Investigating and Combating Health Insurance Fraud

March 15, 2022

Adrienne A. Harris
Superintendent

Table of Contents

Introduction

Adrienne A. Harris, the Superintendent of Financial Services, respectfully submits this report, pursuant to Section 409(c) of the New York Financial Services Law, summarizing the activities during 2021 of the Department of Financial Services ("DFS") in combating health insurance fraud.

2021 Highlights

The DFS Insurance Frauds Bureau ("the Bureau") has a longstanding commitment to combating insurance fraud. It is responsible for the detection and investigation of insurance and financial fraud and the referral for prosecution of persons or entities that commit those frauds. The Bureau is headquartered in New York City, with offices in Garden City, Albany, Syracuse, Oneonta, Rochester, and Buffalo.

DFS, working with its entities, has a longstanding commitment to combating insurance fraud. Highlights of the Department's efforts in combating healthcare fraud in 2021 include the following:

- The Bureau opened 60 healthcare fraud investigations, resulting in 16 arrests;
- The Bureau received 25,242 reports of suspected healthcare fraud: 23,279 no-fault reports, 1,797 accident and health insurance reports, and 166 disability insurance reports,[1] and;
- Reports of suspected no-fault fraud accounted for 68% of the 34,201 suspected insurance fraud reports received, which represents a 13.6% increase from the previous year.

In addition to these core functions, in response to COVID-19, the Governor's Office assigned DFS investigators to multi-agency task forces to combat violations of executive orders related to the state-wide coronavirus response. DFS investigators have staffed a 24-hour daily hotline that was created to allow the public to report violations of executive orders by telephone. DFS investigators also responded to online reports of executive order violations. Each report is logged and routed to the appropriate state or local agency for investigation. In addition, DFS investigators have been assigned to enforcement details at airports, licensed premises and areas that have been identified as COVID-19 "hotspots." In instances of credible violations of executive orders, DFS investigators have issued summonses and have testified at administrative hearings.

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

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, for example, estimates that losses due to healthcare fraud are in the tens of billions of dollars each year. Combating such fraud and abuse helps reduce the escalating costs of healthcare in New York and the United States.

Types of Healthcare Fraud

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

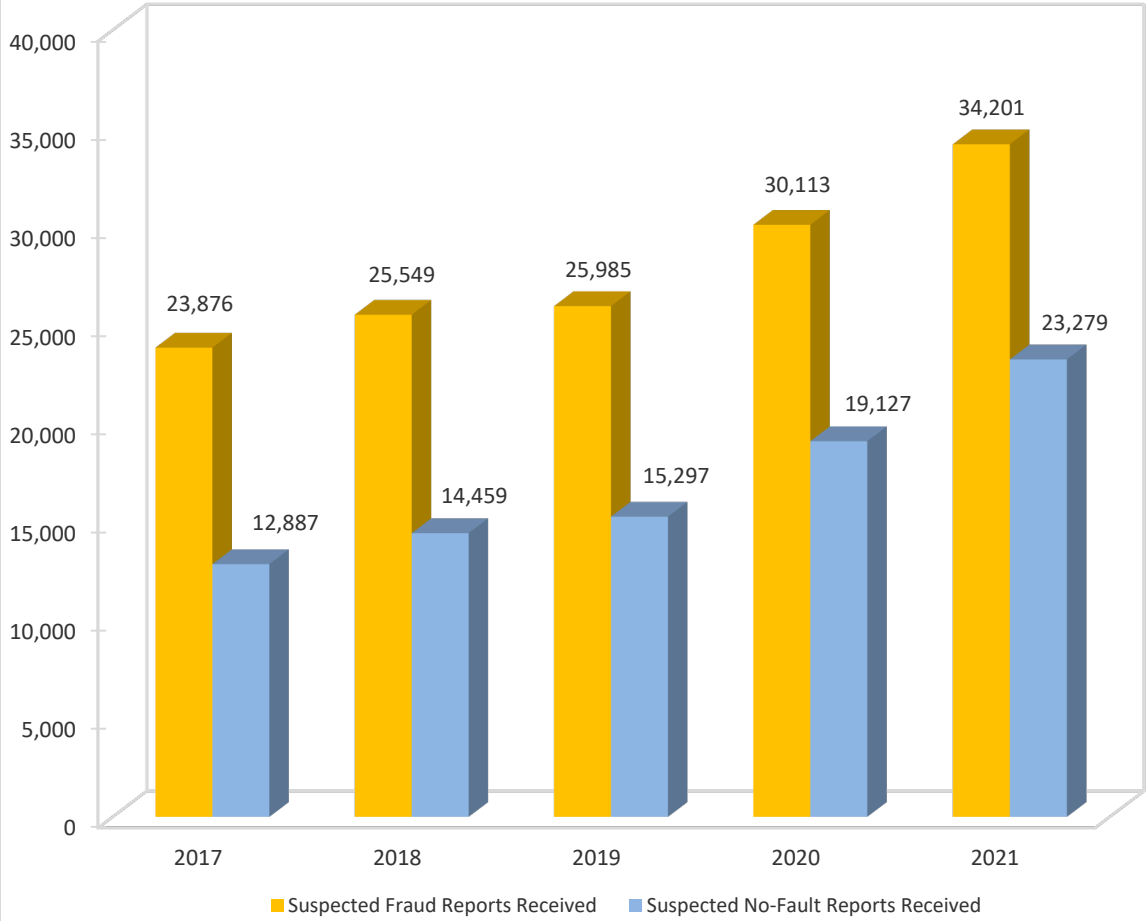
- Prescription drug diversion and misuse;
- Medical identity fraud;
- Billing for services that were never rendered or products that were not provided;
- Billing for more expensive procedures or services than were actually provided, commonly known as upcoding;
- Performing medically unnecessary treatments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

In 2021, 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 by the Numbers

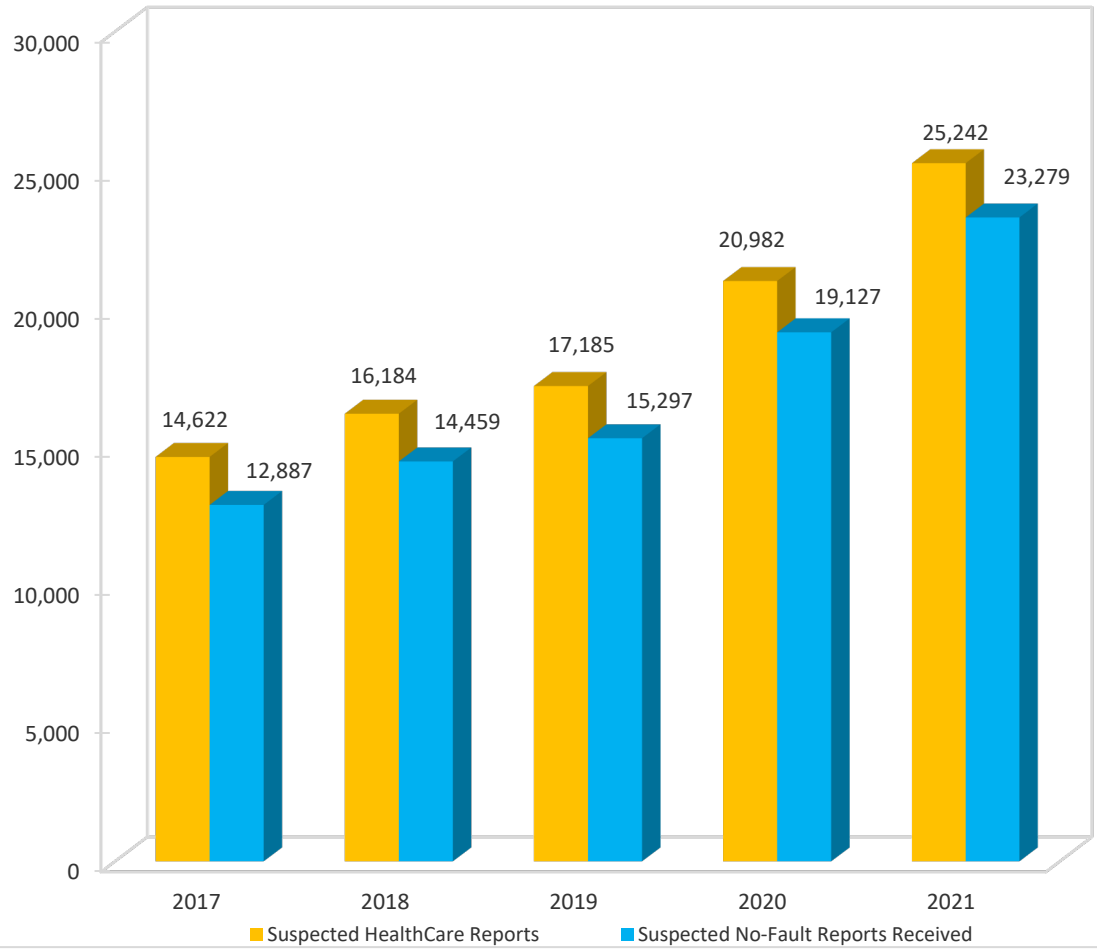
As shown in Figure 1, suspected no-fault fraud reports accounted for 68% of all fraud reports received by DFS in 2021.

Figure 1. Number of Suspected Fraud Reports Received Compared with Number of Suspected No-Fault Reports Received 2017 - 2021



As shown in Figure 2, the number of suspected no-fault fraud reports accounted for 92% of all healthcare fraud reports received in 2021 and at least 90% of all healthcare fraud reports received since 2017.

Figure 2. Number of All Suspected HealthCare Fraud Reports Received Compared with Suspected No-Fault Fraud Reports Received 2017 - 2021



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 11 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:

- New York State Department of Health Vaccine Complaint Investigation Team
- 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 broader 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.

DFS had been working on various COVID-19-related matters that commenced in 2020 and lasted well into 2021. DFS manned the New York State COVID-19 Complaint Hotline; DFS investigators were deployed throughout the state to enforce executive orders such as mask mandates along with the New York State Department of Health (DOH), NYSP and other state agencies. DFS investigators have had a presence at most area airports enforcing the COVID-19 Form for contact tracing.

DFS Insurance Fraud Bureau (IFB) investigators have been assisting DOH with COVID-19 vaccine investigations and have been assigned to work on the DOH Vaccine Complaint Investigation Team ("the Team"). The IFB investigators assigned to the Team conducted 171 investigations in the 2021 calendar year. Two cases led by IFB investigators resulted in arrests. The first occurred on May 28, 2021, when DOH received a complaint from the owner of a trucking company who reported that he needed to verify a COVID-19 vaccination card presented by an employee on May 19, 2021, because the card appeared suspicious. The Team subsequently

determined that the vaccination card had not, in fact, been issued by Walgreens Pharmacy as was stated on the card. On October 1, 2021, the Team interviewed the employee about his COVID-19 vaccination card and presented the employee with a copy of the card that he had submitted, as proof of vaccination, to the trucking company. During the interview, the employee stated that the original card was a counterfeit and that he had destroyed it. The employee was charged with one count of Criminal Possession of a Forged Instrument.

In a similar case, the Team investigated a suspicious vaccination card of an employee at a care facility. A human resources assistant at the care facility received the employee's vaccination card on October 11, 2021 and called a local supermarket to verify the card's authenticity. The supermarket advised that no one with the employee's name or date of birth had been vaccinated at that location. The employee admitted that the vaccine card was counterfeit. On November 17, 2021, the employee was charged with Criminal Possession of a Forged Instrument.

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 electronically submit reports of suspected fraud. In 2021, insurers electronically submitted approximately 97% of the 34,201 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 18 calls per month in 2021. The "Consumers" section of DFS's website also includes a link to an electronic 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. Likewise, 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), specific staffing levels within the SIU and other anti-fraud efforts.

Fraud Prevention Plan Requirements

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

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

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

In 2021, 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, 15 property and casualty insurers writing accident and health insurance had approved SIUs during 2021.

Health and life insurers reported $509 million in savings resulting from SIU investigations in 2020 (the most recent year for which data is available). Health and life insurers reported $36 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.

2021 Healthcare Fraud Reports Received and Arrests Made

DFS received 25,242 reports of suspected healthcare fraud during 2021: 1,797 involved accident and health insurance, 166 involved disability insurance, and 23,279 involved no-fault claims. DFS opened 60 healthcare fraud cases for investigation. Of those, 26 involved accident and health insurance, six involved disability insurance and 28 involved no-fault insurance. DFS investigations resulted in 16 arrests in 2021.

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 the internet. Additionally, billboards target 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 19 entities with Fraud Prevention Plans on file in 2021. 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, one insurance company has an ongoing internal program 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 numerous other confidential investigations of healthcare fraud that are pending.

- In November 2021, DFS investigators, working with other law enforcement agencies, arrested and charged a marketer of medical creams ("Marketer") with one count of Conspiracy to Commit Health Care Fraud. The marketer was involved in a conspiracy to market compound medications to employer-based prescription drug plans whose benefits included coverage for expensive compound medications. The compound medications were intended to be tailored to the medical needs of the individual patients. The Marketer and his associates, however, conspired to have the prescriptions written to include unnecessary ingredients that carried higher reimbursement rates from health insurers. The marketer's illicit actions caused $7,816,055.00 to be fraudulently paid from Blue Cross Blue Shield, Verizon Medical Expense Plan for New York and New England Associates, National Grid USA, and Sunovion Pharma.
- The Health Care Fraud Task Force, which includes DFS, investigated a pharmacy in Morrisville, New York, that was formerly owned and operated by a licensed pharmacist. The pharmacist submitted fraudulent claims to private insurance companies, Medicaid, and Medicare for expensive brand name drugs while, in fact, actually dispensing cheaper generic drugs to customers. Between 2010 and 2015, the pharmacist overbilled insurers by approximately $110,962. On October 7, 2020, the pharmacist signed a plea agreement with the US Attorney's Office for the Northern District of New York, in which she agreed to plead guilty to one count of Health Care Fraud. On October 28, 2020, the pharmacist entered a guilty plea to one felony count of Health Care Fraud. On September 1, 2021, the pharmacist was sentenced to two years of probation and ordered to pay a $10,000 fine as well as restitution in the amount of $110,431. In addition to DFS, the Health Care Fraud Task Force is comprised of the Federal Bureau of Investigation; the

U.S. Department of Health and Human Services; Office of Inspector General; the U.S. Drug Enforcement Administration; the U.S. Department of Labor-Employee Benefits Security Administration; and the New York Attorney General's Medicaid Fraud Control Unit.

- On March 11, 2021, the co-owner of a non-emergency medical transport provider for Medicaid recipients was arrested and charged with one count of Health Care Fraud. The charge stemmed from a multi-year investigation conducted by DFS and other law enforcement agencies wherein it is alleged that Medicaid and Managed Care companies were defrauded out of millions of dollars. The transport company provides transportation to patients to and from methadone clinics in Buffalo, New York. Between September 2016 and December 2020, employees of the company submitted fraudulent insurance claims stating that they had provided patients with single-rider transports, when, in fact, they had only provided group rides. By claiming the single rider rate, the company fraudulently received a larger reimbursement.

- On December 17 and 18, 2020, three individuals conspired to submit three separate no-fault insurance claims to Progressive Insurance ("Progressive"), all of which contained fabricated information. One subject stated that on December 17, 2020, he was involved in a motor vehicle accident while driving his 2015 Jeep Cherokee. He reported to the Rochester Police Department ("RPD") and Progressive that an unknown vehicle cut him off, causing his vehicle to hit a third vehicle, head on. A second female subject also submitted an insurance claim to Progressive stating that on December 17, 2020, she was involved in a motor vehicle accident while driving her 2010 Mercedes ML350. She reported to the RPD and Progressive that an unknown vehicle, a 2015 Jeep Grand Cherokee, cut her off, causing the two vehicles to hit each other head on.

  On December 18, 2020, the female subject's boyfriend submitted an insurance claim to Progressive stating on December 17, 2020, he was involved in a motor vehicle accident while driving his girlfriend's 2010 Mercedes ML350. The boyfriend reported to the RPD and Progressive that an unknown vehicle, a 2015 Jeep Grand Cherokee, cut off his vehicle, causing the two vehicles to hit each other head on. Progressive conducted an independent accident reconstruction, which included the examination of data from each vehicle's computer. The reconstruction yielded evidence that the accident did not occur as reported. The vehicles had never, in fact, hit one another head on. The 2015 Jeep Grand Cherokee owner attempted to obtain $16,046.20 from Progressive. The Mercedes owner attempted to obtain $11,544.97 from Progressive, and the Mercedes owner's boyfriend also attempted to obtain $11,544.97 from Progressive. All three claims were denied following the investigation. On August 6, 2021, the three individuals were charged with Insurance Fraud.

Conclusion

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