



The Empire
Plan

SPECIAL REPORT

February 2019

Health Insurance Fraud

Health insurance fraud and abuse are expensive and potentially harmful crimes. National Health Expenditure Accounts (NHEA) data indicate that the United States spent \$3.5 trillion on health care in 2017, with estimated losses attributable to fraud and abuse amounting to \$230 billion. The FBI estimates that the greatest area of growth is in the number of cyberthefts involving individual medical identities.

So, how does this directly affect you? Fraud and abuse losses increase your health insurance premiums and contribute to rising out-of-pocket expenses, such as copayments and deductibles.

Fraud and abuse can also have a negative impact on your health and safety. For example, a provider may knowingly subject you or your family members to unnecessary or dangerous medical procedures solely to bill your insurance company and increase profits.

Theft of your medical identity to obtain fraudulent medical services and the filing of false insurance claims for profit can directly affect your credit and lead to the creation of false medical records.

Fraud and Abuse

Health insurance fraud involves knowingly deceiving, concealing or misrepresenting information that results in health care benefits being paid to an individual or group. The most common types of health insurance fraud involve false statements or distorted information that affect the payment of a claim.

Health insurance abuse, like health insurance fraud, typically involves charging for services that are not medically necessary, do not conform to professionally-recognized standards or are unfairly priced. However, unlike fraud, it is quite difficult to establish that the abusive acts were done with the intent to deceive the insurer.

Both fraud and abuse are wrong and needlessly drive up the cost of health insurance. Knowingly and willfully defrauding any health care benefit program is a federal crime, punishable by up to 10 years in prison and significant financial penalties, as well as other state or federal charges that may apply.





Health Insurance Fraud

Provider Fraud

Health insurance fraud is primarily committed by a small number of health care providers. According to the National Health Care Anti-Fraud Association, the most common types of provider health fraud include:

- Waiving patient copayments, coinsurance or deductibles and overbilling the insurance carrier or benefit plan
- Upcoding, or billing for more expensive services or procedures than those that were provided
- Unbundling, or billing each step of a procedure as if it were a separate procedure
- Falsifying a patient's diagnosis to justify tests, surgeries or other procedures that are not medically necessary
- Misrepresenting non-covered treatments as medically necessary covered treatments for purposes of obtaining insurance payments
- Performing services that are not medically necessary solely to generate insurance payments
- Billing for services never rendered
- Accepting kickbacks for patient referrals
- Medical identity theft
- Prescription shorting
- Patient brokering

Enrollee Fraud

While it may be more typical for providers to commit insurance fraud, some enrollees are guilty of this crime too. There are many different forms of enrollee fraud, but the most common include:

- Enrollment of ineligible dependents
- Use of another person's health insurance identification card to obtain medical care, supplies or equipment
- Alterations on enrollment forms
- Failure to report other coverage
- Failure to disclose claims that were another party's responsibility
- Falsifying or fabricating medical claims or invoices
- Prescription drug misuse



Common Health Insurance Scams

Although opportunities to commit health insurance fraud are numerous, there are some scams criminals use to steal health care dollars that have become more prevalent due to the Internet and the opioid crisis. By being aware of the types of scams and fraud described below, you can better protect yourself and The Empire Plan.

Medical Identity Theft

To defraud insurers, some criminals commit what is called medical identity theft by stealing victims' names, health insurance policy numbers and other personal data, including Social Security Numbers. Medical identity theft due to cybersecurity breaches is the fastest growing form of fraud. The number of thefts has risen steadily from 135,000 cases in 2009 to 2.9 billion cases in the first nine months of 2018. And, that number continues to grow.

Criminals use victims' identities to obtain medical services for themselves or to create false insurance claims from which they can profit. It is estimated that, in the first nine months of 2018, stolen medical records cost the health care industry nearly \$3.9 billion, according to a joint study by the Ponemon Institute and IBM. These criminals alter individual medical records to create false medical claims that can take months to discover. Victims often don't realize their identities have been stolen until their credit scores drop or they start receiving calls from collection agencies about unpaid medical bills. The Coalition Against Insurance Fraud estimates that insured individuals pay an average of nearly \$13,500 in out-of-pocket costs to resolve fraudulent claims.

Creation of False Medical Records

Another form of fraud involves the alteration of medical records by dishonest providers who create false or inflated diagnoses so they can submit fake insurance claims for higher payments. Like medical identity theft, false information entered in your medical file can be very difficult to detect and correct, and it may affect your future medical treatment. It can also jeopardize your

ability to obtain certain jobs, licenses or even future insurance such as life insurance and long-term care policies.

“Free” Medical Treatments and Equipment

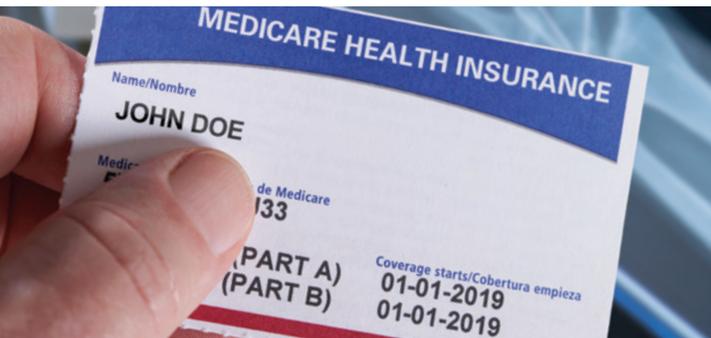
Offers of “free” medical treatments, consultations and medical equipment, such as orthotic braces, wheelchairs and other durable items, can come in the form of advertisements, door-to-door solicitations and email or telephone offers. While they may sound legitimate and very appealing, these offers may be attempts by con artists to get your insurance information so they can submit falsified medical claims and bill your insurance company for services you never received or overpriced equipment. False claims for durable medical equipment, due to Internet and telephone scams, is the second fastest growing form of fraud after medical identity theft.

Prescription Scams and Frauds

New York State passed legislation to address prescription drug abuse in 2015. The I-STOP Act requires that all prescriptions be sent electronically as a means of preventing drug diversion that results from the forgery and theft of paper prescriptions. While this legislation has reduced the number of opioid prescriptions and quantity of pills dispensed, incidents of prescription shorting, prescription splitting and drug diversion continue to occur.

Prescription shorting occurs when a pharmacy fills a prescription for fewer days than a doctor has prescribed and then bills the patient's insurance company for the cost of the full prescription. By falsifying the number of pills used to fill a prescription, the pharmacy can then sell the medication not dispensed for profit or return it to inventory.

Another scheme called prescription splitting involves pharmacies filling half a prescription and then asking the patient to come back later for the second half. The pharmacy then bills the insurance



company for the full prescription twice, once when the prescription is first submitted and a second time when the patient returns for the remainder.

Drug diversion occurs when a pharmacist talks a patient into getting a prescription from their doctor, then having it filled and billed to their insurance company in return for a cash payment. The prescription and the drugs are then cycled back into the pharmacy or sold on the street.

Fee Forgiving or Coinsurance Waivers

Another scheme used by some medical providers is called fee forgiving or coinsurance waivers. It occurs when a provider, who is nonparticipating or out-of-network, offers to accept a plan's payment as full payment for services while waiving any fees owed by the enrollee. The provider then submits a specific charge for services to the insurance company that is higher than the fee being charged and paid by the enrollee. By overstating charges, the provider inflates the insurance reimbursement, which ultimately has the effect of increasing health insurance premiums.

If The Empire Plan is made aware that a provider is consistently billing it for a higher fee than the provider is collecting from an enrollee, the enrollee may ultimately be held responsible for the rest of the out-of-pocket costs required by the Plan.

Patient Brokering and Addiction Treatment Fraud

Patient brokering is a practice in which brokers collect payment from out-of-network addiction treatment providers in exchange for referring patients to those programs. A broker can be a health care provider, health care facility, substance use program, addiction counselor, credentialed professional or any other individual who engages in this practice. Often, the care being offered is located outside New York State and is more expensive and of lower quality than care provided within New York State. In these instances, instead of providing treatment as promised, these brokers use patients solely for financial gain.

In August 2018, New York State passed legislation to prohibit patient brokering. Under the new law, physicians in New York State who are engaged in patient brokering can have their credentials and licensure revoked and be subjected to fines.

Warning Signs of Patient Brokering:

- Patient brokers might offer incentives to attend a facility, such as free airfare, free or reduced rent, prepaid debit cards, cellphones or cash, or to waive or reimburse out-of-pocket insurance costs.
- When researching a facility online, its website should provide specific facility information such as a local telephone number, physical address, and the names and credentials of treating physicians. If the website only provides a toll-free number, it likely belongs to a patient broker.

Medicare Card Scams

To help protect seniors from identity theft, Congress mandated that Medicare, which is administered by the Social Security Administration and the Centers for Medicare and Medicaid Services, remove Social Security Numbers from Medicare ID cards by April 2019, and that new cards be reissued to all Medicare beneficiaries.

While the change is meant to help protect seniors, it has sparked a series of telephone scams involving callers pretending to be from Medicare. They tell seniors they need their Social Security Numbers in order to verify that the new ID cards are correct. Criminals may also try to convince seniors that they need to buy a temporary card while they wait for their new card to be issued as a means of obtaining bank account or credit card information.

Remember, Medicare will automatically issue you a new card with your new ID number on it. You do not have to do anything. Medicare will never call you to ask you for personal or private information.

Personal Injury Mills

Personal injury mills involve dishonest attorneys and doctors who use accident victims or workers' compensation claimants to bill insurance companies for nonexistent or minor injuries. The typical scam includes "cappers" or "runners" who are paid to recruit legitimate or fake vehicle accident victims or workers' compensation claimants. The victims are then referred to specific doctors or medical providers who are also in on the scam.

To try to maximize medical expenses, the providers fabricate diagnoses and provide expensive but unnecessary services. The goal of the personal injury mill scam is to keep all the diagnoses and treatment within the same facility to avoid any outside influence. The lawyers involved may then seek settlements based on the fraudulent or exaggerated medical claims.

How to Report Health Insurance Fraud

If you suspect that you may be a victim of health insurance fraud or abuse, you should report it immediately by filing a complaint.* Provide a detailed explanation of what you suspect is wrong and why. For example, you paid for services that were not performed, you suspect someone has used your insurance information inappropriately, or you were given tests and services that were unnecessary. Save all your medical bills, receipts, test results, claim forms, prescription records and Explanation of Benefits (EOB) statements since they may be useful in the investigation of your complaint.

* See the top of page 6 for the three steps you can take to report health insurance fraud or abuse.

To report health insurance fraud or abuse, please take the following steps immediately:

1. Call The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and choose the applicable program.
2. Report the incident to the Department of Financial Services Fraud Bureau at 1-888-FRAUDNY (1-888-372-8369).
3. Contact the Office of Alcoholism and Substance Abuse Services at StopTreatmentFraud@oasas.ny.gov.

Prevention

While The Empire Plan monitors provider billing practices and enrollment records, your awareness of fraud and abuse and careful monitoring of your benefit usage is critical to protect yourself and the Plan from illegal activity.

Here are some simple steps you can take to protect yourself and the Plan:

- Report lost or stolen benefit cards.
- Notify your HBA or the Employee Benefits Division whenever your or your dependents' eligibility changes.
- Never give your Empire Plan or Medicare identification number to anyone except your physician or health care provider.
- Do not share medical or insurance information by phone or email unless you initiated the contact.
- Monitor your EOB statements for suspicious activity. If anything looks incorrect or unusual, call The Empire Plan immediately.*
- Never sign a blank insurance claim form.
- If you have access to MyNYSHIP from your NYSHIP Online homepage, carefully review the information about you and your enrolled dependents to make sure it is accurate and current.
- Keep accurate records of all health care appointments, including names of the physicians or providers you saw, the date and time of appointments and the services provided.
- Do not allow anyone except your appropriate medical professionals to review your medical records or recommend services.
- Avoid a provider of health care items or services who tells you that they know how to get your Plan to pay for an item, equipment or service that is not usually covered.
- Be suspicious of providers who charge copayments for services covered in full by your Plan, routinely waive copayments or coinsurance for services or use pressure or scare tactics to sell you high-priced medical services, diagnostic tests or supplies.
- Count the number of pills dispensed when you fill prescriptions. Avoid pharmacies that fill your prescription for fewer days than your doctor has prescribed.
- Be wary of unsolicited referrals to out-of-state addiction treatment facilities. Instead, contact the Mental Health and Substance Abuse Program, the Beacon Health Clinical Referral Line or your primary care provider for a referral to a state-certified treatment program.

* See the top of this page for contact information to report fraud or abuse.

Health Insurance Fraud Q & As

Q. I visited an out-of-network specialist for some testing and was told not to worry about paying my coinsurance. That's not health insurance fraud, is it?

A. Under certain circumstances, yes, it can be fraud. Medical providers who routinely waive patient out-of-pocket obligations, such as deductibles and coinsurance, may be engaging in fraudulent behavior. Out-of-pocket reimbursement is determined from the provider's actual submitted charge and not the lesser amount that the provider was willing to accept from the enrollee as payment in full for their services. You should discuss this issue and your potential out-of-pocket liability with your provider before you receive services. If you suspect provider fraud or abuse, call The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and choose the applicable program.

Q. My doctor sent me to a lab to get blood work done to test my cholesterol. When I got my Explanation of Benefits (EOB) Statement, I noticed the provider billed The Empire Plan for services I didn't receive. Is that health insurance fraud?

A. Yes, under certain circumstances, it could be fraud. If a medical provider charges for services that were not rendered, they could be committing health insurance fraud. If anything on your EOB statement is inaccurate or looks suspicious, contact The Empire Plan immediately at 1-877-7-NYSHIP (1-877-769-7447) and choose the applicable program. After you file a report, an investigation will be performed to determine the circumstances of the billings and whether they should be considered fraudulent or abusive in nature.

Q. My wife and I just got divorced. The court said I must keep paying for her health insurance. Can I keep her as a dependent on my Empire Plan coverage?

A. No. Your spouse, including a legally separated spouse, is eligible, but if you are divorced or your marriage has been annulled, your former spouse is not eligible, even if the court orders you to maintain coverage. If your marriage ends, you must notify your HBA and end coverage for your former spouse, effective the date the marriage ends. Your former spouse may be able to continue coverage under COBRA (see the COBRA: Continuation of Coverage section of your *General Information Book*).



Resources

NEW YORK STATE

NYSHIP

New York State Health Insurance Program

1-877-7-NYSHIP (1-877-769-7447)

www.cs.ny.gov/employee-benefits

New York State Department of Financial Services Insurance Fraud Bureau

One Commerce Plaza

Albany, NY 12257

1-888-FRAUDNY (1-888-372-8369)

www.dfs.ny.gov/consumer/scamsfraud.htm

New York State Department of Health Office of Professional Medical Conduct

Riverview Center

150 Broadway, Suite 355

Albany, NY 12204-2719

1-800-663-6114

www.nyhealth.gov/professionals/doctors/conduct

New York State Office of the Professions

1411 Broadway, 10th Floor

New York, New York 10018

Phone: 1-800-442-8106

Fax: 212-951-6420

www.op.nysed.gov/opd

FEDERAL GOVERNMENT

National Health Care Anti-Fraud Association

1201 New York Avenue, NW Suite 1120

Washington, DC 20005

Phone: 202-659-5955

Fax: 202-785-6764

www.nhcaa.org

Office of the Inspector General U.S. Department of Health & Human Services

1-800-HHS-TIPS (1-800-447-8477)

TTY: 1-800-377-4950

www.oig.hhs.gov/fraud/report-fraud

MEDICARE

1-800-MEDICARE (1-800-633-4227)

www.medicare.gov/forms-help-resources/help-fight-medicare-fraud

New York State Department of Civil Service, Albany, New York 12239, www.cs.ny.gov

It is the policy of the New York State Department of Civil Service to provide reasonable accommodation to ensure effective communication of information in benefits publications to individuals with disabilities. These publications are also available on the Department of Civil Service website (<https://www.cs.ny.gov>). Click on Benefit Programs then NYSHIP Online for timely information that meets universal accessibility standards adopted by New York State for NYS Agency websites. If you need an auxiliary aid or service to make benefits information available to you, please contact your agency Health Benefits Administrator. COBRA Enrollees: Contact the Employee Benefits Division.

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