State of New York
Office of the Attorney General
Division of Social Justice

HEALTH CARE BUREAU

Real Solutions for New Yorkers: 2011-2012

Prepared by
The Health Care Bureau

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INTRODUCTION

This document briefly describes the work of the Attorney General's Health Care Bureau (HCB) in the period of January 1, 2011 through December 31, 2012. For further information about the HCB, including press releases on our most recent work, consumer information materials, and reports, please visit http://www.ag.ny.gov/bureau/health-care-bureau.

THE HEALTH CARE BUREAU

The Health Care Bureau is part of the Social Justice Division[1] in the New York State Office of the Attorney General. The Health Care Bureau's principal mandate is to protect and advocate for the rights of health care consumers statewide through:

○ **Operation of the Health Care Helpline**. This toll-free telephone hotline (800-428-9071) provides assistance to New York health care consumers by employing advocates who provide helpful information and referrals, investigate individual complaints, and mediate resolutions to help protect consumers' rights within the health care system.

○ **Investigations and enforcement actions.** The HCB conducts investigations and litigation against health plans, health care providers, and other individuals and entities that engage in fraudulent, misleading, deceptive or illegal practices in the health care market.

○ **Consumer education.** Through outreach and dissemination of information and materials, the HCB seeks to inform New Yorkers about their rights under state and federal health and consumer protection laws.

○ **Legislation and policy initiatives.** The HCB promotes legislative and policy initiatives to enhance the rights and well-being of consumers and their ability to access high-quality and affordable health care in New York State.

THE HEALTH CARE BUREAU'S HELPLINE[2]

The HCB's Health Care Helpline is the Attorney General's front line in registering and resolving consumer complaints regarding health care.

Between January 1, 2011 and December 30, 2012, the Health Care Helpline handled over 10,000 cases. Of these cases, 6,929 complaints were investigated by HCB staff and another 3,438 consumers were provided with information or referred to an appropriate agency to handle the inquiry. The complaints handled by the Health Care Helpline highlight the challenges faced by New York health care consumers and identify systemic problems in New York's health care system. Problems identified through the Helpline have sparked investigations of and enforcement actions against health plans, providers, and other entities operating in the health care market with the objective of protecting consumers' health care rights by providing affirmative, systemic relief to solve the

[1] In addition to Health Care, the Social Justice Division includes Civil Rights, Labor, Environmental Protection, Charities, and Tobacco Compliance, each of which enforce the relevant laws to protect consumers in New York.
[2] Please see "CONSUMER TIPS!" at end of report, for a summary of consumer advice, in light of consumer complaints filed with the Health Care Bureau Helpline.

problem and by helping affected consumers obtain appropriate monetary refunds (known as "restitution").

OUR FINDINGS: January 1, 2011 - December 31, 2012

In looking at our complaint data over this two-year period, we found the following:

- The greatest single issue that prompts New Yorkers to contact the HCB Helpline (26% of all handled, non-referred complaints) is provider billing. The majority of these complaints (60.4%) relate to improper provider billing practices, such as the improper balance billing of patients and the failure to submit claims to insurance companies.

- The other most common issues prompting New Yorkers to contact the HCB Helpline are: claims processing and payment problems, such as disputes between providers and the insurance plans (23.8%); health plans' denials of care or coverage, such as denials based on the treatment not being "medically necessary" (14.6%); wrongful business practices, such as false advertising (11.6%); problems obtaining and keeping health insurance coverage (7.9%); and problems accessing prescription medications (5.7%).

- Many consumers who call the Helpline are confused about their benefits, the rules to follow to secure coverage for care, doctor or hospital charges, appeal rights, or where to get help with some other aspect of health care. While not all consumer complaints and inquiries can be resolved in the consumer's favor (*e.g.,* where the consumer is frustrated with a valid denial of care, a legitimate bill, or the inherent imperfections of the health care system), the HCB Helpline plays a crucial role as a source of reliable and objective information for health care consumers.

In the two-year period between January 1, 2011 and December 31, 2012, the HCB Helpline secured over $6 million in restitution for consumers across New York State, and helped countless New York individuals and families obtain medically necessary care that was previously being denied.

CONSUMER COMPLAINTS AND HEALTH CARE BUREAU ENFORCEMENT ACTIONS:

HIGHLIGHTS

The following provides further information on the most common issues prompting health care consumers to call the Helpline, as well as actions taken by the Helpline advocates to resolve consumer complaints and the HCB's enforcement actions.

(1) Provider Billing Practices

26% of all HCB consumer complaints are prompted by concerns regarding provider billing practices. Although state regulations and many participating provider health insurance contracts forbid providers from billing consumers, some providers nonetheless improperly bill consumers and subject them to collection actions. Typical complaints related to provider billing include:

- That consumers are being billed by an out-of-network provider who participated in the consumer's care — often to the surprise of the consumer who either received services in

the emergency room by an out-of-network provider, or in the context of a planned hospital procedure, did not know that the provider was part of the medical team providing services (e.g., out-of-network anesthesiologists or radiologists providing care at an in-network hospital).

- That the provider failed to submit the claim to the insurance company.
- That consumers are being balance-billed by in-network providers, whereby in-network providers bill patients when they have agreed to accept the contracted payment from the insurance company.

Enforcement Action[3]

- **NY Medical & Diagnostic Balance Billing:** In May 2012, New York Medical & Diagnostic Center, Inc. (NYMDC), a twenty-provider practice, signed an Assurance of Discontinuance[4] to remedy its illegal "balance-billing" of patients who were members of insurance plans with which NYMDC participated. Doctors who are participating in a health plan's network are not permitted to bill patients in that health plan. The Assurance of Discontinuance requires NYMDC to comply with the balance billing requirements of New York law and the terms of its provider contracts, provide restitution to consumers, and pay a penalty of $7500.

Helpline Resolutions

- **Improper Out-of-Network Provider Balance Billing:** A consumer had received treatment in the emergency room (she required immediate neurosurgery), which was provided by, unbeknownst to her at the time, an out-of-network provider group. She contacted the Helpline after receiving a bill from the out-of-network provider group for $145,898 (the bill noted that the insurance company had not paid the claims). Upon receiving the complaint, an advocate checked with the insurer and found that the out-of-network surgeons had agreed to accept the contract rate and *not* bill the consumer for the balance. The insurance company confirmed that the providers were paid according to this agreement and contacted the provider group to determine why the patient still received a bill. The medical group acknowledged that the patient should not have been billed and wrote off the $145,898 balance.

- **Out-of-Network Balance Billing for Emergency Care:** A municipal employee contacted a consumer advocacy group in response to large bills he received after undergoing emergency surgery and hospitalization. While the hospital participated in the patient's plan, his surgeons did not, and the patient received over $200,000 in medical bills. The plan covered very little in out-of-network reimbursement to the surgeons, and the patient was billed for the difference. The advocacy group called the Helpline, and both groups, together, worked to address the patient's situation. The plan argued that its reimbursement was appropriate because, notwithstanding contrasting information on a public website, the member's

[3] "Enforcement Action" refers to action — including, investigation, litigation, resolution — taken by assistant attorneys general to address an illegality.

[4] An Assurance of Discontinuance ("AOD") is a settlement document that the Attorney General may accept instead of filing a civil lawsuit in any case for which a person or entity has engaged in acts or practices that are in violation of law.

handbook states that the plan relies on fee schedules for out-of-network claims. As a result of the HCB advocate's involvement, an agreement regarding appropriate reimbursement was reached, and the case was resolved without the patient facing any financial liability.

(2) Claims processing and payment problems

Nearly one quarter of HCB complaints (23.8%) arise from health plan mistakes in preparing, processing, or paying claims. Nearly 40% of these complaints involved errors by the health plans, including the plan's failure to process or pay the claims, the health plan paying the incorrect amount, or errors by the health plans regarding deductibles and/or copayments. Some of the most common complaints relating to health plans' claims and payment processes include:

- That health plans did not process claims at all or did not process them in a timely manner.

- That consumers did not understand out-of-network providers' reimbursement rates — in particular, consumers did not understand when a policy had changed from one reimbursement methodology to another, how little the out-of-network provider would be paid, or how to calculate an out-of-network provider's reimbursement rates.

Enforcement Actions

- **GHI Out-of-Network Coverage:** GHI agreed to sign an Assurance of Discontinuance to resolve its mishandling of claims in violation of its own policy of covering certain out-of-network provider services (e.g., radiology and pathology) as in-network when: (1) provided at an in-network facility; (2) the primary service is by an in-network provider; or (3) provided in the context of emergency services. The settlement will yield an estimated $514,000 in restitution to members.

- **AXA Equitable - Reimbursement Methodology:** AXA Equitable agreed to sign an AOD to address improper changes to its out-of-network reimbursement methodology. In September 2011, AXA replaced its usual and customary rate reimbursement methodology with a different methodology that resulted in lower payments to providers and a greater financial burden on its members. AXA never disclosed this change to its members. In the AOD, AXA agreed to stop using its new out-of-network reimbursement mechanism and to adopt a reimbursement methodology based on data from FAIR Health. AXA also agreed to fully disclose its new methodology to members. Additionally, AXA agreed to provide restitution to members, which ultimately led to restitution of over $160,000.

- **Excellus - Proper Calculation of Deductibles:** The HCB received many complaints from consumers that their health care claims were not being properly paid by Excellus after their required deductibles had been met. The HCB's investigation revealed that Excellus's automated claims system was failing to properly account for payments toward the members' deductibles. Excellus found that this was the result of a technical computer error and responded by fixing the error, as well as notifying and reimbursing appropriate members. In November 2012 Excellus signed an AOD in which it agreed, amongst other provisions, to certify that the technical problem had been fixed, to ensure that all impacted members received restitution for any amount paid in excess plus interest, and to take steps in the future to monitor the program to ensure deductibles are properly assessed.

Helpline Resolution

- **Incorrect Reimbursement by Health Plan:** A provider called the Helpline on behalf of a patient, stating that the patient was incompletely reimbursed by the health plan for an inpatient stay lasting approximately one month. While the plan approved and paid for the last six days of the inpatient admission, it denied coverage for the beginning of the stay. The plan cited various reasons for the denial, including that coverage was not in effect for those dates and that an authorization was not obtained. The provider, however, had a letter from the plan authorizing the first three weeks of the stay. The HCB advocate contacted the plan and confirmed that the patient was covered for the entirety of the time in question. The health plan agreed to cover the remainder of the inpatient stay and reimbursed the provider approximately $15,000.

(3) Denials of care or coverage

Approximately 15% of all HCB consumer complaints involve health plan denials of care or coverage for care. Such denials most often occur based on claims that the care was not medically necessary or that the care provided was not a covered benefit, and in approximately 25% of these complaints the denial was due to health plan error.

Enforcement Action

- **Childhood lead testing:** An investigation of hundreds of denials of childhood lead tests settled in March 2012 with Excellus BlueCross BlueShield. The settlement requires the health insurer to accurately process claims for lead screening tests. It also requires Excellus to fix its faulty claims system and provide refunds to members who paid for lead screening tests out-of-pocket after initially being denied. The refunds totaled $27,330.

Helpline Resolutions

- **Medical Necessity Denial**: A consumer contacted the HCB Helpline because his HMO denied authorization for an MRI of his lower back. The consumer was experiencing constant pain running down both of his legs and numbness from his knees to his feet. The MRI was requested by his physician, who had been treating the patient for over four decades. The patient was concerned that his physician's opinion was being questioned by doctors who were not familiar with his medical condition. The HCB advocated on the patient's behalf, and the denial was overturned. The MRI revealed a pinched nerve, which was fixed with subsequent surgery. The patient's pain and numbness were relieved, and he was able to return to work.

- **Coverage Denial Due to Provider Error:** A consumer called the HCB Helpline because a claim was paid by his insurance company as if the provider was out-of-network, when in fact the provider was in-network. The advocate contacted the health care plan, which discovered that the claim was filed with the provider's personal tax ID (which was non-participating) rather than his medical group's ID. The plan fixed this error and paid the claim as an in-network benefit.

- **Coverage Denial Due to Plan Error:** A consumer called the Helpline because she was scheduled to undergo breast cancer reconstruction with an out-of-network plastic surgeon

who has expertise in performing DIEP flap reconstruction. The day before the scheduled surgery, the hospital told the patient that it needed proof of authorization before noon or they would cancel the surgery. The plan denied the authorization on the basis that it has in-network surgeons who can perform the surgery. However, that denial was based on incorrect information because the in-network surgeon could not do this particular type of reconstruction. The plan's case manager acknowledged this error to the patient but claimed she did not have authority to overturn the decision and there was no way to know when the medical director with authority to overturn it would be able to do so. The advocate intervened and contacted the plan, and the denial was overturned by the deadline. While an authorization letter could not be generated in time, the advocate was able to secure a screen print of the authorization so the hospital had proof of coverage. The patient was able to undergo the reconstruction surgery without delay.

- **Mental Health Coverage Denials:** In 2011 and 2012, the Helpline received 156 complaints regarding insurance coverage of mental health and substance abuse disorder treatment. In one such case, the family of a young woman with severe anorexia nervosa contacted the HCB because its health insurance company denied coverage for her treatment. The young woman had been medically hospitalized after refusing to eat and rapidly losing weight, and had tried outpatient programs without success. The insurance company, however, refused to cover any days of inpatient or residential treatment for her condition. With the HCB's assistance, the insurance company's denial was overturned and the young woman was able to receive medically necessary care in specialized inpatient and residential treatment facilities.

(4) Wrongful practices

Nearly 12% of consumer complaints were due to wrongful practices. Most of the consumer complaints (62%) related to wrongful business practices, such as false advertising, outdated provider directories, and predatory lending/healthcare financing. Another 36% of the consumer complaints related to the quality of care received from their providers.

Enforcement Actions

- **Walgreens Administration of Flu Vaccine:** An investigation into Walgreens's improper advertisements of free flu shots settled in October 2012. The HCB received complaints that some Walgreens stores were advertising free flu shots to Empire Plan enrollees, while in fact the plan only covered the vaccinations if administered in a physician's office. Over 3,000 Empire Plan members received their flu shots at Walgreens and later received unexpected bills. As part of the AOD, Walgreens agreed to implement a program that would alert its pharmacies that the Empire Plan does not cover flu vaccinations at Walgreens. It also agreed to stop making such representations, ensure that Empire Plan members are notified they will be charged for the vaccination, and issue appropriate refunds.

- **Provider Directories:** In December 2011, Empire HealthChoice HMO, Inc., Empire HealthChoice Assurance, Inc., Health Insurance Plan of Greater New York, HIP Insurance Company of New York, United HealthCare of New York, Inc., Oxford Health Plans of New York, United HealthCare Insurance Company of New York and Vytra Health Plan signed AODs resulting from the HCB's investigation of inaccurate online provider directories for these HMO and PPO plans. The plans agreed to update their provider directories to correct or remove inaccurate listings and to take measures to keep their directories accurate in the

future. The plans further agreed to undergo independent audits to assess compliance and to file periodic reports with the OAG. Members affected by the inaccurate provider directories were provided with an opportunity to obtain restitution, and the OAG recovered $60,000 in costs.

Helpline Resolution

- **Health Care Financing Complaint:** A consumer contacted the HCB Helpline for assistance with a complaint regarding health care financing. The consumer received treatment from a dental provider that participated in her insurance plan. This provider told the patient that the crown she needed to address the pain in her bad tooth was not covered by her insurance company and required the patient to pay $900 up front. The provider also convinced the patient to open a credit card that provides a line of credit to cover medical procedures. The consumer then spoke with other individuals who received treatment at the facility and learned that they had never been asked to pay money prior to treatment. The HCB contacted the patient's plan, which advised that it covers all services and that the provider must accept plan payment. The HCB contacted the facility, which reversed the $900 charge. The HCB also ensured that the health care credit card removed the negative credit information that resulted from the consumer's late first payment.

(5) Getting and keeping coverage

Nearly 8% of consumer complaints involved getting and keeping coverage. 24% of these complaints implicate employers as a primary culprit. Consumers complain that some employers terminate coverage without informing employees, neglect to pay premiums (even when employees have paid their share), and refuse to allow employees to continue coverage as required by state and federal law (commonly referred to as COBRA).

Helpline Resolutions

- **Small Group Policy Improperly Terminated:** A consumer contacted the Helpline for assistance with reinstating coverage for her group plan that covered a small five-person firm. Despite the firm having paid its invoices, one of the employees noticed that she was terminated. The firm never received any audit letters or a Notice of Termination, and it continued to receive invoices that were paid. The plan claimed that it had requested multiple documents for its review to meet its credentialing requirements. An advocate intervened and ensured there was no gap in enrollment or coverage while the firm reapplied for insurance.

- **Recertification Under Child Health Plus:** A consumer contacted the Helpline because she was having trouble recertifying her children for the Child Health Plus program. The consumer said that she sent in the enrollment packets three times, while the plan claimed that the enrollment packets were not received in time. The plan terminated each of the consumer's five children from the program, one of whom had an urgent need to access medication. The advocate worked with the consumer to provide the plan with all needed information. All of the children were reinstated and the consumer's pharmacy was contacted to authorize the child's medication.

- **Termination from Child Health Plus:** A consumer was informed by Child Health Plus that four of her five children were terminated from coverage because of alleged non-payment and

that she would have to reapply, even though she had paid all of her premiums that were due. This was an urgent situation because she had one sick child who needed to see a doctor, and two of her other children had upcoming dentist appointments that were made months in advance. The consumer faxed her invoices to the HCB, and an advocate observed that the plan had only applied her payment to one child instead of allocating it evenly among the others. The advocate contacted the plan and Child Health Plus to notify them of the situation. The plan agreed to conduct a full reconciliation of each child's account and to make any necessary corrections. The plan also immediately reinstated all of the children so they could keep their appointments.

(6) Access to Prescription Drugs

Nearly 6% of HCB consumer complaints concerned accessing prescription medications. These complaints ranged from problems with the formularies, problems with mail order drugs (including delays and non-deliveries), and denials of preauthorization for high-cost specialty drugs. Such complaints include:

- Denial of coverage or higher copayments for prescribed drugs that are not on the insurance plan's formulary or which are on a higher tier (and therefore have a higher copayment); assistance is often provided in obtaining preauthorizations for the medications or with filing appeals of adverse determinations.

- Confusion regarding insurance plan requirements to obtain certain medications through mail-order pharmacies instead of retail pharmacies, as well as confusion regarding a change in the law that narrowly expands patients' ability to obtain drugs at retail pharmacies.

Helpline Resolutions

- **Prescription Mail Orders:** A consumer contacted the HCB Helpline because she did not find out that her copayment for a certain drug would be $150 until her doctor had already submitted the prescription to be filled. The consumer contacted the mail-order pharmacy to cancel the medication once she found out, but the pharmacy would not cancel the order even though the medication had not yet shipped. With the advocate's help, the pharmacy agreed to credit the cost of the medication.

- **Specialty Medications:** The HCB Helpline received a call from a group representing several individuals who all had diseases requiring regular access to specialty medications. These individuals were all members of an insurance company that recently imposed a requirement that specialty medications be obtained through mail order pharmacies. The advocate explained that these members, who take approximately 40 medications a day, rely on retail pharmacies because those pharmacists are familiar with their diseases and potential drug interactions. There was concern that mail order pharmacists will not be similarly informed of their conditions and that some of the patients may have difficulty communicating with new pharmacists due to mild dementia. The advocate and HCB attorneys contacted the plan to discuss the possibility of creating hardship exceptions. It was agreed that the plan would develop criteria for a hardship exception so qualified members could continue to receive their specialty medications from a retail pharmacy instead of through mail order.

- **Override for Access to Needed Medications:** The HCB Helpline received an urgent call from a 25-year old veteran who needed help obtaining an authorization for needed high dose pain medication. The consumer was severely injured and had extensive reconstructive surgeries to his face and skull due to his injuries. While the patient lived in NY, he received his reconstructive surgeries in a nearby state, and the only doctor who could prescribe his pain medication was located there. The consumer advised that he was travelling to the other state that night and needed to fill his prescription the next day because he was leaving for the west coast to see his family for Christmas. Without the prescription he would suffer from withdrawal and severe pain. The plan denied his request on the grounds that he already received an override in the past for the same reason. With only two hours to try to resolve this problem, the advocate contacted the plan's general counsel's office and relayed all of the patient's information. The office responded immediately and started the process to resolve this issue. The consumer was granted an authorization and was able to fill his out-of-state prescription and travel to be with his family for Christmas.

Conclusion

The Health Care Bureau's Helpline is an invaluable resource for health care consumers in New York State. As these examples demonstrate, our advocates ensure that consumers understand their rights within the healthcare system and work to protect those rights across the broad range of issues highlighted in this report. Additionally, the Health Care Bureau analyzes these complaints to identify systemic health care problems, and can then take appropriate affirmative steps to address these systemic problems, including initiating investigations of fraudulent practices and bringing enforcement actions, or advocating for legislation that can further protect consumers' rights.

Consumer Tips

DO:

- Become an informed health insurance consumer -- carefully examine your health plan's policy and understand its terms, conditions and exclusions.

- Pay special attention to the description of **in-network** and **out-of-network coverage**. Plans may say they have out-of-network coverage, but may in fact pay very little to out-of-network providers, leaving you to pay the balance between what the plan pays and the provider's charge.

- If you want to stay in-network, check with your plan and all providers who will be treating you -- even the lab -- and confirm that the providers are in-network. If you are relying on a website to determine who participates in your plan, print out the page that reflects the provider's in-network status and keep for your records. Best to confirm with your plan that the provider is in-network in any case.

- If you get a bill from your in-network provider that you don't fully understand, question it. You should not have to pay more than your deductible, co-pay or co-insurance for any in-network provider.

- Remember not all treatment you receive will be covered by your plan. If the plan determines that the treatment is not medically necessary, for example, it will deny your claim. Enlist the help of your provider if you get such a denial.

- If you receive care at a hospital that you cannot afford, ask about their financial aid program. If you are not eligible for financial aid, ask whether the hospital will accept a discounted payment.

- Check the list of drugs that your plan will cover (the "drug formulary") to see if your medication is on it, and whether you will be required to use a mail order pharmacy or be subjected to any other limitations such as prior authorization. If your plan requires you to use mail order and you believe you cannot, ask your plan about a hardship waiver that will allow you to use a retail pharmacy.

- When you speak with someone about insurance coverage or medical payment issues, write down the date of the conversation, the person to whom you spoke, and what was said.

- Exercise your internal and external appeal rights if your health plan denies a claim.

- If you are required by your plan to use a mail-order company for your prescriptions and this presents a hardship for you, ask your plan whether they would consider an exception in light of your particular hardship.

- Call the Health Care Bureau Helpline at 800-428-9071 if you have a question or need our assistance!

DON'T:

- Give up! If you believe you have been treated unfairly, call the **Health Care Bureau Helpline at 800-428-9071.**