Investigating and Combating Health Insurance Fraud

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Superintendent

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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 Department of Financial Services' ("DFS" or the "Department") efforts in combating health insurance fraud in 2024.

2024 Highlights

The DFS Insurance Frauds Bureau ("IFB") 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. IFB is headquartered in New York City, with offices in Garden City, Albany, Syracuse, Rochester, and Buffalo.

Highlights of the Department's efforts in combating healthcare fraud in 2024 include the following:

- IFB received 41,686 reports of suspected healthcare fraud: 38,846 no-fault reports, 2,646 accident and health insurance reports, and 194 disability insurance reports. Eighty nine percent of these reports were designated by the insurer as "for intelligence purposes" only or that the insurer is continuing to investigate the claim[1] with the remaining 4,585 reports recommended for further review by the Department.
- IFB opened 71 healthcare fraud investigations, resulting in 42 arrests.
- DFS required larger insurers to develop and submit for Department approval internal fraud prevention plans. Health and life insurers reported $3 billion in savings resulting from these efforts in 2023 (the most recent year for which data is available) and reported $30.6 million in recoveries.

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 $30 to $300 billion

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

each year.[2] 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 accident and health, private disability, and no-fault auto insurance lines. Combating fraud and abuse helps reduce the escalating costs of healthcare in New York and the United States. Common types of healthcare fraud include the following:

- 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.

Reporting 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.

[2] National Health Care Anti-Fraud Association, "The Challenge of Health Care Fraud," https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud.

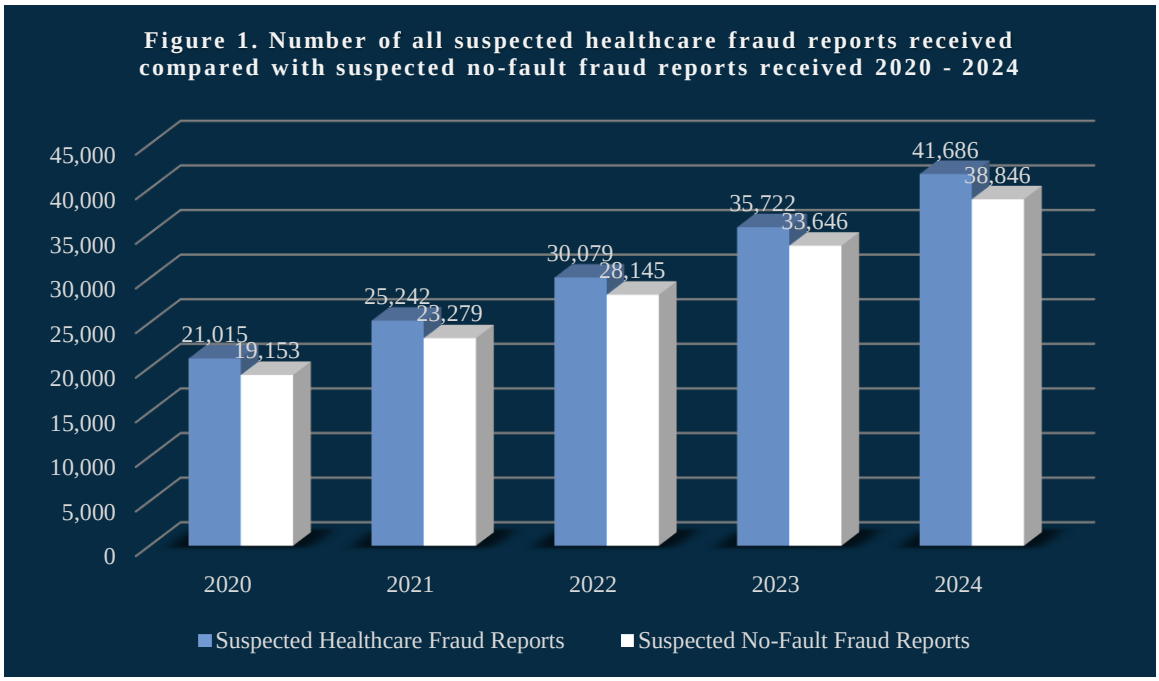
Consumer Reporting

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 67 calls per month in 2024. The Consumers section of DFS's website also includes a link to an electronic fraud reporting form and instructions for reporting fraud.

Healthcare Fraud Referral Statistics

In 2024, DFS received 41,686 reports of suspected healthcare fraud. Healthcare fraud reports accounted for approximately 80% of all fraud reports received by DFS in 2024. Eighty nine percent of these reports were from licensees required to submit reports of suspected fraud to DFS and designated by the insurer as "for intelligence purposes" only or that the insurer is continuing to investigate the claim. The remaining reports were from other sources, such as consumers and anonymous tips.

In 2024, DFS recived 38,846 no-fault fraud reports, accounting for 93% of all healthcare fraud reports received by the Department. The remaining healthcare fraud reports included 2,646 involving accident and health insurance and 194 reports involving disability insurance.



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.

While the vast majority of fraud referrals are designated by the insurer as "for intelligence purposes" only or that the insurer is continuing to investigate the claim and are not actionable, in 2024, DFS opened 71 healthcare fraud cases for investigation. DFS investigations resulted in 42 arrests in 2024.

DFS 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 healthcare fraud. Those task forces and working groups are the following:

- Central New York Health Care Fraud Working Group
- Drug Enforcement Administration Tactical Diversion Task Force (Upstate/Downstate)
- FBI New York Health Care Fraud Task Force/Medicare Fraud Strike Force
- High Intensity Drug Trafficking Area Program
- Long Island Financial Crimes Group
- Nassau County District Attorney's Office Revenue, Auto, Insurance, and Labor Crime Unit
- National Insurance Crime Bureau Working Group
- New York Alliance Against Insurance Fraud
- New York Anti-Car Theft and Fraud Association
- New York State Department of Health Vaccine Complaint Investigation Team
- Rochester Health Care Fraud Working Group
- Suffolk County District Attorney's Office Financial Crimes Bureau
- Western New York Health Care Fraud Task Force

IFB'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 DFS's participation in the Drug Enforcement Administration Tactical Diversion Task Force, which investigates organized drug diversion schemes.

Compliance with Section 409 of the New York Insurance Law

Section 409 of the New York Insurance Law ("Section 409") 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 also must 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 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 in 11 NYCRR 86.1 ("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 2024, there were 54 insurer SIUs operating in New York. These SIUs were housed within accident and health insurers, HMOs, life insurers, nonprofit medical insurers, and dental indemnity and health service corporations. In addition, 15 property and casualty insurers writing accident and health insurance had SIUs operating in New York in 2024.

Based upon the data gleaned from the annual SIU reports filed by the 54 accident and health insurers in the first quarter of 2024, health and life insurers reported $3 billion in savings

resulting from healthcare SIU investigations in 2023 (the most recent year for which data is available) and reported $30.6 million in recoveries from healthcare 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.

Public Awareness Programs

The 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 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 10 entities with Fraud Prevention Plans on file in 2024. In total, 59 HMOs, health insurers, or health insurer groups (an organization comprising affiliated insurers) with Fraud Prevention Plans on file 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. These anti-fraud messages reach millions of New Yorkers each year.

The Year in Review

Major Healthcare Investigation Highlights in 2024

Summarized below are additional major healthcare fraud investigations that IFB conducted during the past year (to the extent that information is public). IFB has numerous other confidential investigations of healthcare fraud that are pending.

- DFS partnered with the New York State Comptroller's Office and the Otsego County District Attorney's Office in an investigation concerning a business that operated as a Medicaid transport provider. The investigation determined that the business stole over $3.1 million from the Medicaid program over approximately four years through fraudulent billing. The business' main function was transporting patients to substance abuse treatment facilities in New York. The investigation found that the business submitted invoices and was paid by the Medicaid program based on fictious and misleading events, including phantom managed care services, phantom transportation events, billing for individual patient trips when they were actually group trips, and billing for fictious tolls and parking fees. The investigation culminated in the arrest and prosecution of two co-conspirators by the Otsego County District Attorney's Office.

- DFS partnered with the Suffolk County District Attorney's Office Financial Crimes Bureau to investigate fraudulent medical billing. The investigation determined that a service provider marketed themselves in the community as a licensed clinical social worker trained in psychotherapy and treated patients under that representation. However, the investigation found that the provider misled the community and insurers with respect to their credentials, having never passed the licensing examinations to be a clinical social worker. The provider also fraudulently billed insurers approximately $350,000 for phantom services that they never provided. The investigation resulted in the provider's arrest and prosecution by the Suffolk County District Attorney's Office.

- DFS, working in partnership with NYPD Fraudulent Collision Investigation Squad and the National Insurance Crime Bureau, investigated a no-fault insurance claim concerning a motor vehicle striking a pedestrian. The investigation determined that the pedestrian engineered the collision pursuant to a scheme, thereby putting themselves and others at risk for serious physical injury. The pedestrian was recruited into the scheme in return for a monetary payout. The investigation found that following the collision, the co-conspirators caused the pedestrian to be fraudulently treated at a medical clinic resulting in fraudulent billing to the insurer. The case is being prosecuted by the Bronx County District Attorney's Office.

- DFS partnered with the Metropolitan Transportation Authority ("MTA") to investigate a no-fault insurance claim involving a rider's injury sustained while on an MTA bus. The rider subsequently sought treatment for their alleged injuries at numerous medical services providers causing over $31,000 to be paid by the MTA. The investigation determined that the rider's injury claims were fictious, and his medical billing was fraudulent. The investigation resulted in the rider's arrest and prosecution by the New York County District Attorney's Office.

- DFS, working in partnership with the New York State Police, investigated a health insurance policyholder for submitting fraudulent claims for reimbursement. The investigation determined that the policyholder used their children's identity to submit over 200 claims for reimbursement for fictious medical services, resulting in a payout in excess of $31,000. The investigation resulted in the policyholder's arrest and prosecution.