

State of New York
Office of the Attorney General
Health Care Bureau

2002 Health Care Helpline Report



– Complaint Patterns –
– Consumer Tips –
– Reform Recommendations –

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Acknowledgments

This Report was written primarily by David Sharpe, Assistant Attorney General.

It is dedicated to the Health Care Bureau Helpline's Mediators and Intake Specialists. Their compassion, commitment, and perseverance inspire us all.

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EXECUTIVE SUMMARY

HEALTH CARE HELPLINE

This report analyzes the 8,806 cases handled by the Health Care Helpline of the Attorney General's Health Care Bureau (HCB) between January 1, 2001 and June 30, 2002. Specifically, the report provides an analysis of 3,494 consumer complaints that were investigated by HCB staff and a breakdown of 4,694 consumer inquiries to which HCB staff responded by providing information or referrals to other agencies. Complaints from providers accounted for the remaining 618 Helpline cases. Our cases highlight the experiences of New York health care consumers and indicate some stress points in New York's health care system.

Enforcement Actions. Helpline complaints and inquiries sparked investigations of and enforcement actions against health plans, providers, and other entities operating in the health care market. The HCB's objective in these enforcement actions has been to protect consumers' health care rights, to rectify systemic problems, and to provide restitution to affected consumers.

OUR FINDINGS

While we have analyzed consumer complaints and inquiries separately, two interesting findings emerge when both categories are considered together:

- " the greatest single issue that prompts New Yorkers to contact the HCB (25% of all complaints and inquiries combined) is access to health care coverage – getting it and keeping it; and
- " many consumers who call the Helpline are confused – about their benefits, about the rules to follow to secure coverage for care, about doctor or hospital charges, about appeal rights, or about 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.

CONSUMER COMPLAINTS AND HCB ENFORCEMENT ACTIONS: HIGHLIGHTS

The 3,494 consumer complaints involved: (1) claims processing and payment problems; (2) denials of care or coverage by health plans; (3) problems gaining

access to specialty care; (4) problems getting and keeping health insurance coverage; (5) billing errors by providers; and (6) access to prescription drugs. The first three categories – claims processing and payment problems, denials of care or coverage by health plans, and problems gaining access to specialty care – account for 72% of all consumer complaints received by the Helpline during the 18-month period covered by the report.

Claims processing and payment problems

30% of all HCB consumer complaints arise from provider or health plan mistakes in preparing, processing or paying claims, and roughly two-thirds of these mistakes (20% of all consumer complaints) are made by health plans. By far the most common complaint relating to health plans' claims and payment processes (12% of all consumer complaints) is that health plans do not process claims at all or do not process them in a timely manner.

Enforcement Actions. As a result of two separate enforcement actions by the Attorney General, Group Health Incorporated (GHI) agreed to (1) reimburse members of its FlexSelect plan for emergency room (ER) claims it had erroneously not paid in full and to implement correct payment procedures for ER claims, and (2) reimburse members of another plan who were erroneously assessed co-insurance of up to \$2,000 per claim for inpatient rehabilitation and other services.

Health plan denials of care or coverage for care

23% of all HCB consumer complaints involve health plan denials of care or coverage for care. Medical necessity determinations (generally called "Utilization Review" or "UR") that resulted in denials of care or coverage by health plans accounted for 11% of all consumer complaints.

Enforcement Actions

- " Six of the state's largest health plans agreed to improve their denial notices by including the specific medical findings on which the plans relied in denying a treatment deemed "not medically necessary," so that consumers can better prepare appeals.
- " Excellus Health Plan agreed to review more than 25,000 denied emergency claims and to retain a revised emergency claim process that includes a prudent layperson review of presenting symptoms. The New York State Departments of Health and Insurance subsequently issued guidance letters that apply many of the terms of the Attorney General's settlement with Excellus to health plans across the state.

- " Empire Blue Cross Blue Shield agreed to reimburse certain Empire members with *alopecia areata* whose requests for wigs had been denied, and to cover all future claims for wigs for members with *alopecia* whose plans provide coverage for prosthetics.
- " Mutual of Omaha and two divisions of Excellus Health Plan agreed to correct any of their contracts and/or denial notices that contained incorrect or incomplete definitions of " pre-existing condition," and agreed to review 156 claims and 16,621 claims, respectively, that were denied since 1997 primarily due to alleged pre-existing medical conditions.

Access to specialty care

19% of all HCB consumer complaints involve problems accessing or paying for specialty medical care. The majority of these complaints concern health plans' inadequate " usual and customary" reimbursement of non-participating providers, which leaves consumers with a hefty portion of the bill. Other complaints demonstrate consumer confusion about specialist referral or preauthorization processes and health plan errors in administering these processes.

Complaints from HMO consumers who were denied coverage for out-of-network services that they believed were necessary because no similarly qualified in-network providers existed, highlight a flaw in the UR appeals process. Because such denials are considered to be coverage denials rather than medical necessity denials, they can only be challenged through a plan's internal grievance process, with no right to an external review.

Enforcement Actions

- " Aetna agreed to improve its referral and claim payment process and allow health members and medical specialists to resubmit claims from 1999 and 2000 that were denied for lack of a referral.
- " HealthNow agreed to identify clearly in all consumer materials those of its dentists who provide a free second annual dental exam, and to reimburse certain members who were wrongly required to pay for such an exam.

Getting and keeping coverage

15% of consumer complaints and 25% of the total of both complaints and consumer inquiries involve getting and keeping coverage. A significant number of inquiries come from seniors trying to find coverage for prescription drugs.

8% of all HCB consumer 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 of the premiums), and refuse to allow employees to continue coverage as required by state and federal law (commonly referred to as COBRA).

Enforcement Actions

- " HealthFirst 65 Plus agreed to adopt procedures that will help protect seniors from being "slammed," enrolled in a health plan without their informed consent.
- " Two companies that offer medical discount cards – U.S. HealthCard and Medisavers – agreed to reform their advertising practices, fully disclose all costs and limitations to consumers before enrollment, and accurately list participating health care providers.

Billing errors by providers

10% of HCB consumer complaints are prompted by a provider's improper or illegal billing of consumers. Although state regulations and many participating provider contracts forbid providers from billing consumers in most instances, some providers illegally bill consumers and subject them to collection actions.

Enforcement Action. An agreement between the Attorney General and nine prominent nursing homes across the state required the homes to eliminate from their admission contracts (1) so-called "third-party guarantees" that imposed financial obligations on families as a condition of admission (although none of the homes had illegally billed third parties) and (2) vague language that allowed wide latitude to involuntarily discharge residents.

Access to prescription drugs

3.5% of HCB consumer complaints were about access to prescription drugs. With drug costs rising precipitously, health plans are limiting such costs, primarily through the use of formularies – lists of covered medications. Not surprisingly, two thirds (67%) of all consumer complaints about prescriptions involved the use of formularies and "switching" – the practice of switching consumers from a brand-name medication to a generic one or from one brand-name drug to another that the plan "prefers" (usually because it saves the plan money through price reductions or rebates).

Enforcement Actions

- " After the HCB found that almost 40% of surveyed pharmacies across the state failed to comply with New York's " Pharmacy Price Poster" law, all the non-compliant pharmacies agreed to take specific steps for future compliance and to contribute towards an educational campaign about the importance of comparison price shopping for prescription drugs.
- " HealthNow agreed to resolve ongoing consumer complaints by establishing a 24-hour toll free hotline for consumers, and to log and prioritize consumer complaints regarding pharmacy services.

FIVE KEY REFORM RECOMMENDATIONS

- " Lack of prescription drug coverage for people with Medicare could be addressed by providing comprehensive prescription drug coverage through Medicare. If Congress does not create this benefit, the eligibility criteria of the state's Elderly Pharmaceutical Insurance Coverage (EPIC) program should be expanded to include Medicare participants with disabilities who are under age 65.
- " Disputes about denials of out-of-network referrals to specialists can be better addressed by allowing consumers access to the external appeals process to review such denials.
- " Inadequate and confusing denial notices can be addressed by mandating a model claim denial notice for use by all health plans.
- " Widespread confusion on the part of consumers and their concomitant inability to protect their rights and access benefits can be ameliorated by fully funding the Managed Care Consumer Assistance Program.
- " Non-compliance by plans and providers with the Managed Care Consumer Bill of Rights can be addressed by providing statutory penalties for violations.

KEY TIP FOR CONSUMERS

Challenge denials of coverage for necessary health care services through the health plan's grievance and appeal process. Generally, very few people who receive denials appeal, but most of those who appeal win more coverage.

INTRODUCTION

HEALTH CARE COVERAGE IN NEW YORK STATE: A SNAPSHOT

Consumer Confusion: A Maze of Coverage Options and Benefit Eligibility Rules

New Yorkers with health insurance coverage receive it from a variety of sources – 55% receive health coverage through employment, 15% have coverage through Medicaid, 11 % have Medicare, 4% have individual direct-pay insurance contracts with private insurers, and 15% have no health insurance coverage at all.¹ Within the health insurance marketplace, consumers must choose from an alphabet soup of coverage options – HMO, HMO-POS, PPO, and others (see box at right). For convenience, we use the term “health plan” in this report to refer to the many variations of health insurance and managed care plans, except when we discuss a specific type of plan.

The number of types of coverage, the variety of health insurers offering those types of coverage and the range of different benefits, rights and protections that are available make it all but impossible for health care consumers to understand how to get the health coverage and care they need with a minimum of frustration. Given the complexity of health plan choices and rules, it is not surprising that 51% of insured American adults under age 65 report having some problem with their health plan over the period of a year.²

Types of Health Plans

Network-model HMOs create a “network” by contracting with a variety of hospitals and physicians to provide services. “Classic” or “pure” HMOs require patients to have preauthorizations for certain services and referrals to see specialists, and generally do not pay for services received from an “out-of-network” or “non-participating” provider.

HMO-Point of Service (HMO-POS) plans are a more flexible version of the Network HMO. They provide some level of coverage for members to go out-of-network and may not require preauthorizations and referrals.

Preferred Provider Organizations (PPOs) are networks of doctors, hospitals and other providers that are individually contracted to provide services. In PPOs, consumers typically have more flexibility to choose their doctors and are not limited to doctors in one particular group. In general, PPO members do not have to get a referral to see a specialist.

Fee-for-service means that the doctors and hospitals are paid a fee for each service provided to a health care consumer. Consumers are not restricted to any particular doctor or hospital.

Source: Health Rights Helpline, The Impact of the Health Rights Helpline: Making a Difference for Health Care Consumers Through Direct Service, Advocacy and Systemic Change. Sacramento CA, June 2001, p. 8.

Consumer Rights

New York health care consumers enjoy a range of rights and protections. Both Medicare and Medicaid provide an array of grievance and appeal rights, while those consumers with most private health plans receive three primary areas of protection under New York's Managed Care Consumer Bill of Rights (MCCBOR).³

- " The right to contest certain health plan decisions through mandatory grievance and utilization review appeal procedures;
- " The right to access specialty, out-of-network and emergency care; and
- " The right to obtain a range of information about the health plan in which the consumer enrolled.

Helping to ensure that consumers are made aware of these rights, understand how to exercise them, and receive any necessary help for such exercise constitutes a core function of the Attorney General's Health Care Bureau (HCB).

THE HEALTH CARE BUREAU AND THE HEALTH CARE HELPLINE

The HCB is part of the Division of Public Advocacy in the Office of the New York State Attorney General. The HCB's principal mandate is to protect and advocate for the rights of health care consumers statewide, through:

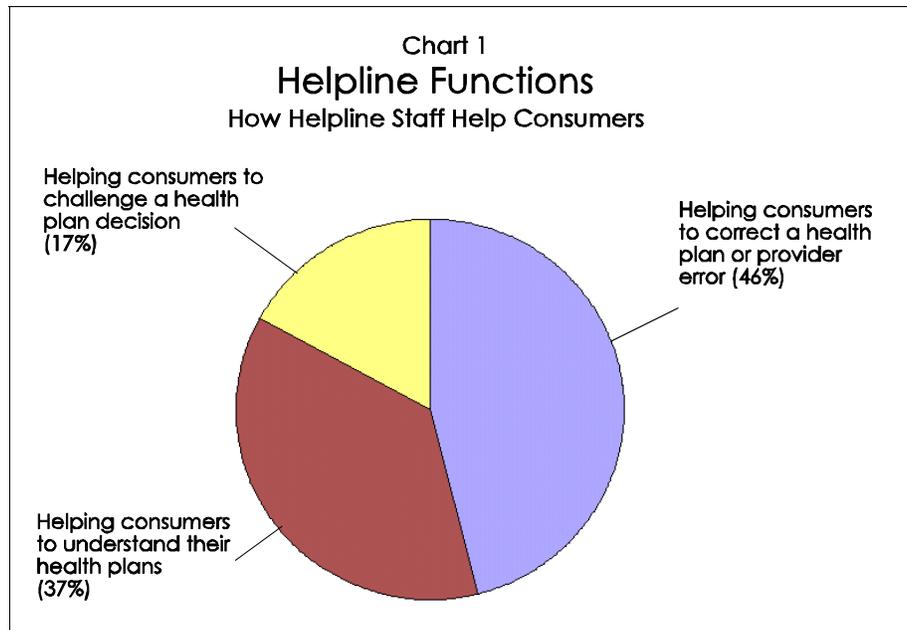
- " **Operation of the Health Care Helpline.** This toll-free telephone hotline provides assistance to New York health care consumers by employing mediators who provide helpful information and referrals, investigate individual complaints, and attempt to mediate a resolution that will help to ensure that each consumer obtains access to the health care to which the consumer is entitled.
- " **Investigations and enforcement actions.** These activities target health plans, providers, and other individuals and entities that engage in fraudulent, misleading, deceptive or illegal practices in the health care market.
- " **Consumer Education.** Through education initiatives, the HCB seeks to acquaint New Yorkers with their rights under the MCCBOR and other health and consumer protection laws.
- " **Legislation and policy initiatives.** Such projects are aimed at enhancing the rights of health care consumers and their ability to obtain good, affordable health care in New York State.

Health Care Helpline

The HCB Health Care Helpline is the Attorney General's front line in registering and resolving consumer complaints regarding health care. Helpline staff handled each of the 8,806 cases analyzed in this report (see Table A on page 5 for a breakdown of consumer complaints). Of these 8,806 cases, 3,494 were consumer complaints resolved by Helpline mediators and 4,694 were consumer inquiries to which mediators and intake staff responded by providing information or referrals to other agencies (see Table 7 on page 34 for a breakdown of these referral-and-information inquiries). The remaining 618 cases were provider complaints handled by HCB mediators.

As illustrated in Chart 1, the work of the Helpline can be divided into three critical consumer assistance functions:

- " helping consumers to correct mistakes by providers or health plans that led to denials of care or coverage for care and a range of claim, billing and payment problems (46% of cases);
- " helping consumers to understand how to obtain benefits through their health plans or the limitations inherent in the health care system (37%); and
- " helping consumers to challenge a denial of care or coverage for care by health plans (17%).



The Helpline intake specialists and mediators play a pivotal role in both the functioning of the Helpline and the identification of systemic problems that become the focus of the HCB's enforcement actions. First and foremost, Helpline staff assist consumers with complaints by gathering information, helping consumers and their health plans identify the exact nature of particular disputes,

putting each dispute in a legal context, and then moving the parties towards a resolution.

If a Helpline mediator, in consultation with an HCB Assistant Attorney General, identifies a pattern of conduct that suggests a provider or health plan is violating federal or state law by, for example, acting in a fraudulent or deceptive manner, the HCB may decide to investigate the matter further and may ultimately bring an enforcement action. Thus, the complaints and inquiries received by the Helpline provide invaluable insight into the problems affecting New York's health care consumers and, in some instances, uncover illegal activity that the HCB can address through its enforcement actions.

The consumer assistance functions illustrated in Chart 1 above, and the day-to-day experience of Helpline staff, reveal the need for additional resources to assist health care consumers. Of all the players in the health care system, it is individual consumers who know the least about how the system works. Because New Yorkers are forced to navigate a maze of procedures, rules, rights, and remedies, often without the benefit of any prior experience or organized support, additional funding for expansion of the New York State Managed Care Consumer Assistance Program (MCCAP)⁴ and other consumer assistance organizations is clearly warranted.

THIS REPORT

The 8,806 cases handled by the HCB Health Care Helpline between January 1, 2001 and June 30, 2002 and analyzed in this report exemplify the experience of the State's health care consumers and indicate some stress points in the state's health care system.

The 3,494 consumer complaints (cases in which HCB staff intervened on behalf of the consumer) involved six general areas: (1) claims processing and payment problems; (2) denials of care or coverage by health plans; (3) problems accessing specialty care; (4) problems getting and keeping health insurance coverage; (5) billing errors by providers; and (6) access to prescription drugs. Each of these categories is discussed in a separate chapter in the report. We note that three issues – claims processing and payment problems, denials of care or coverage by health plans, and problems accessing specialty care – account for 72% of all consumer complaints received during the 18-month period covered by the report.

Included in each chapter are descriptions of Helpline complaints that illuminate both the nature of the issue under discussion and the kind of assistance the Helpline provided to individual consumers.⁵ In addition, side-panels describe

enforcement actions pursued by the HCB regarding that particular issue, and offer tips to consumers on how to deal with problems or questions more effectively. Finally, other side-panels present recommendations for reform of various systemic problems identified by the HCB through its work.

Table A Helpline Cases by Type and Issue		No. of Helpline Cases	% of Consumer Complaints	% of all Helpline Cases
Ch.	Consumer Complaints – Issue			
1	Claims processing and payments problems	1,029	29.5	11.7
2	Denials of care or coverage by health plans	810	23.2	9.2
3	Access to specialty care	664	19.0	7.5
4	Getting and keeping coverage	511	14.6	5.8
5	Billing errors by providers	347	9.9	3.9
6	Access to prescription drugs	122	3.5	1.4
	Other	11	0.3	0.1
	<i>Sub-total – Consumer Complaints:</i>	3,494	100.0	39.7
	Provider complaints	618		7.0
App.	Referrals and information – not handled by mediators	4,694		53.3
TOTAL		8,806		100.0

The 4,694 consumer inquiries identified in Line 7 of Table A (cases in which HCB staff provided information or a referral) fall into five issue categories: (1) access to coverage; (2) quality of care; (3) consumer rights and benefits; (4) business practices; and (5) special needs of particular populations. (See Table 7 in the Appendix.) While the report does not analyze consumer inquiries in detail, it is worth noting that health care coverage issues – how to get coverage and how to keep it – comprise 25% of all Helpline cases if inquiries and complaints on this issue are combined.

THE HELPLINE DATASET

All calls by the public to the Helpline are entered into a Microsoft Access database. The fields in the database allow for extraction of cases according to how they were handled (complaint, information, referral), the source of the inquiry (consumer, provider), the issue raised by the inquiry, and a range of other variables. The initial body of data that formed the raw material for this report – all inquiries and complaints to the Helpline received and logged in 2001 and the first six months of 2002 – totaled 11,224 matters. These were reviewed for completeness of information. 2,418 matters lacked sufficient information to be classified and analyzed. This left 8,806 cases – the dataset for this report.

In general, this report describes consumer complaints in two different ways, depending on how far a mediation or investigation had progressed by the time the report was written. In many cases, it is possible to determine whether a health plan or provider made a mistake or violated a law. In these cases, it is possible to assign a degree of responsibility for the problems at issue – for example, Table 2 refers to a category of cases with the phrase, “ Denials of care or coverage caused by health plan error.”

At other times, however, it is not possible to know whether a dispute arose because of some mistake or violation of the law, or whether the complaint reflects the consumer’s frustration with a valid denial of care, a legitimate bill, or simply the inherent imperfections of the health care system. In these cases, all that can be said is that a dispute arose between party A and party B on issue X. These kinds of cases are classified and labeled without denoting fault on the part of any party – such as in Table 2.2, “ Covered benefit denials: Plan deems service ‘Custodial’.” Where it was possible to assign responsibility to one party or the other, the language in the report makes this clear; where all that is known for certain is the issue in dispute, the report avoids assigning fault, and no such element should be inferred.

CONSUMER COMPLAINTS – FINDINGS AND RECOMMENDATIONS

1. CLAIMS PROCESSING AND PAYMENT PROBLEMS

If the complaints received by the HCB are any indication, it seems that consumers' problems with the health care system tend to begin with the paperwork and electronic transmissions that inevitably follow any doctor-patient encounter.

This paperwork consists of providers and consumers preparing and submitting claims, health plans processing those claims, and those

Table 1 Consumer complaints: Claims processing and payment problems	No. of Helpline Cases	% of all Consumer Complaints
Due to health plan errors	681	19.5
Due to provider errors	348	10.0
TOTAL	1,029	29.5

same plans issuing payments. In HMO, HMO-POS plans or PPO plans,⁶ most of this paperwork passes between providers and health plans, increasingly by electronic means. The efficiency and accuracy of the entire claims processing system depend on the diligence of providers and the administrative competence of health plans. Consumers, generally speaking, play a small role and have little expertise.

Judging from Helpline complaint patterns, providers and health plans sometimes do a poor job of managing the claims and payment process. As Table 1 shows, almost a third of all Helpline consumer complaints (29.5%) arise from provider or health plan mistakes in claims preparation, processing, and payment, and roughly two-thirds of these mistakes are attributable to health plans.

Claims processing and payment problems due to health plan errors

By far the most common complaint relating to health plans' claims and payment processes is that health plans fail to process claims at all or do not process them in a timely manner. These failures account for nearly 12% – almost one in eight – of all Helpline consumer complaints (see Table 1.1, below).⁷

Mr. J called the HCB Helpline to complain that, more than two months after he submitted a claim, his health plan still had not reimbursed him \$750 for services he had paid for out-of-pocket. When contacted by the HCB, the health plan said that it could not locate Mr. J's claim. He re-submitted the claim but still could get no response, despite several phone calls to the health plan. After further HCB intervention, the health plan paid the claims with interest as required by law.

These failures take place in the context of the state’s “ prompt payment” law, which requires health plans to pay “ clean claims” within 45 days of receipt.⁸ If the health plan believes in good faith that it is not responsible for paying some or all of a claim, it must notify the consumer or provider in writing within 30 days of receipt of the claim it disputes, providing a specific reason why the plan believes it is not liable or specifying what additional information it needs to determine its liability for the claim. If the health plan does not promptly pay claims, it is subject to fines and must pay interest on late payments.⁹

Table 1.1 Consumer complaints Claims processing and payment problems Due to health plan errors	No. of Helpline Cases	% of all Consumer Complaints
Health plan not processing and paying claims	406	11.6
Health plan paid wrong amount	51	1.5
Health plan overpaid provider	50	1.4
Health plan paid wrong person	33	0.9
Health plan error regarding deductible or co-payment	30	0.9
Other claims processing or payment problem	111	3.2
TOTAL	681	19.5

Other processing errors include payments of the wrong amounts, payments to the wrong person, mistakes in the application of consumers’ deductibles, and the imposition of inaccurate co-payment amounts.

Compounding all of these problems are failures on the part of health plans’ customer service departments. Some Helpline consumers reported that they had difficulty getting through to a health plan representative; they also complained that they were regularly left on hold for extended periods of time or transferred multiple times – usually with an assurance that the next person they speak to would be able to help them.

HCB Enforcement Actions	
<u>Health Plan Claims and Payment Errors</u>	
"	The HCB’s inquiry into Group Health Incorporated’s (GHI’s) payment of emergency room claims under its “FlexSelect” plan found instances in which GHI failed to fully pay emergency room claims, in apparent violation of the terms of the plan. GHI agreed to reimburse members for approximately 195 claims totaling almost \$35,000, and to take steps to ensure that all of its member service personnel would implement correct coverage procedures for emergency room visits.
"	Spurred by complaints from consumers with another GHI plan, the HCB determined that GHI was erroneously assessing a co-insurance charge of 20 percent of the total bill, up to a maximum of \$2,000, for inpatient rehabilitation and other services, even though the certificate of coverage did not require such co-insurance. GHI agreed to reimburse affected

Reform Recommendations

Consumer Assistance and Information Disclosure

- " Expand the Managed Care Consumer Assistance Program (MCCAP) through additional funding for existing MCCAP organizations and new MCCAP organizations to serve all of New York's geographic, cultural and linguistic communities.
- " Amend the MCCBOR to prescribe statutory penalties for violations of its provisions.

Denials of claims due to provider errors

Health plans rely on providers to submit accurate and complete information. If information the provider submits is wrong in even the smallest way, health plans generally deny payment. One in ten consumer complaints is about a health plan's denial of care or coverage in which the original cause was found to be a mistake by a doctor, hospital, or other provider in submitting the consumer's claim.

The most common provider mistake is entering the wrong diagnostic or procedure code on a claim form. In most situations where the mistake is

typographical, only

one or at most two codes will be wrong, but this will almost always cause a mismatch between the diagnosis and the treatment. Health plan computer systems, which are set up to catch these types of problems, will reject such a claim, typically stating that the health service identified by the (incorrect) code is not medically necessary or is not a covered benefit.

Similar problems arise when a provider fills in the wrong claim form, fills in the correct form improperly, or submits the claim to the wrong health plan.¹⁰

Mr. S called the HCB on behalf of his wife, who had surgery for breast cancer. Instead of billing her health plan, the hospital billed his plan, which correctly denied payment. When the hospital discovered its error, it filed the original claims with Mr. S's plan, but these were denied for being filed too late. The hospital then inappropriately sent bills to Mr. S and Mr. S's wife totaling \$25,000. Following intervention by the HCB, the claims were settled under the wife's plan.

	No. of Helpline Cases	% of all Consumer Complaints
Wrong diagnostic or procedure code	124	3.5
Late filing of claim	53	1.5
Insufficient clinical information	51	1.5
Other provider error	120	3.4
TOTAL	348	10.0

Late filing of claims is the next most common provider error, followed closely by failure to submit sufficient clinical information to adjudicate the claim. Medical necessity determinations – or, more generally, “utilization review” – are a key aspect of managed care, and health plans will routinely insist on seeing additional clinical information from providers before approving coverage.

Virtually all of these cases have been resolved promptly by Helpline staff contacting the provider and asking that corrected information, or additional information, be submitted to the health plan. In many of these cases, the consumer had been making the same request for weeks, if not months, to no avail.

Consumer Tips

Avoiding Provider and Health Plan Claims Errors

- " Read your health insurance policy carefully to know the extent and limits of your coverage.
- " Take special note of the services for which you have to pay – through co-payments, deductibles or co-insurance – and make sure you understand how much you have to pay and when.
- " Keep a careful record of all health care expenses that may be applied toward your deductible. Keep receipts showing co-payments and co-insurance payments.
- " If you are asked to pay a charge you do not understand, ask your plan or provider to explain the charge and to direct you to the relevant provision of your policy that requires it.

2. HEALTH PLAN DENIALS OF CARE OR COVERAGE FOR CARE

Most health plans approve most requests for coverage of health care services. However, the denial of coverage for health services according to established and legally permissible criteria is an essential aspect of managed care and of health insurance generally. Such denials fall into two broad categories: medical necessity denials and coverage denials. In addition, as shown in Table 2, the HCB found that health plans incorrectly denied care or coverage in nearly one third of the denials brought to our attention during the relevant period.

Table 2 Consumer complaints Health plan denials of care or coverage for care	No. of Helpline Cases	% of all Consumer Complaints
Medical necessity denials	374	10.7
Denials due to health plan errors	246	7.0
Covered benefit denials	190	5.4
TOTAL	810	23.2

Medical necessity denials

Many health plans spend significant time and resources deciding whether a service or procedure is medically necessary. A denial of coverage on the ground that the service is not medically necessary is called an "adverse determination."¹¹ While each plan has its own definition of medical necessity, generally a service is deemed medically necessary if:

- " it is appropriate and required for the diagnosis or treatment of the patient's sickness, pregnancy or injury; and
- " it is safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications; and
- " there is not a less intensive or more appropriate diagnostic or treatment alternative that can be used in lieu of the service or supply requested.

This decision-making process is known as Utilization Review (UR), and is governed by New York's "UR Law": Article 49 of the Insurance Law and Article 49 of the Public Health Law. UR can take place at three different stages: in advance of a requested service (known as preauthorization or precertification), after the service has been delivered (known as retrospective review), and during the delivery of an ongoing service (known as concurrent review).

The UR Law ensures:

- " that only medical professionals issue adverse determinations;
- " that decisions to authorize or deny care are made within a specified period of time (3 days for preauthorizations, 1 day for concurrent reviews, and 30 days for retrospective reviews);
- " that consumers and their providers receive timely and informative notice of adverse determinations, including a clear statement of the reasons and clinical rationale, if any, for the denial; and
- " that consumers and providers have certain appeal rights:
 - (1) a standard internal appeal or an expedited appeal, which are conducted by a clinical peer reviewer¹² within the health plan who was not involved in the initial adverse determination;
 - (2) an External Appeal to an independent clinical peer reviewer.¹³

Table 2.1 shows the frequency with which New York consumers contacted the HCB Helpline with complaints concerning health plans' UR practices.

Table 2.1 Consumer complaints: Health plan denials of care or coverage Medical necessity denials	No. of Helpline Cases	% of all Consumer Complaints
Preauthorization denials	101	2.9
Retrospective denials	74	2.1
<i>Denials of emergency care</i>	43	1.2
Concurrent denials	71	2.0
Denials of care as experimental or investigational	39	1.1
Plan considered service to be "cosmetic"	31	0.9
Plan considered care to be "custodial"	25	0.7
Defective or late denial notices, late appeal decisions	17	0.5
Medical necessity - other	16	0.5
TOTAL	374	10.7

Preauthorization denials

Complaints about preauthorization account for almost a third of all consumer complaints relating to medical necessity denials. Almost a quarter of all Helpline consumer complaints in this category are triggered by a

preauthorization denial of a prescription medication.¹⁴ Preauthorization denials of surgery account for 20% of the complaints in this category; denials of diagnostic tests for 16%; denials of inpatient care for 11%;¹⁵ and denials of physical or occupational therapy for 9%.

Ms. K's health plan denied preauthorization for a gastro by-pass operation. She appealed the denial twice but her health plan upheld its initial denial on the ground that such surgery was not medically necessary for her condition. HCB Helpline staff advised Ms. K to request an external appeal and to support her request with a letter of medical necessity from her doctor. The independent external reviewer overturned the health plan's denial and

Retrospective denials

Retrospective review occurs, by definition, after care has been provided. The majority of complaints received by the Helpline about retrospective denials concerned denials of coverage for emergency care. In the eighteen months covered by this report, 43 New Yorkers contacted the HCB to complain that their health plans had denied coverage for what they believed were emergency services.¹⁶

Under New York law, it is illegal to deny an emergency claim for lack of a physician referral where the presenting symptoms have met the "prudent layperson" standard.¹⁷ Health plans must cover emergency claims when the individual has symptoms that an ordinary, prudent layperson would consider to pose a serious health risk.¹⁸ Consumers are entitled to coverage for claims that meet the prudent layperson standard even if the final diagnosis is not as severe as the patient originally thought. For example, if a patient with severe chest pains has an ultimate diagnosis of indigestion, the health plan generally must pay for the emergency room services.

A related protection prohibits health plans from insisting that members receive preauthorization before seeking emergency care.¹⁹ It is also illegal for health plans to require that consumers who have received emergency services notify the plan afterward as a condition for coverage of the care.²⁰

Despite these protections, health plans occasionally still issue “no referral or preauthorization” denials in ER situations. Some plans have also failed to adequately implement the prudent layperson standard (see Box, above).

HCBS Enforcement Action

Improper Denials of Coverage for Emergency Care

In July 2001, following an investigation by the HCB, Excellus Health Plan entered into an agreement with the Attorney General to review more than 25,000 emergency room claims it had denied between April 1997 and November 2000, and to reimburse consumers and hospitals, with interest, for any claims meeting the prudent layperson standard.

In November 2001 and January 2002, the Department of Health and the Department of Insurance, respectively, issued opinion letters tracking the outlines of the Attorney General's

Mr. R received emergency surgery in a Massachusetts hospital. Because he had no referral for this service at a non-participating hospital, Mr. R's plan denied coverage for his \$73,000 bill. Following the intervention of the HCB, the plan paid the hospital bill.

Concurrent denials

Another form of UR that can lead to denials of care is concurrent review. Not all health plans perform concurrent review, but those that do tend to focus their attention on inpatient hospital stays, including inpatient mental health treatment. If a health plan has chosen to conduct concurrent review, it must decide within 24 hours of a request for continuing coverage of a health care service whether or not to approve the request. If the health plan needs additional information and requests it, the 24-hour time period begins when the plan receives that information. Clinical information passes back and forth between the provider and the health plan, and the plan makes a decision about the appropriateness of the care being provided.

Most concurrent review denials state that the patient's condition does not warrant the level of care being provided. This occurs most commonly when a hospital patient's condition has improved to the point where, according to the health plan, the patient can be safely discharged.

Mr. T was admitted to the hospital for psychiatric care. His doctor wanted to keep him there until March 26, but his health plan wanted him discharged on the 21st. The doctor replied that, if Mr. T had to be discharged, he would need partial hospitalization; the health plan, however, refused coverage. Upon the advice of HCB staff, Mr. T's doctor wrote a letter explaining the medical necessity of partial hospitalization, and the plan finally approved coverage.

Plan considered service to be "cosmetic" or "custodial"

New York law permits health plans to exclude coverage for cosmetic and custodial services.²¹ Generally, the determination of whether a health service is cosmetic or custodial is a medical necessity determination.²²

HCB Enforcement Action

"Cosmetic" Service Denials

After receiving a complaint regarding a 9-year old girl with *alopecia areata*, a disease that can result in complete hair loss, the HCB investigated Empire Blue Cross Blue Shield's policy of denying wigs for patients diagnosed with that disease. The HCB determined that Empire had denied coverage because it found the wig "cosmetic" and not "medical" under the terms of its contract, even though Empire had already lost a lawsuit involving similar facts and similar policy language. Empire agreed to reimburse Empire members with *alopecia* whose requests for wigs had been denied.

Denials of care as experimental or investigational

Most health plans only pay for services that have been proven safe and effective, rejecting those they deem "experimental" or "investigational." Some providers, particularly specialists at the forefront of their field, may recommend procedures and treatments that have not yet been fully accepted in the broader health profession. Wary of approving a procedure that later turns out to be unsafe or ineffective, some health plans may rely on directories and manuals that list only the most widely used procedures and treatments.

Mr. F had been receiving chemotherapy for six months to treat his cancer and needed a stem cell transplant. His health plan denied preauthorization, saying the procedure was experimental. When Mr. F appealed through his union, the union told him to speak to its attorneys, but he received no response when he contacted them. After Mr. F called the HCB Helpline, an HCB mediator learned that the stem cell transplant had been recently approved under Medicare guidelines. The mediator wrote to the union attorney, attaching a copy of the Medicare Decision Memorandum,²³ and stated that a procedure cannot be considered experimental if Medicare has approved it. The union health plan approved the procedure.

Defective or late denial notices, late appeal decisions

While only 0.5% of all Helpline consumer complaints clearly indicate a possible violation by a health plan of its obligations to provide timely and accurate denial notices and appeal decisions under the UR Law, the HCB has documented a number of UR Law violations by plans (see Box at right). Even seemingly minor errors by health plans in their UR procedures can have serious consequences for consumers. For example, a consumer who does not receive proper notice of the right to an appeal may miss an opportunity to receive coverage for a needed health service.

HCB Enforcement Action

Medical Necessity Denials

The HCB conducted an extensive investigation of the UR practices of certain New York health plans during the period January through June 1999. This investigation revealed a number of violations of the UR Law by each of the plans, including late notices and a widespread failure to include in denial notices a sufficiently detailed statement of the reasons and clinical rationale for the denial, as required by the UR Law.

The Attorney General negotiated settlements with six plans, requiring them to ensure: (1) that letters acknowledging requests for appeals explain in detail member rights during the appeal process, and (2) that the required statement of the reasons and clinical rationale for a denial provide an individualized medical basis for the denial and refer to the specific medical data the reviewer considered when issuing the denial.

HCB attorneys are now in the midst of a two-year monitoring period and have noticed an improvement in the quality and consistency of the plans' UR practices, in particular the

Ms. M was discharged after 4 days in the hospital for treatment of severe abdominal pain. In the final two days of her stay, the health plan's case manager noted that Ms. M "has taken minimal pain medication since 2/5 and no pain medication on 2/7 or 2/8. Doctor stated the patient may have outpatient workup." On the day of discharge, the Medical Director wrote: "Could have been done as outpatient." In spite of having this kind of clinical information in its possession, the health plan offered the member and hospital the following inadequate reason and clinical rationale for its adverse determination: "The requested service has been denied because the member does not meet Interqual ISD-AC Adult criteria."

When health plans fail to provide a meaningful explanation for their denials of care, consumers and providers have no idea how to mount an effective appeal.

Reform Recommendation

Utilization Review Practices: Denial Notices

Health plans should be required to use a standardized state-mandated denial form for all denials. Such a form could be similar to the one required for Medicare denials and, ideally, would include the phone numbers of the local MCCAP office and other consumer assistance

Denials due to health plan errors

Health plans are large, complex organizations that must process thousands of claims each year and make determinations about eligibility, medical necessity, and benefit levels.

The experience of the HCB Helpline suggests that health plans sometimes do a poor job administering claims. Health plans sometimes issue denials and send bills to members, asserting that a member or a provider has made

an error or failed to provide information when, in fact, the plans themselves are to blame for the supposed error or lack of information. Table 2.2 shows the most common types of errors by health plans.

Table 2.2 Consumer complaints Health plan denials of care or coverage Denials due to health plan errors	No. of Helpline Cases	% of all Consumer Complaints
Coordination of benefits - primary/secondary	117	3.3
Improper "Late filing of claim" denials	57	1.6
Improper "Lack of information" denials	32	0.9
Improper "Not a covered benefit" denials	13	0.4
Other – including computer problems	27	0.8
TOTAL	246	7.0

Coordination of benefits – primary/secondary

Individuals are often covered by more than one health plan (e.g. their own plan and their spouse's plan). In these situations, health plans need to "coordinate" the benefits being provided to the member. One plan will be primary, meaning that it must pay first. Once the primary plan has paid, it issues an Explanation of Benefits (EOB). The consumer then submits this EOB to the secondary plan, which may then (and only then) issue a payment to discharge its own obligation.

Mrs. H called on behalf of her husband, who has prostate cancer. Mr. H had left his job and continued his health coverage under COBRA (see Chapter 4). He was then diagnosed with prostate cancer. Mr. H's health plan claimed that it could not be his primary plan because he was covered under his wife's plan. According to Mrs. H, the couple had been paying premiums to three different health plans all but three were refusing to pay benefits. An HCB mediator contacted Mr. H's health plan to confirm his enrollment in COBRA and then

informed it that it was therefore his primary plan. Mr. H's plan began paying his claims.

Complaints about incorrect denials also arise from the following situations:

- " claims submitted within the required time-frame by both members and providers are not received and processed by the proper health plan staff and the services are therefore denied for "late filing of claim";
- " clinical information submitted by a member or a provider to support a request for coverage is not passed on to the proper department in the health plan, and a denial is issued for "lack of information";
- " health plans sometimes deny as "not a covered benefit" a health service that is in fact covered under the contract – see the case example, below;²⁴
- " a plan adjudicates a claim according to the wrong contract terms;
- " the health plan enters or uses incorrect provider information, such as a tax ID number, and all claims submitted by that provider (using the correct number) are rejected as coming from a non-participating provider; and
- " the health plan enters an incorrect diagnosis or procedure code, causing the claim to be denied.

Ms. W called the HCB Helpline for help getting coverage for an enteral nutritional formula for her child. New York State law mandates that health plans cover the cost of enteral formulas if certain conditions are met.²⁵ When Ms. W asked her pharmacist to fill an order for the formula, however, the health plan's computerized authorization system responded that the product was a non-covered over-the-counter medication. After Ms. W contacted the Helpline, an HCB attorney informed the health plan that enteral formulas are a mandated benefit, even though they are available over-the-counter. Within a day, the plan promised to cover the formulas and made arrangements with its pharmacy benefit manager (PBM) to change its computer system to reflect the requirements of New York law.

Covered benefit denials

According to HCB Helpline complaints, when health plans deny coverage for a service as not a covered benefit, they often argue that the procedure or treatment is to treat a “pre-existing condition” or the member has reached the benefit maximum under the contract.

Table 2.3 Consumer complaints Health plan denials of care or coverage Covered benefit denials	No. of Helpline Cases	% of all Consumer Complaints
Pre-existing condition	37	1.1
Consumer has reached benefit maximum	24	0.7
Other covered benefit denials	129	3.7
TOTAL	190	5.4

Consumer Tips
Preventing Covered Benefit Denials

- " Before receiving care, read your health plan benefits booklet and check with your health plan to make sure the treatment is a covered benefit.
- " If the procedure or treatment is not a covered benefit, discuss your needs with your doctor; there may be a similar health service that is covered under your contact.
- " Be sure to obtain a preauthorization if required.
- " Keep copies of all documents and notes of all conversations with your plan.
- " If you receive a denial, file a grievance with your plan, stating why you think the care is covered. Get help from your doctor or from the Attorney General’s Health Care Helpline at (800) 771-7755 (option 3).

Pre-existing condition

The Helpline assisted 37 consumers who believed that they were denied coverage for medical care because the care was for an alleged “pre-existing condition.” State and federal law require that a pre-existing condition be covered unless diagnosis or treatment of the condition was actually recommended or received six months prior to enrollment by the consumer in the plan.

HCB Enforcement Action
Covered Benefit Denials: Pre-existing Condition

The HCB began an investigation of Excellus and Mutual of Omaha after receiving complaints that the plans had wrongly denied coverage due to alleged pre-existing conditions. The HCB found that the plans’ contracts and/or denial notices contained incorrect or incomplete pre-existing condition definitions, and omitted or incorrectly stated the members’ right to be credited with previous health insurance. Excellus and Mutual of Omaha agreed to correct all contracts and notices and to review 16,621 and 156 denials, respectively.

If a pre-existing condition does exist, health plans can impose a waiting period before providing coverage

for the pre-existing condition, but the period usually may not exceed twelve months after the enrollment date. A waiting period due to a pre-existing condition must be reduced by any amount of time the insured was previously covered under another health plan, as long as there was no break in coverage of more than 63 consecutive days between the end of membership in the prior plan and the start of membership in the current plan.²⁶

A widow called the HCB after her health plan billed her over \$200,000 for medical services provided to her late husband. Her husband had twisted his knee several weeks before he joined the plan. Diagnostic tests conducted after his enrollment revealed that, in addition to the sprain, a malignant tumor in his knee had spread throughout his body. The plan refused to cover her husband's care, arguing that his cancer existed before his enrollment. A review of the plan's contract revealed that it had incorrectly defined a pre-existing condition as one "which manifests itself in symptoms which would cause an ordinary prudent person to seek medical advice, diagnosis, care or treatment." After the Attorney General's office contacted the plan, it reversed its decision and paid for the care.

Consumer Tips

Appealing Denials of Care

- " Appeal. Very few people who receive denials appeal, but most of those who appeal win more coverage. So, always appeal any denial of coverage for care that you and your doctor think is necessary - the odds are in your favor.
- " Get a clear explanation in writing from your health plan of the reason your care was denied. You have a right to this explanation, so demand one if you don't receive it because this will help you prepare your appeal.
- " Get your doctor to help you by writing a letter explaining why you need the care. If possible, have your doctor call the health plan's medical director on your behalf.
- " Follow the time lines for submitting your appeal - submit it on time, send it by certified mail, and keep calling to find out the status. Keep a paper trail of everything you send to the health plan and a record of every time you call the plan and who you talk to.
- " Get help with your appeal. Call the Attorney General's Health Care Bureau at 1-800-771-7755 option 3.

3. ACCESS TO SPECIALTY CARE

Most New Yorkers belong to health plans that require or encourage them to receive health care services from “participating” providers who are in the plan’s network of providers and who have agreed to accept the plan’s fixed rates as payment for such services. For example, HMO members generally receive coverage only for services received from participating providers and must have a referral to a provider of specialized care (e.g., a cardiologist) in order for such care to be covered. (But see the exceptions discussed on pages 13 and 23-24.) If HMO members follow these rules, their personal liability for such services is limited to a small co-payment amount, usually between \$5 and \$20.

PPOs encourage members to use participating providers by generally providing full coverage (except for a nominal co-payment) for their services. Generally, PPO members do not need a referral to see a specialist and are usually free to visit non-participating providers, but they pay a much higher share of the cost of such out-of-network care.

Table 3 Consumer complaints Problems Accessing Specialty Care	No. of Helpline Cases	% of all Consumer Complaints
Consumer disputed balance owing to non-par provider	175	5.0
Consumer received out-of-network services w/out preauthorization	129	3.7
Plan issued improper “No preauthorization” or “No referral” denial	108	3.1
Plan refused a referral to an out-of-network provider	69	2.0
Consumer received surprise bill from unknown non-participating provider	58	1.7
Plan gave wrong information on the “participating” status of a provider	54	1.5
Consumer received an in-network service without preauthorization	43	1.2
Other	28	0.8
TOTAL	664	19.0

Judging from the pattern of Helpline complaints in this area, it appears that some health plans do not always appropriately reimburse consumers for out-of-network care. Moreover, it appears that some consumers do not understand the concept of in-network and out-of-network care and the need for a referral or preauthorization to access certain types of care from certain types of providers. Further adding to the confusion and trouble for consumers, plans make mistakes in administering provider networks and in processing requests for coverage of specialty care.

Consumer disputed the balance owing to a non-participating provider

5% of all Helpline complaints come from consumers – generally those with HMO-POS and PPO plans (see panel, “Types of Health Plans,” on page 1) – who see a non-participating provider and call to complain that their plan paid the provider too little, leaving them with a hefty balance to pay themselves. Most plans pay a set percentage of what is often called the usual and customary rate (UCR) charged for a particular service,²⁷ and the member is liable for the remainder of the UCR plus whatever balance the provider charges.

Example: Health plan payment to out-of-network provider (80% of UCR) and the amount left for HMO-POS or PPO member to pay	
Amount charged by out-of-network surgeon	\$10,000.00
Health plan’s “usual and customary rate” for this procedure	\$5,500.00
Health plan pays provider 80% of UCR	\$4,400.00
Balance owed by member	\$5,600.00

Generally, plans are allowed to draw up their own schedules of rates for health services, procedures, treatments, and items of equipment,²⁸ using data purchased from a commercial vendor that presents statistics on providers’ charges across the country, broken down by treatment code, ZIP code, and other factors.²⁹ Judging by Helpline consumer complaints, some UCRs set by some health plans are lower than the amount customarily charged by providers in some areas of the state. Thus, some consumers with HMO-POS and PPO plans are shouldering an undue financial burden for using non-participating providers.

Mr. B called to complain that his health plan had reimbursed him at a very low level for his wife’s surgery at a non-participating hospital. Every time he complained to the health plan, it asked for more information and, after further review, paid more money. Still believing that the reimbursement was too low, Mr. B contacted the HCB. After HCB intervention, the plan issued a final payment that brought his total reimbursement to within 9% of the hospital’s actual charge.

Consumer received out-of-network services without preauthorization

Many health plans require that a member who wants coverage for out-of-network care must first obtain authorization from the health plan. Unfortunately, many consumers do not do this and are upset when they learn that they are responsible for the full cost of the services.³⁰

In some cases, consumers and providers contact health plans and obtain what they think is a preauthorization, only to find out after the fact that they did not. For example, a member – or even a nurse in a provider’s office – might call the member’s health plan to seek preauthorization of an upcoming hip surgery and ask if it will be “covered.” The plan representative hears the question as, “Is a hip replacement a covered benefit under my contract?” The representative answers, “Yes, it’s a covered benefit,” not understanding that the consumer is asking for preauthorization of impending surgery. The member, however, erroneously believes that she has just received a preauthorization, proceeds with the operation, and later receives a denial notice because she actually did not receive a specific preauthorization for that care.

Enforcement Action

Access to Specialists

When the HCB investigated complaints from consumers regarding Aetna’s denial of coverage for specialist care despite valid referrals from physicians, we found that denials had occurred because primary care physicians did not always process referral paperwork correctly and Aetna had failed to properly process referrals and specialists’ claims. Aetna, acknowledging administrative problems, agreed to make improvements in its referral and claim payment process and allowed health members and specialists to resubmit claims from 1999 or 2000 that were denied for lack of a referral.

Plan wrongly issued a “No preauthorization” or “No referral” denial

Preauthorizations and referrals issued by one department in the health plan are often not logged into the health plan’s computer system, resulting in a denial of care or coverage for care.

Mrs. K received a series of injections between January and March 2001 but then received bills from the facility for \$300 – the balance remaining after her plan had paid its usual and customary rate for the service. She called the HCB and said that the injections should have been covered in full. HCB staff called her plan and learned that it had paid the claims at the out-of-network rate because it believed there was no referral on file. After finding the valid referral, the plan paid all the claims in full.

Plan refused to authorize a referral to an out-of-network provider

New York law provides HMO members with the right to full coverage for care from an out-of-network health care provider if their health plan does not have a participating provider with experience and expertise in the treatment or service needed.³¹ An out-of-network referral is usually sought when (1) the member’s condition is unusual or unusually serious and (2) the member’s condition calls for either an uncommon medical service or a provider with unusual training and

expertise, that cannot be found within the health plan's network.

In recent years, a debate has emerged over whether denials of out-of-network referrals necessarily involve medical judgment, or whether they are administrative in nature. The distinction is important because denials based on judgments about the medical necessity of a health service are governed under the UR Law, which guarantees (1) that all decisions at the initial stage and on appeal are made by medical professionals and (2) the right to an external appeal. Under the current statutory scheme, denials of out-of-network referrals are not medical necessity determinations. Appeals of such denials are therefore handled as grievances, which cannot be externally appealed.

Reform Recommendation

Referrals to Out-of-Network Providers

Amend Article 49 of the Public Health Law and Article 49 of the Insurance Law to require that denials of referrals to out-of-network providers be treated as adverse determinations under the UR Law, allowing access to the external appeals process.

Ms. J's 2 year-old son was born with a cleft palate and required plastic and dental surgery, as well as audiology and speech therapy. Her health plan would not cover the services of an out-of-network plastic surgeon at a prestigious out-of-state hospital. With help from the HCB, Ms. J filed a grievance over the plan's denial, supported by a letter from her primary care doctor demonstrating that no in-network surgeon could perform this sophisticated surgery. The health plan reversed its decision.

Consumer received a surprise bill from an unknown non-participating provider

A particularly irritating situation involving specialty care occurs when an HMO member goes to a participating provider or facility for covered services, yet receives a bill weeks later from a non-participating provider who was "brought in" during the procedure or service and is now billing the consumer directly.

When a consumer in an HMO or an HMO-POS plan obtains a referral from a participating provider to a non-participating specialist, hospital or other facility, the consumer should be "held harmless" (*i.e.* not be held liable for any more than would be charged by a participating provider: the relevant in-network co-payment).³² Consequently, if a participating provider involved in providing a service decides to "bring in" a non-participating provider, the matter should be resolved between the health plan and the participating provider. Nevertheless, some HMOs erroneously insist that members are responsible for the full cost of services provided by non-participating providers in these situations.

Mr. M rushed his daughter to the ER for an appendectomy. He specifically requested that the surgery be performed by doctors in his health plan's network. He later received a bill from a non-participating doctor who assisted in the surgery. When he called his HMO about this, he was told the plan would not cover the non-participating doctor's services. Following HCB intervention, Mr. M's health plan paid the doctor in full, plus interest of \$140.

Health plan provided inaccurate information on the "participating" status of a provider

This situation is perhaps best illustrated by the following enforcement action:

Enforcement Action

Participating Providers

After a complaint from a HealthNow Community Blue (HN) member who could not access a promised free second annual dental exam, the HCB telephoned each dentist listed as participating in HN's Dental Discount Program and found that of the 205 participating dentists listed, only 18 confirmed that they would give the free second annual dental exam. HN conducted its own investigation and acknowledged that not all dentists listed in its directory of participating dentists had agreed to give a free second annual exam. HN agreed that it would clearly identify in all future consumer materials those dentists who provide the free exam.

Consumer received an in-network service without preauthorization

As already explained, it is a central aspect of HMOs that members who want to receive certain types of specialized health services must first obtain a referral from a primary care physician (PCP), or preauthorization directly from the health plan. HMOs therefore have the right to deny coverage for in-network services when a member did not get a referral or a preauthorization. The 43 complaints on this issue suggest that some HMO members do not sufficiently understand how their health coverage works. They need more education, information, and guidance if they are to avoid unexpected bills.

Mr. A went for an MRI without preauthorization and his health plan denied coverage. Mr. A said that he didn't know about the need for preauthorization, partly because he hardly ever goes to the doctor but also because, when he had gone in the past, he had never needed a preauthorization. HCB staff explained that, while most services do not require preauthorization under Mr. A's type of coverage, an MRI does. Mr. A filed a grievance, with a supporting letter from the HCB, and the health plan decided to grant an exception to its policy and paid for the MRI.

4. GETTING AND KEEPING HEALTH COVERAGE

Given the fact that there is a multitude of types of coverage available, that more than one in seven New Yorkers lacks health coverage, and that a significant number of others may lose it at any time,³³ it is not surprising that the issue most often on the minds of New Yorkers who contact the Helpline – accounting for one in four calls and letters to the HCB – is coverage: how to get it, what kinds are available, how to keep it, why one loses it and how to get it back.

Consumer complaints about getting and keeping health coverage break down into the six categories shown in Table 4, below. Three-quarters of coverage-related complaints are prompted by policy terminations by employers and failures by employers to make premium payments (141 cases), by employer errors relating to COBRA (135 complaints: see explanation of COBRA on page 27), or by health plan errors (68 cases).

Enforcement Action
Protecting the Uninsured
 Medical discount cards are an alternative for those unable to afford health insurance. A joint investigation by the HCB and the Attorney General’s Consumer Frauds and Protection Bureau found that two companies – U.S. HealthCard and Medisavers, Inc. – failed to truthfully disclose the costs and benefits of their discount card programs. The two companies agreed to reform their advertising practices, fully disclose all costs and limitations to consumers before they enroll in the program, and accurately list participating health care providers.

Table 4 Consumer complaints Problems getting and keeping coverage	No. of Helpline Cases	% of all Consumer Complaints
Policy terminated	141	4.0
<i>By employer</i>	76	2.2
<i>By health plan due to employer premium default</i>	65	1.9
COBRA - problems getting enrolled; employer mistakes	135	3.9
Enrollment prevented or policy terminated – health plan error	68	1.9
Enrollment prevented or policy terminated – consumer error	46	1.3
Health plan computer glitches causing eligibility problems	13	0.4
Other eligibility problems	108	3.1
TOTAL	511	14.6

Since most New Yorkers have health insurance through their employment, they face the prospect of losing coverage or having to change health plans whenever they take a new job or lose a job, and whenever their employer terminates coverage (because of a large premium increase, for example).³⁴ Losing your health insurance coverage while you are still working is especially hard to understand. Still, judging from complaint patterns, it is a crisis many New Yorkers confront.

Policy termination by employer/union or health plan

The 141 consumer complaints classified in this sub-section each arose from either an employer's deliberate termination of its group health policy or its failure to make premium payments to the health plan. In many of these cases, the employer was collecting premium payments from the employees' paychecks – and allowing the employees to continue to believe that they had health coverage – but was failing to forward the premiums to the health plan. Many of these non-payment cases involved businesses that were in serious financial difficulty or in bankruptcy. Employees frequently discovered that their plan has been terminated after they have already received care.

COBRA - Problems getting enrolled, employer mistakes

Fortunately, both federal and state law require employers to offer most terminated employees and their dependents continued health coverage for either 18, 29 or 36 months, if employees pay the premiums (such continuation coverage is commonly referred to as "COBRA").³⁵ However, few people take advantage of their COBRA rights. Only 23% of insured adults who are eligible to enroll in the program say they would be likely to use it if they lost their jobs.

The reason: it is simply too expensive. Of low-income employees, only 16% say they would enroll.³⁶

Consumer Tips

Protecting your COBRA rights

- " When you lose or leave your job, ask your employer for information and forms to enroll in COBRA continuation coverage. If possible, do so in advance.
- " Always comply with all COBRA enrollment and premium payment deadlines.
- " For more information, go to www.ins.state.ny.us/fagcs1.htm #cobra.
- " If your employer refuses to comply, contact the Attorney General's Health Care Helpline at (800) 771-7755 (option 3).

Many of the Helpline's COBRA-related calls and letters during the relevant period were from employees facing the possibility of layoff who wanted to make sure they understood in advance how to enroll in COBRA. Many others, however, were from consumers whose employers had failed in one way or another to fulfill clear legal obligations, with the result that consumers and often families had lost their coverage. The most common failures by employers were: not telling employees in advance about COBRA, not providing them with enrollment forms and other materials, and not telling them about filing deadlines.

When Ms. F left her job in January, she asked to continue her health insurance under COBRA, but her employer refused to fill out the form. This left her with no coverage. After several months, she contacted the HCB. A Helpline mediator

called Ms. F's former employer, who said that he would send her the COBRA election forms. The mediator had explained to the employer that, under NY law, employers with fewer than 20 employees must offer COBRA to departing employees.

Employers' failures often leave consumers without health insurance coverage at a time when they are financially most vulnerable. And, again, consumers are often the last to learn that their coverage has been terminated, receiving denial notices and even collection notices when they thought they would be fully covered.

Final Note – Prescription Drug Coverage

We noted earlier that 25% of all complaints and inquiries involve getting and keeping health coverage. Anecdotally, the largest group of inquiries in this area concern prescription drug coverage and come from some of the most vulnerable New Yorkers – seniors and people with disabilities. Medicare does not provide outpatient prescription drug coverage, and many of New York's seniors and people with disabilities with Medicare must pay out-of-pocket for their prescriptions. New York's EPIC program helps many low- and middle-income New Yorkers over age 65 with prescription drug costs, but disabled New Yorkers with Medicare are not eligible to join the program as currently constituted.

Reform Recommendations

Coverage for Prescription Drugs

- " Congress should enact a comprehensive Medicare prescription drug benefit.
- " New York should expand EPIC's eligibility criteria so that people under 65 with disabilities covered by Medicare can receive the affordable prescription drug coverage they so desperately need.

Enforcement Action

Preventing Medicare HMO "Slamming"

To protect seniors from being duped into joining a Medicare HMO that may not meet their health care needs, the HCB investigated complaints that HealthFirst 65 Plus, a Medicare HMO, was enrolling seniors without their knowledge or consent. In a recent agreement concluding the investigation, HealthFirst adopted procedures to help ensure that seniors who enroll in the health plan fully understand the limitations and the benefits of Medicare HMOs.

5. IMPROPER BILLING BY PROVIDERS

We have already noted how errors by providers in claims processing account for 9.9% of Helpline complaints (See Chapter 1). Another 9.9% of Helpline complaints are prompted by providers' improper billing of consumers.³⁷ Almost half of these concern the billing of health plan members by participating providers, while the rest are about processing errors of one kind or another by doctors' offices, hospital billing departments, diagnostic facilities, and other health care providers.

Table 5 Consumer complaints: Improper billing by providers	No. of Helpline Cases	% of all Consumer Complaints
Balance billing by participating providers	171	4.9
Wrong amount or wrong code	81	2.3
Bill already paid	22	0.6
Wrong person	17	0.5
Other billing problem	56	1.6
TOTAL	347	9.9

Balance billing by participating providers

State regulations prohibit a provider from billing a consumer who is properly enrolled as a member of an HMO licensed to do business in New York State if (1) the provider participates with the consumer's HMO, and (2) the services rendered by the provider are covered benefits. If these two conditions are met, the provider must seek payment for covered services (other than applicable deductibles, co-insurance or amounts designated by the HMO as the consumer's responsibility in the certificate of coverage) solely from the HMO, not the consumer. The provider can bill a consumer only if the consumer is not an eligible member of the HMO or the services provided are not covered benefits under the consumer's certificate of coverage. To bill a consumer for any other reason constitutes prohibited "balance billing."³⁸ Similar protection is usually afforded PPO members through a "hold-harmless"³⁹ clause in the contracts between the PPO and its preferred providers.

Ms. S, an HMO member, was referred to a participating specialist by her PCP. However, the specialist billed her for the balance beyond what her plan paid. Ms. S refused to pay the specialist's bill and was put into collections for \$2,540. Following HCB intervention, the health plan contacted the specialist and explained that the member had received a referral from Ms. S's PCP and that the consumer was therefore not responsible for any "balance." The plan had the specialist remove the account from collections.

Participating providers who balance bill their patients often argue that they are forced to do so by the failure of the health plan in question to process and pay their claims in a timely manner.⁴⁰ Some providers even infer from a plan's lack of response to a claim that the patient was never a member of the plan, or has lost coverage, or is for some other reason liable to the provider directly.

While health plans' mistakes and omissions may be a cause of genuine aggravation to providers, there is no justification for balance billing consumers in violation of state regulations and participating provider contracts. To make matters worse, some of the members who receive these providers' bills pay them because they do not know that laws or in some cases contract provisions specifically forbid the practice. In over one-third of these balance-billing cases, the provider sent the consumer's bill to collections.⁴¹

Mr. Y received services at a hospital but later received a denial notice from his health plan because he lacked pre-authorization. His bill for \$310 was placed in collections. HCB staff contacted the plan and learned that the hospital, as a participating hospital, was responsible for obtaining the preauthorization and cannot bill the member to correct its own mistake. The hospital agreed to write off the \$310.

The remaining complaints in this category result from a provider using the wrong diagnostic or procedure code on an otherwise appropriate bill to a consumer; continuing to demand payment long after the bill has been paid; and billing the wrong consumer entirely.

Enforcement Action

Protecting Nursing Home Residents

With the New York State Office for the Aging Ombudsman Program, the HCB surveyed nursing home admission contracts and found that many contained inaccurate, misleading and, in some cases, illegal language requiring third-party guarantees. The contracts also stipulated arbitrary grounds for discharging residents. Nine prominent nursing homes across the state agreed to change their admission contracts significantly by eliminating (1) third-party guarantees that impose financial obligations on families as a condition of admission and (2) vague language that allowed wide latitude to discharge residents involuntarily (although none of the homes had billed third parties or involuntarily discharged residents illegally).

6. ACCESS TO PRESCRIPTION DRUGS

Many of the 3,372 complaints already discussed in this report – whether they related to denials of coverage, access to specialty care, problems obtaining or losing coverage, or some other issue – involved prescriptions in one way or another. In a number of cases, however, the real issue is the prescription itself – whether, for example, it is medically necessary or covered under the member’s plan. These cases have been collected here for separate presentation and discussion.

Table 6 Consumer complaints: Access to prescription drugs	No. of Helpline Cases	% of all Consumer Complaints
Formulary issues: preferred drugs, generics, substitution	75	2.1
Plan denies preauthorization for a medication	33	0.9
Inquiries about prescription benefits and formularies	9	0.3
Plan cuts number of pills dispensed per visit	5	0.1
TOTAL	122	3.5

Formulary issues: preferred drugs, generics, substitution

With drug costs rising faster than the rate of overall health spending, thus accounting for an increased percentage of all health care spending,⁴² health plans are devoting more energy to containing the cost of prescription benefits, primarily through the use of formularies. A formulary is a list of prescription medications and, sometimes, non-prescription medications covered by a health plan. If a medication is on the formulary, it is covered; any other medication is not covered, or is covered only partially. Formularies are usually managed on behalf of health plans by companies known as pharmacy benefit managers (PBMs).

Formularies are increasingly structured in tiers, with lower co-payments for “preferred” drugs and higher co-payments for others. Preferred drugs are, as the name suggests, those a health plan would prefer its members to use in contrast to other, usually more expensive, drugs. Preferred drugs are usually generic⁴³ versions of brand-name or “pioneer” drugs, but they may also be brand-name drugs that, for one reason or another (e.g. bulk discounts or rebates from manufacturers), are cheaper for the health plan than other brand-name drugs. Health plans encourage the substitution of generics for brand-name drugs wherever possible. Pharmacists are allowed to substitute a generic for a brand-name drug at the time the prescription is filled unless the prescribing physician has written “DAW” (dispense as written) on the prescription.⁴⁴

Three quarters of all consumer calls and letters that dealt specifically with access to prescriptions were about the use of formularies. Most commonly, a consumer was unable to fill a prescription for a drug because it was not on the health plan formulary. In some cases, the health plan told the consumer that it would only pay for the generic version of a drug – *i.e.* it was insisting on substituting a generic for the brand – when the consumer believed there was no generic equivalent to the brand-name drug.

Consumers experience another constraint on their access to health services when a pharmacist refuses to fill an entire prescription and insists that the consumer return another day for the remainder. While such actions are almost always dictated by some policy of the member's health plan or the PBM hired by the plan to

Enforcement Actions

Access to Prescription Drugs

- " In June 2001, an agreement between the Attorney General and HealthNow – the first of its kind in New York – helped resolve ongoing consumer complaints in the wake of a decision by HealthNow to modify its pharmacy network to include Rite Aid and discontinue its relationship with other pharmacies. The agreement required HealthNow to establish a 24-hour toll free hotline for consumers, and to log and prioritize consumer complaints regarding pharmacy services.
- " New York State law required pharmacies to conspicuously display a poster presenting a list of the 150 most prescribed drugs, along with current selling prices so consumers could compare prices.⁴⁵ After an HCB investigation found that almost 40 percent of surveyed pharmacies across the state failed to comply with this law, all the non-compliant pharmacies agreed to out-of-court settlements, promising to take specific steps for future compliance and to contribute toward an educational campaign to inform consumers about the importance of comparison shopping for prescription drugs.

administer the prescription benefit, the practice is often explained to the member as being the result of a limited supply on the shelf or required by the Food and Drug Administration. At other times no explanation is given. A practical effect of this kind of limitation – aside from causing the consumer the inconvenience of additional travel – is that the member often has to make an additional co-payment to receive the remainder of the prescription. This can create an unexpected financial burden for those who maintain their health with prescription medications.

Ms. C called the HCB on behalf of her son, who has cancer of the throat and upper chest. He was undergoing chemotherapy and radiation and needed medication to control his nausea. His oncologist prescribed ZOFRAN, specifying 8 mg tablets, 60 tablets at a time. The pharmacy was only willing to dispense 15 tablets every ten days. Consequently, instead of paying the normal \$5 co-payment to receive 60 tablets, Ms. C's son would have to pay \$20. When the HCB contacted Ms. C's son's health plan and explained his course of treatment, the plan agreed to allow the pharmacy to dispense 60 tablets at a time.

CONCLUSION

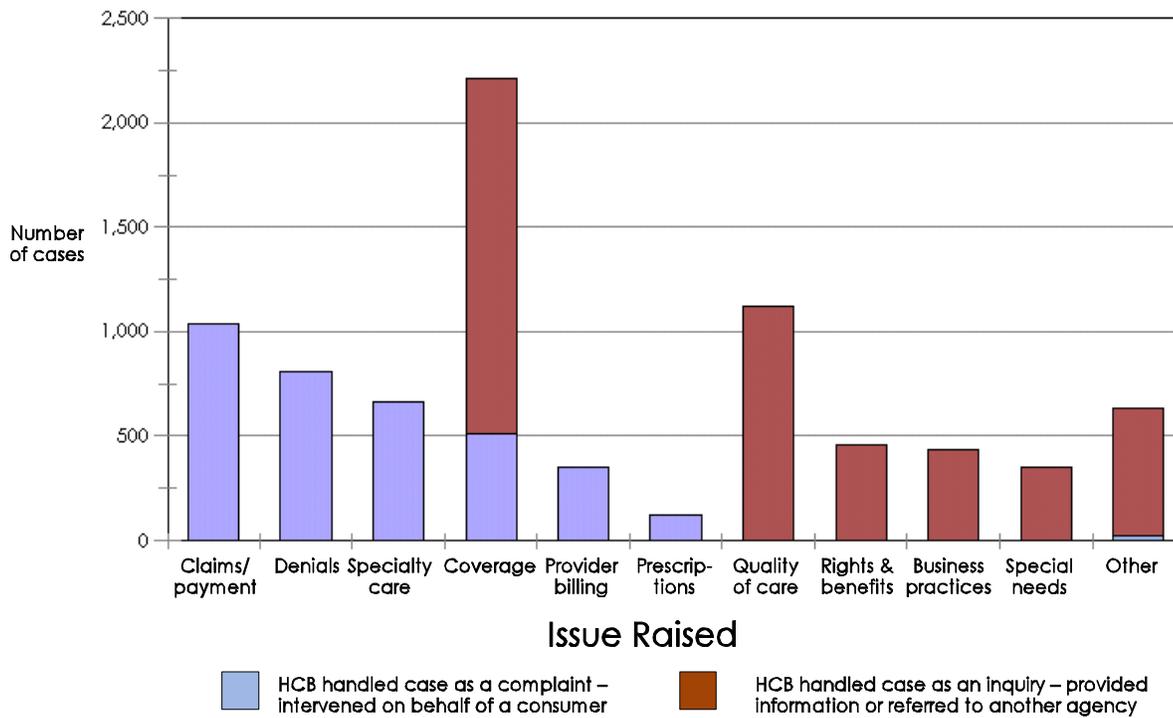
While the experiences of the consumers who contact the HCB Helpline are not necessarily representative of the experiences of all New York health care consumers (for example, we only hear from people who are dissatisfied with their health care or coverage for that care), we believe that the data presented in this report indicates existing impediments in consumers' ability to access care and suggests areas for improvement in the way coverage and care are delivered to consumers. The Attorney General's Health Care Bureau is committed to working with all New Yorkers who have a stake in our vital health care system – consumers, providers, and health plans – to help make affordable, high quality health care available to all.

APPENDIX

TABLE 7: HCB HELPLINE INQUIRIES: REFERRALS AND INFORMATION

Table 7 Referrals and Information: Helpline Inquiries handled by providing information or referrals to other agencies	No. of Helpline Inquiries	% of all Referrals and Information
Coverage issues	1,700	36.2
Medicaid	443	9.4
Managed care: coverage, benefits, exclusions, coordination of benefits	180	3.8
Workers Compensation	164	3.5
Medicare	144	3.1
COBRA - how it works, how to enroll	129	2.7
No-fault insurance	117	2.5
Family Health Plus	114	2.4
Managed care: premiums, deductibles, co-pays	111	2.4
Child Health Plus	98	2.1
Healthy NY	85	1.8
ERISA	41	0.9
EPIC	35	0.7
COBRA - enrollment problems	20	0.4
Policy termination by employer or health plan	19	0.4
Quality of care	1,117	23.8
Physicians, group practices or clinics	746	15.9
Hospitals, including Inpatient Mental Health	248	5.3
Pharmacies, including mail-order service	57	1.2
Nursing homes, adult homes, assisted living facilities	33	0.7
Miscellaneous facilities	15	0.3
Laboratories, diagnostic imaging facilities	12	0.3
Pharmacists	6	0.1
Consumer rights, benefits	458	9.8
Right to see patient records	284	6.1
Labor standards, workplace safety, employer obligations	74	1.6
Privacy, confidentiality, identity theft	34	0.7
Housing, buildings, environmental, landlord/tenant	26	0.6
External Appeal Law, UR Law, MCCBOR	22	0.5
Other consumer services & programs	18	0.4
Business practices	437	9.3
False advertising / misleading materials	387	8.2
Illegality / criminality / fraud	36	0.8
Incompetence / inefficiency / lack of response	14	0.3
Special needs of particular groups	348	7.4
Seniors	170	3.6
Disability, including those needing home health services	127	2.7
Mental health, developmental disabilities	41	0.9
Crime victims	7	0.1
Veterans	3	0.1
Other	634	13.5
TOTAL	4,694	100.0

CHART 2: COMPLAINTS AND INQUIRIES



The lightly-shaded bars represent cases handled as consumer complaints (See Chapters 1 through 6). The darkly-shaded bars represent consumer inquiries handled by the HCB Helpline by providing information or referring the case to another agency. (See Table 7).

ENDNOTES

1. Kaiser Family Foundation, "State Health Facts Online," at <http://statehealthfacts.kff.org>. Statistics are for 1999-2000.
2. Kaiser Family Foundation, *National Survey of Consumer Experiences with Health Plans*, June 2000.
3. The Managed Care Reform Act of 1996 (L.1996, ch. 705) is commonly referred to as the "Managed Care Consumer Bill of Rights." The MCCBOR also includes various statutory provisions enacted subsequently, in particular the External Appeal Law (Article 49, Title II of both the Public Health Law and Insurance Law), which established a right for consumers and providers to appeal certain health plan coverage denials to an independent third party, as well as the Prompt Pay Law (Insurance Law § 3224-a), which requires most health plans to pay or deny claims within certain time frames. For more information about the MCCBOR, see the Attorney General's website at www.ag.ny.gov/bureaus/health_care/about.html; or the Insurance Department website at: www.ins.state.ny.us/hrights.htm.
4. In 2000, the New York State Legislature, recognizing the needs of New York's managed care consumers, established MCCAP to provide education and assistance to help New Yorkers understand their rights and responsibilities as health plan enrollees, and to help resolve consumer and provider complaints about health plans. To view a copy of MCCAP's annual report, go to www.ag.ny.gov
5. In some instances, we have combined facts from different cases to create a complete case scenario.
6. For an explanation of the acronyms, see the panel titled, "Types of Health Plans," on page 1.
7. Wherever investigation revealed some other reason for the delay, the complaint was assigned to the appropriate category. For example, if the health plan was not processing a claim because it lacked sufficient clinical information on which to base a decision (because the provider had not submitted the information), the complaint was assigned to "Claims processing and payment problems: Denials due to provider error: Insufficient clinical information" (see page 9). If a health plan was not paying a claim because it believed that it was not the primary payor when in fact it was, the complaint was assigned to "Denials of care or coverage: Denials due to health plan errors: Coordination of benefits - primary/secondary" (see page 17).
8. Insurance Law § 3224-a.
9. Insurance Law § 3224-a(c). For example, see Department of Insurance Press Release, "MVP Health Plan agrees to pay \$33,800 for Prompt Pay Violations," March 28, 2001; available at www.ins.state.ny.us/p0103281.htm.
10. These cases were classified under "Other provider error."
11. In New York State, a coverage denial can be contested according to procedures set out in § 4408-a of the Public Health Law; such a challenge is known as a Grievance. A medical necessity denial (adverse determination), on the other hand, can be

contested according to UR procedures set forth in Article 49 of the Insurance Law and/or Article 49 of the Public Health Law (the UR Law); such a challenge is known as an Appeal. Final decisions on Grievances are made by the health plan; decisions on Appeals made by the health plan can be challenged through an External Appeal process administered by the Insurance Department.

12. A clinical peer reviewer (CPR) for purposes of making initial adverse determinations under the UR Law must be (a) a licensed physician or (b) a health care professional other than a licensed physician who is licensed, certified, registered or accredited, as appropriate, and who is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review. Insurance Law § 4900(b)(1); Public Health Law § 4900(2)(a).

Note that the same-specialty requirement applies only to non-physician CPRs at the initial adverse determination stage. The qualifications for CPRs hearing internal appeals of adverse determinations were relaxed, effective July 1, 1999. Prior to that date, the UR Law imposed a same-specialty requirement on all CPRs – both physician and non-physician. Now, the UR Law provides that, in the context of an external appeal, a clinical peer reviewer must have at least 5 years of experience in the same or similar specialty and be knowledgeable about the health care service or treatment under appeal. See Insurance Law § 4900(b)(2); Public Health Law § 4900(2)(b); and 11 NYCRR §§ 410.1 through 410.13.

13. Title II of Article 49 of the Insurance Law; Title II of Article 49 of the Public Health Law.
14. Prescriptions account for 24% of all consumer complaints relating to preauthorization denials. See Chapter 6.
15. This includes inpatient hospital stays, acute inpatient rehabilitation, and inpatient mental health care.
16. This number of complaints does not include those that turned out to be unjustified. If a consumer alleged a violation of the prudent layperson standard by a health plan but further investigation revealed that the claim was properly denied on the ground that the care was truly not medically necessary or because non-emergency hospital care was received without preauthorization, the complaint was classified elsewhere – *i.e.* “Denials of care or coverage: Medical necessity denials” (see page 11) or “Access to Specialty Care: Consumer received in-network services without preauthorization” (see page 21).
17. Insurance Law § 4902(a)(8); Public Health Law § 4905(13).
18. Insurance Law § 4900(c); Public Health Law § 4900(3).
19. Insurance Law §§ 4902(a)(8) and 4905(m); Public Health Law §§ 4902(1)(h) and 4905(13).
20. Insurance Law § 4905(m); Public Health Law § 4902(1)(h).
21. See 11 NYCRR § 62 (“Regulation 62”). The definition of cosmetic surgery is set forth at 11 NYCRR § 52.16(c). The definition of custodial care is set forth at 11 NYCRR § 52.25(a)(1).

22. NYS Insurance Department and NYS Department of Health, *New York State External Appeal Program Annual Report, July 1, 2000 - June 29, 2001*, p. 17.
23. Medicare Coverage Policy #CAG-00011B, "Autologous Stem Cell Transplantation (AuSCT) for Multiple Myeloma," available at www.cms.gov/coverage/8b3-c.asp.
24. The complaints discussed here involve health plan denials of services that are clearly included in the contract as a covered benefit.
25. Insurance Law §§ 3216(i)(21), 3221(k)(11) and 4303(y).
26. Insurance Law §§ 4318(a), 4318(b), 3232(a) and 3232(b); *Health Insurance Portability and Accountability Act of 1996*, 42 USC §§ 300gg(a)(1) and 300gg(c)(2)(A).
27. Health plans may use other names for this concept, such as "reasonable and customary charge," "reasonable and customary rate," or "allowed amount."
28. Reimbursements for out-of-network benefits received by direct-pay individual enrollees in non-profit HMOs can be set according to a different method. Under New York Insurance Law § 4322(d), non-profit HMOs can set levels of reimbursement for out-of-network benefits for their individual direct-pay enrollees according to their own fee schedule, as long as they provide a level of reimbursement comparable to 80% of UCR. These fee schedules must be filed with the Department of Insurance.
29. One such service is the Prevailing Healthcare Charges System® (PHCS), a commercial data service offered by Ingenix, Inc. It is used by hundreds of health insurers across the country.
30. In some cases, consumers did obtain preauthorization, but the plan mistakenly told them after the fact that they lacked preauthorization. These cases were classified under "Plan wrongly issues a 'No preauthorization' or 'No referral' denial" (see page 17).
31. Public Health Law § 4408(1)(k).
32. See 10 NYCRR §§ 98-1.13(d) and 98-1.5(b)(6)(ii).
33. See note 30.
34. The costs to businesses of providing health insurance coverage are increasing, making it more difficult for employers to offer coverage. A small employer with seven employees can spend as much as \$6,000 per month on premiums for employees, and premiums have been reportedly increasing at 20 per cent per year. Robert Spear, "After Decline, The Number Of Uninsured Rose in 2001," *New York Times*, Sept. 30, 2002, A22, quoting Kate Sullivan, Director of Health Policy at the U.S. Chamber of Commerce. Of all employers in New York with 50 or more employees, 97% offer coverage, while 52% of those with fewer than 50 employees do so. Kaiser Family Foundation, "State Health Facts Online," at <http://statehealthfacts.kff.org>. Statistics are for 1999-2000.
35. COBRA is an acronym for the federal *Consolidated Omnibus Budget Reconciliation Act of 1985*, 29 U.S.C.A. § 1161 *et seq.* It applies to employees and their dependents who would otherwise lose their insurance coverage as a result of a "qualifying event." The length of additional coverage they receive (18, 29 or 36 months) depends on the

- qualifying event. New York State law provides similar “ continuation coverage” to employees not covered by federal COBRA – specifically, those working for employers with under 20 employees. For New York State law, see Insurance Law §§ 3221(m) & 4305(e); Labor Law §§ 195 & 217; and www.ins.state.ny.us/faqcs1.htm#cobra.
36. Jennifer Edwards, Michelle M. Doty, and Cathy Schoen, *The Erosion of Employee-Based Health Coverage and the Threat to Workers’ Health Care*, The Commonwealth Fund, August 2002 (#559). Available at http://cmwf.org/programs/insurance/edwards_Erosion_ib_559.pdf.
 37. This section discusses only *improper* billing of consumers by providers. When consumers complained about a provider’s bill but further investigation revealed that the provider’s bill was appropriate, those complaints were assigned to other categories. For example, if a consumer received a bill from a non-participating provider for the full cost of health services because the consumer had received services out-of-network without health plan preauthorization, the complaint was classified under “ Access to specialty care: Consumer received out-of-network services without preauthorization” (see page 21).
 38. See 10 NYCRR 98-1.5(b)(6)(ii). See Department of Health, “HMO and IPA Provider Contract Guidelines,” July 31, 1998 (available at www.health.state.ny.us/nysdoh/manicare/hmoipa/guidelines.htm), p. 3.
 39. For an explanation of “ hold harmless,” see page 24.
 40. The problem of health plans’ late reimbursement of providers is discussed on pages 7-8.
 41. In 42% of all balance-billing cases that involved collection action, the participating provider was a hospital.
 42. The Centers for Medicare and Medicaid Services (CMS) recently predicted that prescription drug spending growth between 2001 and 2011 will exceed total health spending growth by almost 5 percentage points per year on average, so that by 2011 prescription drug spending will account for 14.7% of total health expenditures, compared with its 2000 level of 9.4%. Stephen Heffler *et al.*, “ Health Spending Projections For 2001-2011: The Latest Outlook,” *Health Affairs*, March/April 2002, p. 215.
 43. A generic drug is defined by the Food and Drug Administration as “ a copy [of a brand-name drug] that is the same as a brand-name drug in dosage, safety, strength, how it is taken, quality, performance and intended use.” See www.fda.gov/cder/consumerinfo/generics_q&a.htm.
 44. Education Law §§ 6810(6) & 6816-a.