NEW YORK STATE
DEPARTMENT of
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Acting Superintendent

March 15, 2016

Dear Governor Cuomo, Comptroller DiNapoli, Attorney General Schneiderman, Temporary President and Majority Coalition Leader Flanagan, Senate Coalition Leader and Independent Democratic Conference Leader Klein, Speaker Heastie, Chairwoman Young, Chairman Hannon, Chairman Farrell, Chairman Gottfried and Senate Minority Leader Stewart-Cousins:

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.

The Department received 14,452 reports of suspected health care fraud during 2015, of which 1,356 involved accident and health insurance, 205 involved disability insurance and 12,891 involved no-fault insurance. The Department opened 92 health care fraud cases for investigation, of which 37 involved accident and health, 9 involved disability and 46 involved no-fault. Like last year's numbers, these statistics highlight the importance of fighting no-fault fraud, which costs New Yorkers hundreds of millions of dollars in insurance costs. Reports of no-fault fraud totaled 89 percent of health insurance fraud reports and more than half of all types of insurance fraud reports, making no-fault fraud again the biggest single fraud issue faced by the Department.

This report also highlights some of the significant criminal investigations undertaken during 2015, 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 79 arrests for health care fraud in 2015.

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

Respectfully submitted,

Maria T. Vullo
Acting Superintendent of Financial Services

Investigating and Combating Health Insurance Fraud

Report

March 15, 2016

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Acting 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 2015 activities of the Department of Financial Services in combating health insurance fraud.

2015 Highlights

The Department's Insurance Frauds Bureau (Bureau) investigates and combats health care 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: 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 health care fraud in 2015 include the following:

- The Bureau opened 92 health care fraud investigations in 2015 that resulted in 79 arrests;
- The Bureau received 14,452 reports of suspected health care fraud: 12,891 no-fault reports, 1,356 accident and health insurance reports, and 205 disability insurance reports;[1]
- Reports of suspected no-fault fraud accounted for 57% of the total reports received.

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. Experts agree that the costs of health care fraud are exorbitant: the National Health Care Anti-Fraud Association estimates that losses due to health care fraud are in the tens of billions of dollars each year. Combating fraud and abuse helps reduce the escalating costs of health care in the United States.

2015 Health Care Fraud Reports Received and Arrests Made

The Department received 14,452 reports of suspected health care fraud during 2015—1,356 involved accident and health insurance, 205 involved disability insurance, and 12,891 involved no-fault. The Department opened 92 health care fraud cases for investigation. Of those, 37 involved accident and health insurance, 9 involved disability insurance, and 46 involved no-fault insurance. Department investigations resulted in 79 arrests in 2015.

Types of Health Care Fraud

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

- Prescription drug diversion and misuse;

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

- 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 sole purpose of generating insurance payments;
- Misrepresenting non-covered treatments as medically necessary covered treatments, for example billing a 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;
- Accepting kickbacks for patient referrals.

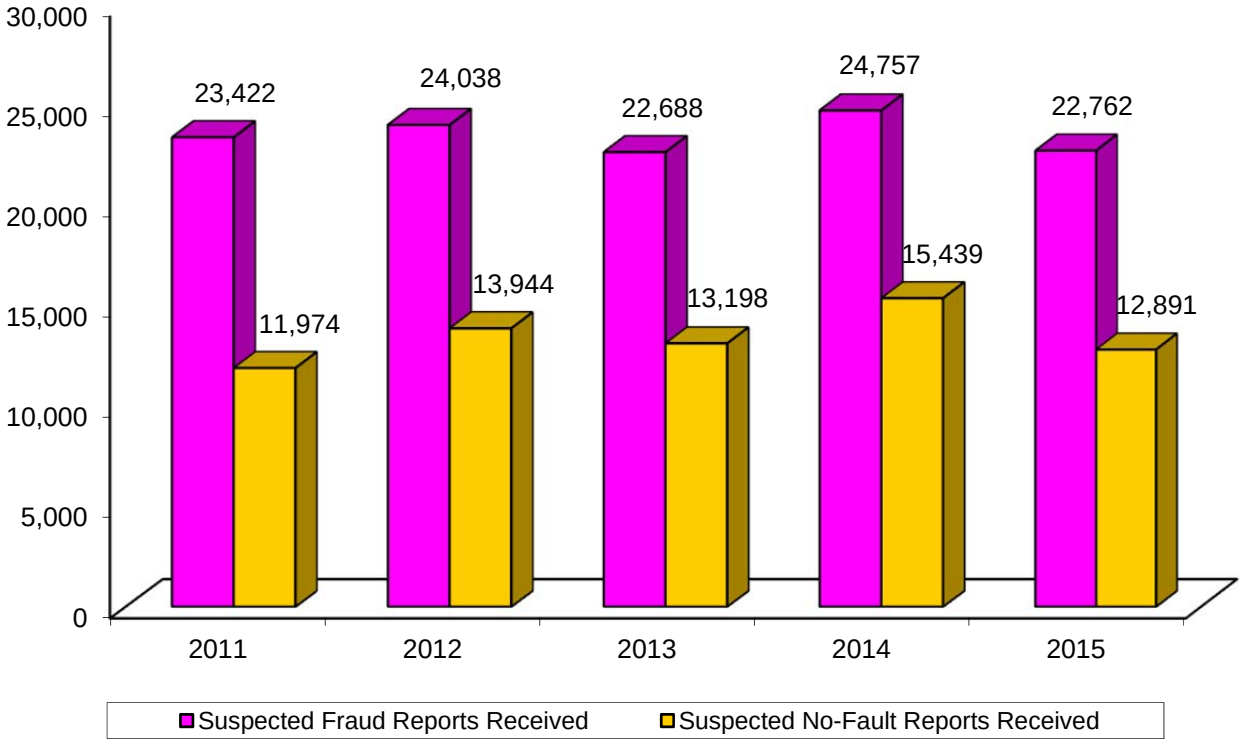
In 2015, the Department received numerous allegations of medical providers billing for services not rendered and prescribing unnecessary durable medical equipment. In addition, reports of prescription drug diversion and misuse, as well as allegations of disability fraud, remained persistent issues.

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. In 2015, the Bureau continued to work with the insurance industry, prosecutors, and law enforcement on investigations ranging from small, non-organized staged accidents and jump-ins, to complex investigations involving medical mills and unscrupulous health care providers who fraudulently billed insurers under the no-fault system. These large-scale investigations require the use of sophisticated investigative techniques, including court-ordered wiretaps, as well as undercover officers to infiltrate highly organized no-fault rings.

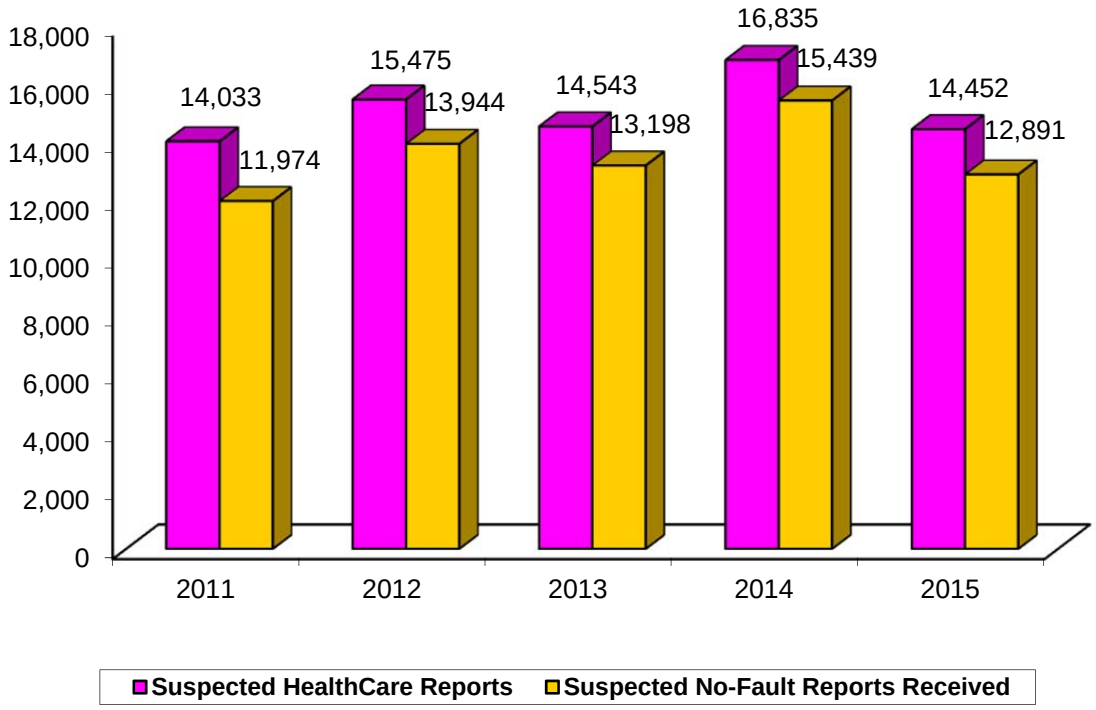
As shown in Figure 1 below, suspected no-fault fraud reports accounted for 57% of all fraud reports received by the Department in 2015**.**

Figure 1. Number of Suspected Fraud Reports Received Compared with Number of Suspected No-Fault Reports Received 2011 - 2015



As shown in Figure 2 below, the number of suspected no-fault fraud reports accounted for 89% of all health care fraud reports received in 2015 and at least 85% of all health care fraud reports received since 2008.

Figure 2. Number of All Suspected Health Care Fraud Reports Received Compared with Suspected No-Fault Fraud Reports Received 2011 - 2015



Collaborative Efforts to Combat Health Care Fraud

Department investigators work closely with the insurance industry and law enforcement agencies at the federal, state and local levels to combat health care fraud schemes. The Department is a member of ten task forces and working groups designed to foster cooperation and communication among the many law enforcement agencies involved in combating health care 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

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

Participation provides the opportunity for joint investigations, intelligence gathering, effective use of resources and the study of trends. Several of the Department's investigators have been assigned to those groups and partner with other group members investigating cases involving health care fraud. One example of these successful collaborations is the Drug Enforcement Administration Tactical Diversion Task Force, which investigates organized drug diversion schemes, "doctor shopping," and forgery of controlled-substance prescriptions. Successful investigations by the combined Upstate/Downstate Task Force resulted in 30 arrests in 2015. The Department assigns one investigator full time to each of the Upstate and Downstate offices of the Task Force. As a result of an investigation by the Downstate Office of the Task Force, a physician's assistant was sentenced to 11 years in prison and a fine of $1.8 million. He pleaded guilty to conspiracy to distribute oxycodone for prescribing more than 125,000 pills to individuals with no medical condition warranting prescriptions. He will also forfeit $1,870,680 in proceeds from the scheme and spend three years in supervised release after serving the imposed jail time. In another investigation involving the Downstate Task Force, an internist was arrested for selling 26 prescriptions for oxycodone and other medications to carefully chosen "patients" with no medical need for the medications.

Reporting and Preventing Health Care Fraud

Insurance Company Reporting

Under Section 405 of the New York Insurance Law, insurers are required to report suspected fraud to the Department. The Department has a web-based case management system, known as the Fraud Case Management System ("FCMS"), which allows insurers to submit reports of suspected fraud electronically. In 2015, insurers electronically submitted approximately 96 percent of the 22,762 fraud reports that the Department 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 on-line help screens and an on-line manual of operations, as well as search and cross-reference features.

Consumer Reporting

The Department encourages consumers to report suspected fraud and maintains a toll-free hotline to facilitate reporting. The Department recorded an average of 17 calls per week in 2015. The "Consumers" section of the Department's website includes a link to a fraud report form and instructions for how to report fraud to the Department.

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. Licensed health maintenance organizations (HMOs) with at least 60,000 enrollees also must 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.

In 2015, there were 63 insurer SIUs dedicated to investigating health care fraud in New York State. Those SIUs were housed within accident and health insurers, HMOs, life insurers, nonprofit medical, and dental indemnity and health service corporations. In addition, 13 property and casualty insurers with approved SIUs reported writing accident and health insurance business during 2015.

Health and life insurers reported $332 million in savings resulting from SIU investigations in 2014 (the most recent year for which data are available). Health and life insurers reported $37 million in recoveries from SIU investigations. In addition, three property and casualty insurers writing accident and health insurance reported $89,446 in savings.

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.

Section 409 specifies information that must be included in Fraud Prevention Plans. For example, a Plan must provide for an SIU 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 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 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.

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 19 entities with Fraud Prevention Plans on file. There were 36 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, several individual insurance companies have ongoing programs to heighten awareness and reduce public tolerance for insurance fraud. As a result, these anti-fraud messages reach millions of New Yorkers each year.

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.

The Year in Review

Some of the major health care fraud investigations conducted by the Bureau during the past year are summarized below.

- Ten defendants were arrested for orchestrating and participating in a series of staged accidents and "jump-ins." Many of these defendants allegedly agreed to participate in staged accidents for upfront payments or in expectation of monetary settlements from bodily injury lawsuits. They submitted a total of $137,000 in medical claims for nonexistent injuries. The joint investigation was conducted with the Manhattan District Attorney's Office Rackets Bureau and the NYPD's Fraudulent Collision Investigation Squad.

- Five suspects were arrested on charges stemming from their alleged participation in an insurance fraud scheme involving a staged auto accident. After an insurance company filed a report of suspected fraud, the Bureau initiated an investigation and interviewed the suspects, who admitted they were offered and accepted cash to be parties to a staged accident that one of the scammers set up with an unsuspecting motorist. Each of the participating passengers then sought treatment for nonexistent injuries, filed fraudulent no-fault claims and retained legal counsel to file a bodily-injury lawsuit in an effort to collect a monetary settlement. The insurance company was billed a total of $289,848 for fake injuries, but as a result of the investigation, only paid $1,045. The investigation was

conducted jointly with the NYPD with the assistance of National Insurance Crime Bureau and the insurance company.

- An internist who practiced medicine in New York for 19 years, including examining pilots to certify their physical and mental well-being, was arrested for selling 26 prescriptions for oxycodone and other medications to a group of carefully chosen "patients" with no legitimate need for the medications. He then submitted fraudulent bills to insurers for services that were never rendered. The investigation was conducted by the Drug Enforcement Administration Tactical Diversion Task Force, which included the Special Narcotics Prosecutor's Prescription Drug Investigation Unit, the NYPD, the New York State Health Department's Bureau of Narcotic Enforcement, and the National Insurance Crime Bureau.

- An insurer reported to the Bureau that it had received a credentialing application for a licensed psychologist working at a counseling center that included a copy of her educational degrees and a psychologist license from the New York State Education Department. The insurer checked with the Education Department and learned that the license was fraudulent, a fact that was confirmed in an investigation by the Bureau. Investigators interviewed the owner of the counseling center, who verified that the defendant had provided the reported documents, was seeing patients, and had been paid for her services. Investigators interviewed the defendant, who admitted that she was not licensed. The State Police and the Bureau executed a search warrant at the defendant's home and obtained laptops and other relevant documents. She was arrested and charged with forgery and related crimes.

- A former pharmacy owner plead guilty to grand larceny, after his arrest for submitting fraudulent claims to Medicaid and the New York State Health Insurance Program that used the names of physicians who had not issued the prescriptions. In one instance the alleged prescribing doctor was deceased. The plea anticipates a sentence of a three-year conditional discharge, contingent upon the defendant paying full restitution on the sentence date as follows: $137,459 to the New York State Department of Civil Service and $94,460 to the New York State Department of Health. A joint investigation with the Comptroller's Office and the Nassau County District Attorney's Office.

- An insurance company suspected that one of its policyholders had submitted fraudulent claims and reported the suspected fraud to the Bureau. Bureau investigators learned that the suspect was employed at a dental practice until she was discharged on suspicion of fraudulent billing. Records showed that she had submitted claims to the insurer in the names of her husband and children for dental work purportedly performed by her employer and had arranged to have the reimbursement checks forwarded directly to her. None of the work for which she filed claims was ever performed. She was arrested and charged with submitting fraudulent bills totaling an estimated $44,173. The Bureau worked with the Manhattan District Attorney's Office to secure the indictment.

Conclusion

The problem of health care fraud continues and is a major focus of the Frauds Bureau's work. The Bureau will continue to aggressively combat health care fraud in the year ahead.