



**Department of
Financial Services**

**Investigating and Combating
Health Insurance Fraud**

March 15, 2020

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Introduction

This report, required under Section 409(c) of the Financial Services Law, summarizes the 2019 activities of the Department of Financial Services (“DFS”) in combating health insurance fraud.

2019 Highlights

DFS’s Insurance Frauds Bureau (“Bureau”) investigates and combats healthcare fraud, which affects 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 Garden City and five offices across upstate New York: in Albany, Syracuse, Rochester, Buffalo, and Oneonta. The Bureau, working with DFS-regulated entities, has a longstanding commitment to combating insurance fraud and strives to serve the people of New York State. Highlights of the Department’s efforts in combating healthcare fraud in 2019 include the following:

- The Bureau opened 73 healthcare fraud investigations, resulting in 125 arrests;
- The Bureau received 17,185 reports of suspected healthcare fraud: 15,297 no-fault reports, 1,641 accident and health insurance reports, and 247 disability insurance reports;¹
- Reports of suspected no-fault fraud accounted for 59% of the 25,985 suspected insurance fraud reports received, which represents a 6% increase from the previous year.

Overview of Healthcare Fraud in New York State

The High Cost of Healthcare Fraud

Healthcare fraud is a costly and pervasive drain on the national healthcare system. Experts agree that the costs of healthcare fraud are exorbitant; the National Health Care Anti-Fraud Association estimates that losses due to healthcare fraud are in the tens of billions of dollars each year. Combating fraud and abuse helps reduce the escalating costs of healthcare in New York and the United States.

Types of Healthcare Fraud

As discussed above, healthcare fraud affects three major types of insurance: accident and health, private disability, and no-fault. The more common types of healthcare fraud include:

- Prescription drug diversion and misuse;
- Medical identity fraud;
- Billing for services that were never rendered and products that were not provided;

¹ Section 405 of the New York Insurance Law requires insurers to report suspected fraud to the Department.

- 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 sole purpose of generating insurance payments;
- Misrepresenting non-covered treatments as medically necessary covered treatments, for example, billing a rhinoplasty (cosmetic nose surgery) as a deviated septum repair to obtain insurance payments;
- Unbundling—billing as if each step of a procedure were a separate procedure;
- Staging or causing auto accidents;
- Filing no-fault claims for nonexistent injuries;
- Filing false or exaggerated medical disability claims;
- Staging slip-and-fall accidents; and
- Accepting kickbacks for patient referrals.

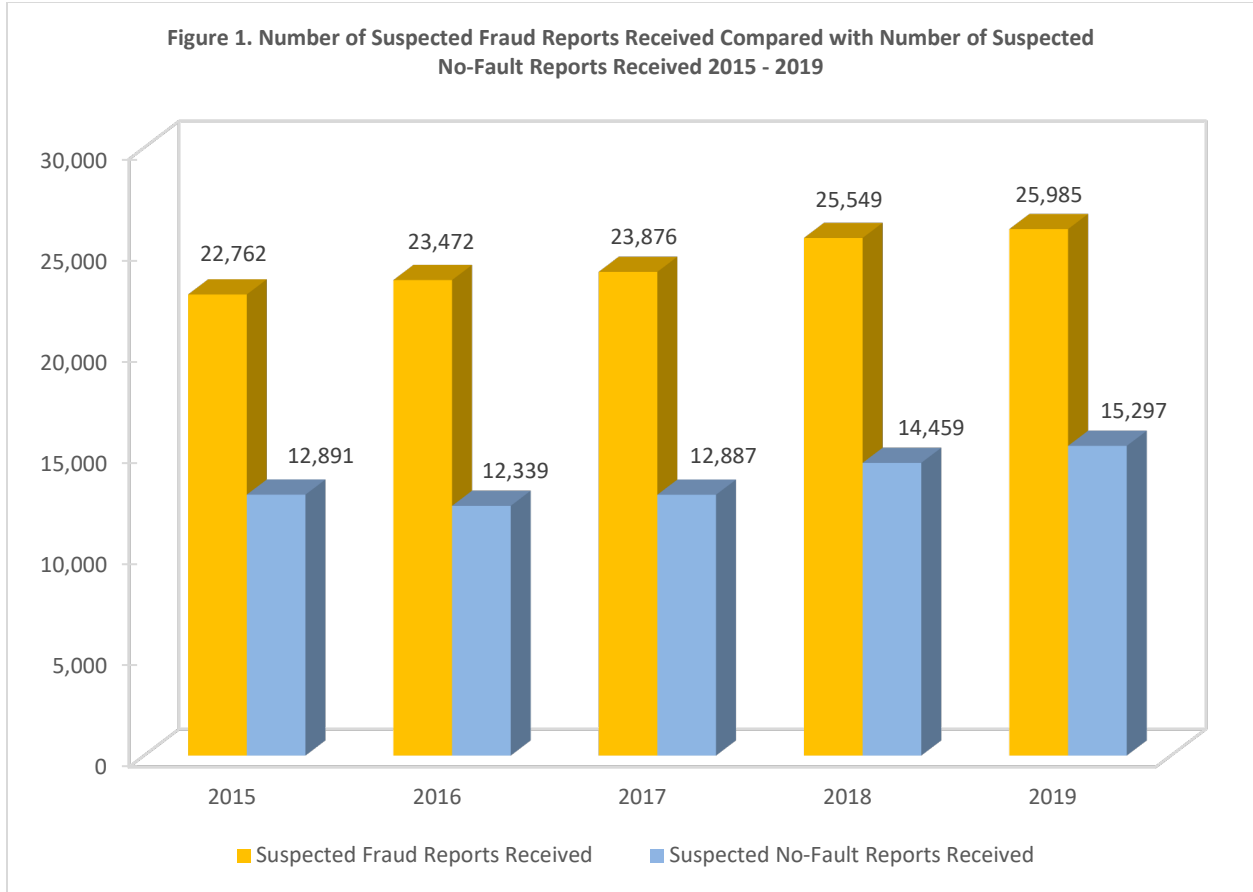
In 2019, DFS received numerous reports of suspected fraud containing allegations of medical providers billing for services not rendered and prescribing unnecessary durable medical equipment. Reports of prescription drug diversion and misuse, as well as allegations of disability fraud, remained persistent issues.

No-Fault Fraud

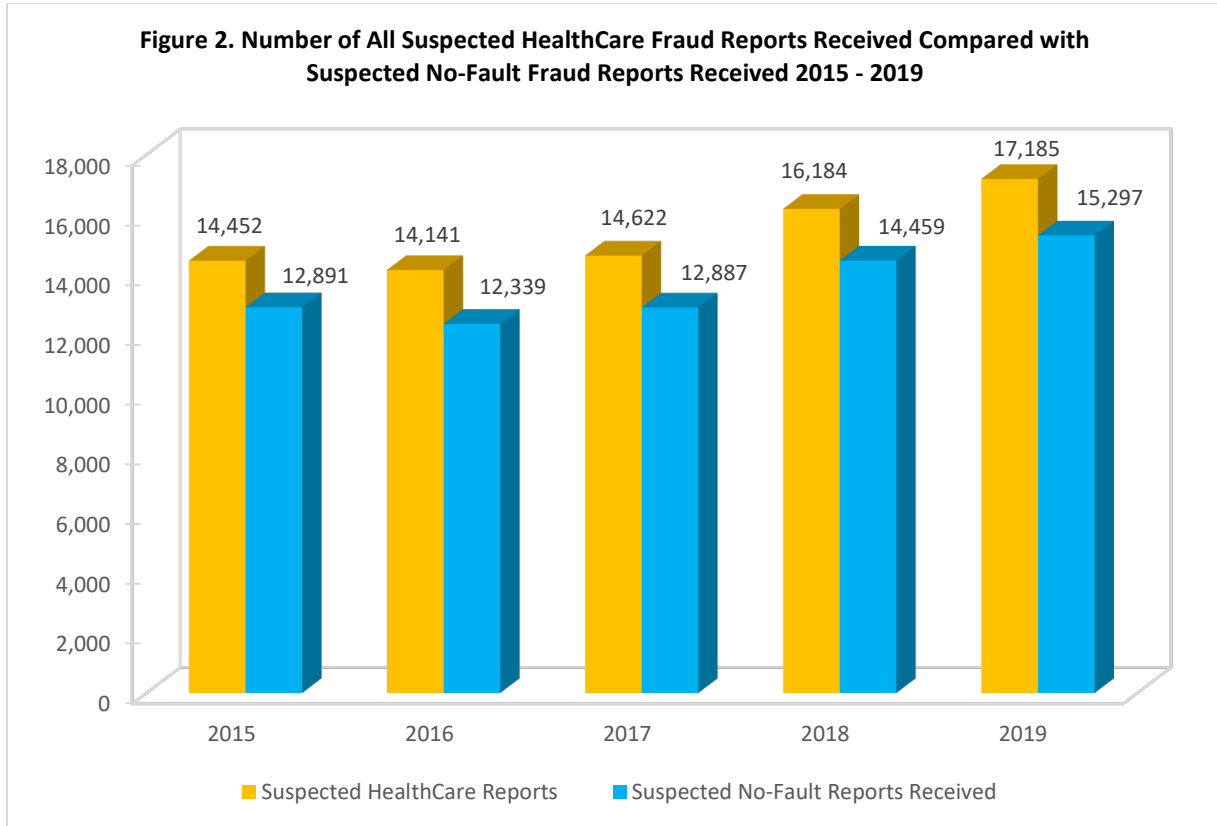
DFS conducted several no-fault investigations in 2019 in conjunction with other law enforcement agencies, prosecutors' offices, and the National Insurance Crime Bureau ("NICB") that led to the prosecution of a wide range of defendants who, in an organized fashion, are exploiting the no-fault system for personal gain. These cases have involved "runners" who stage accidents and refer the phony accident victims to unscrupulous medical clinics and corrupt law firms in exchange for monetary payments. In certain investigations, the defendants used two different scenarios in staging accidents: in the first, drivers intentionally crash into one another and, in the second, the driver of one vehicle causes an accident with an unsuspecting driver. Other no-fault investigations have involved "runners" who solicited victims of motor vehicle accidents at accident scenes to steer them to corrupt medical clinics and coached them to exaggerate and fabricate injuries. Other no-fault investigations involved individuals adding themselves to accident reports when they were not involved in the accident that was the subject of the report.

No-Fault Fraud by the Numbers

As shown in Figure 1, suspected no-fault fraud reports accounted for 59% of all fraud reports received by DFS in 2019.



As shown in Figure 2, the number of suspected no-fault fraud reports accounted for 89% of all healthcare fraud reports received in 2019 and at least 87% of all healthcare fraud reports received since 2015.



Collaborative Efforts to Combat Healthcare Fraud

DFS investigators work closely with the insurance industry and law enforcement agencies at the federal, state, and local levels to combat healthcare fraud schemes. DFS is a member of 10 task forces and working groups designed to foster cooperation and communication among the many law enforcement agencies involved in combating healthcare fraud. Those task forces and working groups include the following:

- Western New York Health Care Fraud Task Force
- Central New York Health Care Fraud Working Group
- Rochester Health Care Fraud Working Group
- FBI New York Health Care Fraud Task Force/Medicare Fraud Strike Force
- New York Anti Car Theft and Fraud Association
- National Insurance Crime Bureau Working Group
- High Intensity Drug Trafficking Area (HIDTA)

- Drug Enforcement Administration Tactical Diversion Task Force (Upstate/Downstate)
- Suffolk County District Attorney’s Office Insurance Crime Bureau
- New York Alliance Against Insurance Fraud

The DFS Insurance Frauds Bureau’s participation in working groups and task forces provides the opportunity for joint investigations, intelligence gathering, effective use of resources and the study of trends. Several DFS investigators have been assigned to groups and task forces and partner with other members investigating cases involving healthcare fraud. An example of successful collaboration is the DFS’s participation in the Drug Enforcement Administration Tactical Diversion Task Force (“Diversion Task Force”), which investigates organized drug diversion schemes.

On April 9, 2019, a DFS Investigator assigned to the Drug Enforcement Administration Tactical Diversion Squad, initiated an investigation into the alleged illegal sale of prescription pills. As a result of information received from out of state, a confidential source was developed. This source provided information into an attorney, a pharmacist, and multiple individuals selling stolen opioid prescriptions from a pharmacy in Kings County. The investigation utilized undercover law enforcement personnel and confidential informants. The surveillance systems captured information leading to the August 19, 2019 arrest of three subjects involved in diverting opioid prescriptions.

Reporting and Preventing Healthcare Fraud

Insurance Company Reporting

Under Section 405 of the New York Insurance Law, insurers are required to report suspected insurance fraud to DFS. The Department’s web-based case management system, known as the Fraud Case Management System (“FCMS”), allows insurers to submit reports of suspected fraud electronically. In 2019, insurers electronically submitted approximately 96% of the 25,985 fraud reports that DFS received.

The benefits of the FCMS to insurers include automatic acknowledgment of receipt of fraud reports and notification of case assignments and eventual case disposition. Insurers also benefit from online help screens and an online manual of operations, as well as search and cross-reference features.

Consumer Reporting

DFS encourages consumers to report suspected fraud and maintains a toll-free hotline to facilitate reporting. Consumers may call 1-888-FRAUDNY (1-888-372-8369) for information regarding insurance fraud, including how to report insurance fraud. DFS recorded an average of 22 calls per month in 2019. The “Consumers” section of DFS’s website also includes a link to a fraud reporting form and instructions for reporting 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, and/or automobile policies, or group policies that cover at least 3,000 individuals issued in or issued for delivery annually in New York, to submit to DFS a Fraud Prevention Plan for the detection, investigation, and prevention of insurance fraud. Licensed health maintenance organizations ("HMOs") with at least 60,000 enrollees must also submit a Fraud Prevention Plan. Plans must provide for a full-time Special Investigations Unit (SIU), as well as specific staffing levels within the SIU.

Fraud Prevention Plan Requirements

Section 409 specifies information that must be included in Fraud Prevention Plans. For example, a plan must provide for an SIU that is separate from claims and underwriting, and must include details regarding the staffing and other resources dedicated to the SIU. To be designated an SIU investigator, individuals must meet certain educational and/or professional experience criteria enumerated in Section 409 and Department Regulation 95.

Section 409 and Regulation 95 also require that all Fraud Prevention Plans include the following information and/or procedures:

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

In 2019, there were 63 insurer SIUs committed to investigating health fraud in New York State that were housed within accident and health insurers, HMOs, life insurers, nonprofit medical, and dental indemnity and health service corporations. In addition, 17 property and casualty insurers writing accident and health insurance had approved SIUs during 2019.

Health and life insurers reported \$265 million in savings resulting from SIU investigations in 2018 (the most recent year for which data are available). Health and life insurers reported \$35.3 million in recoveries from SIU investigations.

DFS monitors insurer compliance with Section 409 through the analysis of data provided by insurers in annual SIU Reports. DFS may perform field examinations of insurer SIUs to assess

compliance with Section 409, other sections of Article 4 of the New York Insurance Law, and Regulation 95.

2019 Healthcare Fraud Reports Received and Arrests Made

DFS received 17,185 reports of suspected healthcare fraud during 2019: 1,641 involved accident and health insurance, 247 involved disability insurance, and 15,297 involved no-fault claims. DFS opened 73 healthcare fraud cases for investigation. Of those, 31 involved accident and health insurance, 3 involved disability insurance and 39 involved no-fault insurance. DFS investigations resulted in 125 arrests in 2019.

Public Awareness Programs

New York Insurance Law requires that Fraud Prevention Plans address insurers' efforts to increase public awareness of the cost and frequency of fraudulent activities and the methods of preventing fraud. The New York Alliance Against Insurance Fraud and the National Health Care Anti-Fraud Association carry out advertising campaigns via newspapers, radio, television, and billboards targeting insurance consumers on behalf of HMOs and insurers of health products. The National Health Care Anti-Fraud Association conducted public awareness programs for HMOs and insurers of health products on behalf of 18 entities with Fraud Prevention Plans on file. In 2019, there were 43 HMOs, health insurers, or health insurer groups (an organization comprising affiliated insurers) with Fraud Prevention Plans on file that participated in the New York Alliance Against Insurance Fraud program. In addition, two individual insurance companies have ongoing programs to heighten awareness and reduce public tolerance for insurance fraud. As a result, these anti-fraud messages reach millions of New Yorkers each year.

The Year in Review

Summarized below are some of the major healthcare fraud investigations conducted by the Bureau during the past year, to the extent that information is public. The Department has pending numerous other, confidential, investigations of healthcare fraud.

- On January 04, 2019, a DFS Investigator assigned to the Drug Enforcement Administration Tactical Diversion Squad, initiated an investigation into the alleged illegal sale of prescription pills. As a result of information received from a confidential source, an investigation was conducted with the use of a confidential informant, wiretaps and undercovers. As a result of this DFS investigation, a physician assistant and two other subjects were arrested for participating in a scam for prescribing opiates that were not medically necessary and paid for by insurance companies. DFS assisted with the monitoring of wiretaps and with conducting surveillance.
- In 2018, DFS, while working a joint investigation with the Rochester office of the FBI, undertook an investigation of a CVS employee, a Senior Assistant Purchasing Associate. In 2018, CVS's internal systems "red-flagged" suspicious purchases of diabetic test strips at a CVS located in Rochester. Adding to the suspect nature of the package, was the fact that it came from a company with which CVS did not do

business. A subsequent internal investigation by CVS determined that the subject routinely purchased diabetic test strips in excessive amounts that were well over the routine inventory needs for that location. An internal audit could not account for 20,203 boxes purchased by the subject resulting in a financial loss to CVS in excess of \$2 million. These monies were subsequently discovered to have been deposited into the subject's bank accounts. In a long-running pattern of fraud, the subject had ordered the excessive amounts of diabetic test strips and then sold the stolen product to a third party located in Florida. In 2019, the subject pled guilty to wire fraud and was sentenced to 30 months in federal prison and ordered to pay restitution in the amount of \$2,535,307.

- In 2018, DFS jointly ran a multi-agency investigation with the Drug Enforcement Administration (Albany District Office) Tactical Diversion Squad and its Capital District Drug Enforcement Task Force; the Civil Division of the U.S. Attorney's Office for the Northern District of New York, the New York State Police and the New York State Bureau of Narcotic Enforcement. DFS in concert with these other agencies, investigated allegations that a doctor had prescribed controlled substances to individuals who were not his patients. These "phantom patients" included the three young children of one of his patients and the boyfriend of another patient. The fraudulent activity alleged in the complaint occurred between December 2018 and April 2019.

The doctor prescribed controlled substances including Ritalin and its generic equivalents, with the intent of having his patients kick back a portion of each prescription to him for his personal use. The doctor was arrested in August 2019 and charged with distributing controlled substances outside the course of professional practice and for no legitimate medical purpose. The subject faces up to 20 years in prison, a maximum \$1 million fine and at least 3 years of post-imprisonment supervised release.

- In November 2019, DFS, working in conjunction with the FBI Health Care Task Force, New York State Police and the Westchester District Attorney's Office arrested 27 subjects. In March 2014, DFS had received information from a confidential informant who had been approached by a runner, involved in a staged accident scheme. DFS utilized various investigative techniques and a DFS undercover throughout the investigation. The investigation ultimately targeted a doctor and other subjects engaged in no-fault insurance fraud and the diversion of prescription medication. The doctor had billed for unnecessary treatments and provided prescription pain medication (oxycodone) without medical necessity, in return for monetary compensation. DFS provided the undercover Investigator for the infiltration of the target medical clinic.

Conclusion

Healthcare fraud continues as a major focus of the DFS Insurance Frauds Bureau's work. DFS will continue to aggressively combat healthcare fraud in the year ahead.