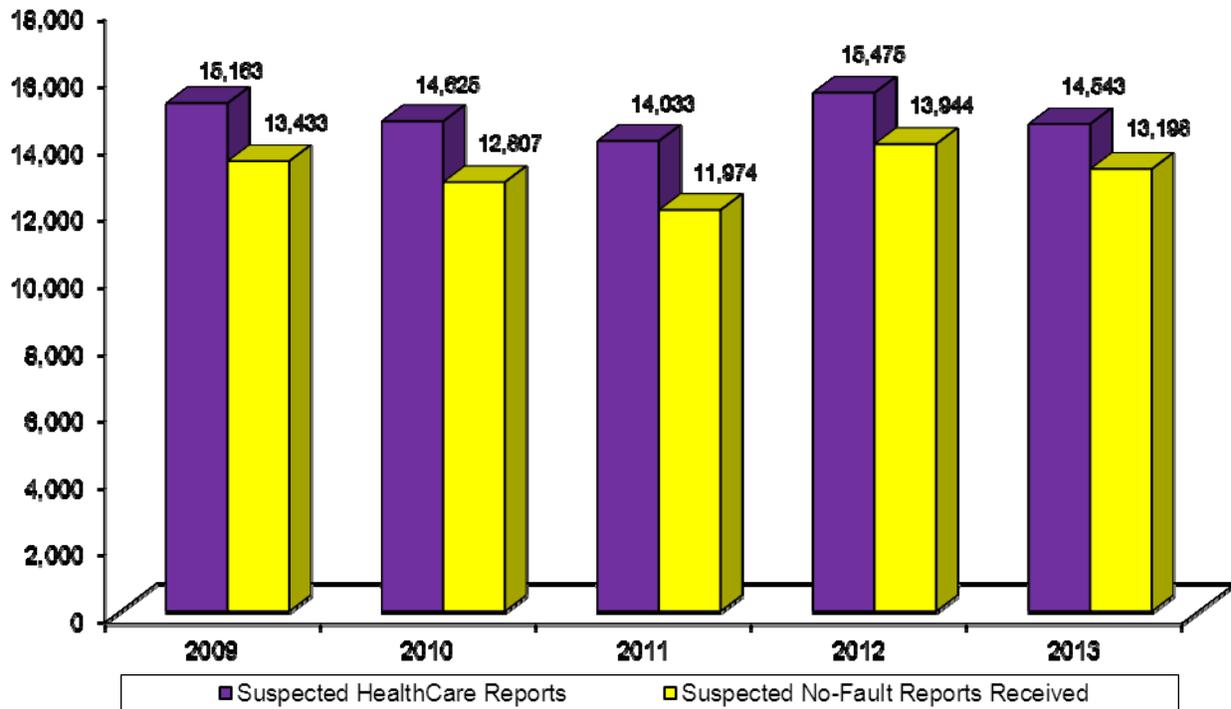
The number of suspected no-fault fraud reports received by the Department decreased by approximately 5% in 2013. However, as shown in Figure 1 below, suspected no-fault fraud reports accounted for 58% of all fraud reports received by the Department in 2013.

Figure 1: Number of Suspected Fraud Reports Received Compared with Number of Suspected No-Fault Reports Received 2009 - 2013



As shown in Figure 2 below, the number of suspected no-fault fraud reports made up 91% of all health care fraud reports in 2013 and have accounted for a minimum of 85% of total health care fraud reports since at least 2008.

Figure 2: Number of All Suspected Health Care Fraud Reports Received Compared with Suspected No-Fault Fraud Reports Received 2009 - 2013



Collaborative Efforts to Combat Health Care Fraud

Department investigators work closely with the insurance industry and law enforcement agencies on the federal, state and local levels to combat health care fraud schemes. Additionally, the department is a member of 13 task forces and working groups designed to foster cooperation and communication among the many law enforcement agencies involved in combating health care fraud. Participation provides the opportunity for joint investigations, intelligence gathering, and effective use of state resources. Toward that end, several of the department’s investigators have been assigned to these groups and partner with other members in investigating cases involving health care fraud. 2013 highlights from these collaborative efforts are below:

Drug Enforcement Administration Tactical Diversion Task Force

The Task Force investigates organized drug diversion schemes, “doctor shopping” and forgery of controlled-substance prescriptions. Successful investigations conducted by the combined Upstate/Downstate Task Force resulted in 66 arrests in 2013. A Department investigator is assigned full time to each office of the Task Force to work side-by-side with other members. An

investigation conducted by the Downstate Office of the Task Force led to the arrest in December of nine defendants charged in a scheme involving insurance fraud, the dispensing of prescriptions for controlled substances, sale and possession of oxycodone and gambling.

FBI New York Health Care Fraud Task Force

In 2013 an investigation conducted jointly with other members of the FBI New York Health Care Fraud Task Force led to the arrest in June of the owner/operator of two Queens pharmacies for his participation in a scheme to bill Medicare, Medicaid and private insurers for fraudulent prescriptions. The amount of the fraud is estimated to be close to \$1 million.

Other Group Participation

The Department actively participates in the Western New York Health Care Fraud Task Force, the Central New York Health Care Fraud Working Group and the Medicare Fraud Strike Force, among others. Participation provides the opportunity for studying trends, planning strategies and conducting joint investigations.

Reporting and Preventing Health Care Fraud

Insurance Company Reporting

Insurers are required by Section 405 of the New York Insurance Law to report suspected fraud to the Department. The Department has a web-based case management system, known as the Fraud Case Management System or FCMS, which allows insurers to submit reports of suspected fraud electronically. In 2013, approximately 95% of the 22,688 fraud reports received were transmitted electronically by insurers. Insurers have access to the FCMS through the Department's portal using secure accounts.

The benefits of the FCMS to insurers include automatic acknowledgment of receipt of fraud reports, notification of case assignments and eventual case disposition. Insurers also benefit from on-line help screens and an on-line manual of operations, as well as search and cross-reference features. Department staff members regularly monitor the system and make improvements and changes as necessary.

Consumer Reporting

Consumers are encouraged to report suspected fraud to the Department. The Department maintains a toll-free hotline to facilitate reporting. The Department recorded an average of 15 calls per week during 2013. The consumer section of the Department's website includes a link to a fraud report form and instructions that consumers can use to report fraud to the Department. The section is designed to help consumers recognize, report and combat insurance fraud.

Compliance with Section 409 of the New York Insurance Law

Section 409 of the New York Insurance Law requires insurers that write at least 3,000 individual accident and health, workers' compensation or automobile policies (or group policies that cover at least 3,000 individuals) issued or issued for delivery annually in New York to submit to the Department a Fraud Prevention Plan for the detection, investigation and prevention of insurance

fraud. Additionally, licensed health maintenance organizations (HMOs) with at least 60,000 enrollees must submit a Fraud Prevention Plan. The Plan must provide for a full-time Special Investigations Unit (SIU), as well as specific staffing levels within the SIU.

In 2013, there were 67 approved insurer SIUs dedicated to investigating health care fraud in New York State. These SIUs included accident and health insurers, HMOs, life insurers, nonprofit medical and dental indemnity or health service corporations. In addition, 15 property and casualty insurers with approved SIUs reported writing accident and health insurance business during 2013.

Health and life insurers reported \$158 million in savings resulting from SIU investigations in 2012 (the most recent year for which data are available). Health and life insurers reported \$29 million in recoveries from SIU investigations. In addition, four property and casualty insurers writing accident and health insurance reported \$7 million in savings and \$338,000 in recoveries.

The Department monitors insurer compliance with Section 409 through the analysis of data provided by insurers in Annual SIU Reports. The Department may perform field examinations of insurer SIUs to assess compliance with Section 409, other sections of Article 4 of the New York Insurance Law and Regulation 95.

Fraud Prevention Plan Requirements

Section 409 of the Insurance Law sets out specific requirements for the information that must be included in Fraud Prevention Plans. For example, Plans must provide for an SIU separate from claims and underwriting and must include details regarding the staffing and other resources dedicated to the SIU. In order to be designated an SIU investigator, individuals must meet certain educational and/or professional experience criteria as specified in Section 409 and Department Regulation 95. Section 409 and Regulation 95 also require the following information and/or procedures to be included in all Fraud Prevention Plans:

- Interface of SIU personnel with law enforcement and prosecutorial agencies.
- Coordination with other units of the insurer for the investigation and initiation of civil actions based on information received by or through the SIU.
- Development of fraud detection and procedures manual to assist in the detection and elimination of fraudulent activity.
- The rationale for the level of staffing and resources devoted to the SIU based on objective criteria.
- In-service training of investigative, claims and underwriting personnel in identification and evaluation of insurance fraud.
- Development of a public awareness program focused on the cost and frequency of insurance fraud and the methods by which the public can assist in preventing fraud.

Electronic Submission of Fraud Prevention Plans

The Department developed a secure online portal application for the submission of insurer Fraud Prevention Plans in 2013. Insurers now submit Fraud Prevention Plans to the Department electronically.

Public Awareness Programs

New York Insurance Law requires that Fraud Prevention Plans contain a provision addressing the insurer's efforts to increase public awareness of the cost and frequency of fraudulent activities and methods for preventing fraud. The New York Alliance Against Insurance Fraud and the National Health Care Anti-Fraud Association carry out advertising campaigns via newspaper, radio, television and billboard to target consumers on behalf of HMOs and health insurers. The National Health Care Anti-Fraud Association conducted public awareness programs for 19 HMOs, health insurers or health insurer groups with Fraud Prevention Plans on file. (A group is an organization comprising affiliated insurers.) 47 life, property or health insurers or insurer groups writing health insurance with Fraud Prevention Plans on file participated in the program. In addition, several individual insurance companies have ongoing programs to heighten awareness and reduce public tolerance for insurance fraud. These anti-fraud messages reach millions of New Yorkers each year.

The Year in Review

Numerous health care fraud investigations were conducted during the past year. Major cases are indicated below.

- 16 defendants were arrested for filing \$331,993 worth of claims that contained false information about accidents and their purported injuries. Most of the defendants are alleged to have agreed to participate in the accidents in exchange for money up front and the promise of settlement money from bodily injury lawsuits after they were treated for nonexistent injuries at a Brooklyn medical clinic. This was a joint investigation with the Attorney General's Office and the NYPD's Fraudulent Accident Investigation Squad (FAIS).
- A woman arrested for fraudulently collecting \$8,477 in benefits from the no-fault portion of her auto insurance policy. She submitted two allegedly forged documents. The first document was a medical record from a local clinic falsely stating that she was unable to return to work for up to six months. The second document was an altered receipt from Rochester General Hospital for payment for an MRI. During an interview, the defendant admitted to faxing the forged documents to Progressive Insurance Company in support of her claim and was arrested on March 19, 2013. This was a joint investigation with the State Police that was initiated based on a referral by Progressive.
- A Westchester County insurance agent was arrested and charged with grand larceny for allegedly stealing \$62,000 in commissions from MVP Health Care of Schenectady. More than 400 individuals were improperly enrolled into small group and sole proprietor health plans insured by MVP and offered through the Otsego County Chamber of Commerce. The Chamber's health plan policies were sold to downstate residents, offering them lower rates than they would have paid for coverage in the New York City area. Since

individuals generally must either reside or work in the geographical area where the health plan is offered, a phony membership category was created so that downstate residents could be enrolled in the Chamber's small group plan. The defendant is alleged to have conspired with a former president of the Chamber of Commerce, who was arrested in November 2011 and is awaiting trial on charges of insurance fraud, grand larceny and falsifying business records. The insurance policies of all 400 people were cancelled after their ineligibility was discovered; however, MVP paid out nearly \$1 million in health care costs for the fraudulently enrolled policyholders.

- A defendant was arrested in May 2013 for falsifying business records and fraudulently collecting more than \$15,000 from nine claims filed with Combined Life Insurance Company for medical services he maintained he had received. In support of the claims, he submitted statements prepared by four different hospitals confirming that the services had been rendered. However, the department investigation revealed that the hospital statements, for legitimate services performed as far back as 2005, had been altered to make it appear that they were for recent services.
- A woman was arrested in May for devising and carrying out a no-fault fraud scheme that resulted in her fraudulently collecting \$29,287 in benefits. She filed approximately 51 claims with Progressive Insurance Company for reimbursement for prescription drug refills under her no-fault insurance coverage. In support of her claims, she submitted receipts for payment she purportedly had made for the refills. However, a department investigation found evidence that only 16 of the claims were legitimate. The remaining 35 claims were for refills she never actually received and for which she fraudulently collected benefits.
- On May 30, 2013, a New York City Transit worker was arrested for grand larceny and other related charges for fraudulently collecting \$4,335.50 in credit disability benefits. The defendant, who sustained injuries while he was a passenger in a vehicle involved in an accident in 2011, filed a claim with Cuna Mutual Insurance Company under a credit disability insurance policy that would cover loan payments if he was disabled. The claim stated that the last full day he worked due to injuries caused by the accident was February 22, 2011 and that his daily activities consisted of "therapy and rest/doctor visits." He subsequently submitted a Return-to-Work Statement purportedly prepared by his employer giving an estimated return-to-work date of May/June 2012. However, the investigation revealed that between February 13, 2011 and March 26, 2012 the defendant was employed full time as a subway conductor. Moreover, the Return-to-Work statement was fraudulent and had not been prepared by the Transit Authority. As a result, the transit worker collected credit disability benefits to which he was not entitled. This was a joint investigation with the Brooklyn District Attorney's Office and the NYPD.
- A Queens woman fraudulently collected more than \$330,000 in claims and was sentenced to one-to-three years' incarceration at the Bedford Hills Correctional Facility after being convicted of grand larceny and falsifying business records. From December 2006 through February 2011, the woman had filed claims with United HealthCare Insurance Company for psychiatric services purportedly provided by two doctors. During interviews conducted as part of a department investigation, the doctors stated that they had not provided the services reported on any of the 1,273 claims filed by the defendant. United HealthCare paid out \$330,000 on more than \$500,000 in fraudulent claims.

- On July 23, 2013 an employee in the dental claims unit of MetLife Insurance Company was charged with insurance fraud and forgery for fraudulently collecting \$2,940 in claims. The submitted claims for dental treatment for herself and her domestic partner after completing claim forms in the name of her domestic partner, forging the signatures of both her partner and the purported provider, and submitted the forms to MetLife over a two year period. MetLife's SIU reported to the department that the claims filed in the name of the domestic partner should have been filed with the partner's own employer-sponsored dental plan as her primary insurer. The MetLife employee had omitted pertinent coordination-of-benefits information on the form and, as a result, she collected insurance payouts to which she was not entitled.
- On September 11, 2013 a physician was charged with tax fraud, larceny and falsifying business records for concealing \$267,000 that was owed to Beth Israel Hospital. Under an agreement with Beth Israel Hospital, the physician was required to share insurance proceeds for medical treatment he provided. However, an investigation revealed that the doctor concealed \$530,000 in payments, thereby depriving the hospital of its fair share of the insurance proceeds, \$267,000. This was a joint investigation with the Manhattan District Attorney's Office.
- The owner/operator of two Queens pharmacies was arrested in June 2013 on a charge of insurance fraud for his role in a scheme to bill Medicare, Medicaid and private insurers for fraudulent prescriptions out of nearly \$1 million. Department investigators working undercover dropped off prescriptions at one of the pharmacies and the defendant allegedly continued to bill the insurers for approximately 20 prescriptions that were not legitimate using the personal medical information of the undercover investigators. The amount of the fraud is estimated to be close to \$1 million. This was a joint investigation with the FBI New York Health Care Fraud Task Force, of which the department is a member.