



New York State Office of the Attorney General Letitia James

Health Care Bureau 2019

Real Solutions for New Yorkers

Each year, the Office of the Attorney General (OAG) helps thousands of New Yorkers navigate the health care system. Through its health care Helpline, OAG works with New Yorkers to mediate disputes with their insurance companies, correct overbilling, and obtain medically necessary health care and medication. The complaints received by the Helpline often lead to larger investigations, enforcement actions, and policy initiatives by the OAG's Health Care Bureau (HCB)¹.

In 2019, ***the OAG secured nearly 2 million dollars*** for health care costs in restitution and savings for New Yorkers. Highlights of the year include reversal of health plan denials of medically necessary surgeries, including surgeries related to the heart, cancer and rare diseases. This report covers 2019, before the COVID-19 pandemic. As our state continues to face serious challenges, the Health Care Bureau and Helpline have remained active in helping New Yorkers sort through new health care issues that are related to the pandemic.

¹ For further information about the HCB, including press releases on our most recent enforcement actions, consumer brochures, and HCB reports, please visit ag.ny.gov/bureau/health-care-bureau.

ADDRESS _____



2019 at a Glance

The HCB Helpline is the OAG's front line for health care – making it easy for New Yorkers to notify the Attorney General's office about their health care concerns by submitting complaints for review and resolution by the Helpline's team of advocates.

In 2019, 3,930 New Yorkers contacted the HCB Helpline for assistance. During the year, Helpline advocates directly handled 2,164 consumer complaints and the Helpline provided another 1,766 consumers with information or referrals to the agency most appropriate for the inquiry. The complaints handled by the Helpline highlight the challenges faced by New Yorkers and are an important means of identifying systemic problems in New York's health care system. In addition, these complaints often provide the basis for further investigation and enforcement actions against health plans, providers, and other entities operating in the health care market, which can result in positive, systemic change.

During 2019, the HCB Helpline secured close to \$2 million for New Yorkers in restitution and savings. These recovered and saved funds were achieved by correcting erroneous medical billing, wrongful rejection and processing of health insurance claims, and rectifying companies' wrongful business practices.

In addition, the HCB Helpline assisted New Yorkers with obtaining medically necessary care or prescriptions where the health plan had previously denied that care or medication; and, obtaining reinstatement of health coverage that a health plan incorrectly terminated.

The main issues for which New Yorkers call the Helpline are

- (i) uncertainty about their benefits,
- (ii) the rules to follow to secure coverage for care,
- (iii) doctor or hospital charges,
- (iv) appeal rights, or
- (v) referral information to other agencies that might deal with health care issues that are out of the scope of our jurisdiction.

While not all consumer complaints and inquiries can be resolved in the consumer's favor, the HCB Helpline plays a crucial role as a source of reliable and objective information for consumers.



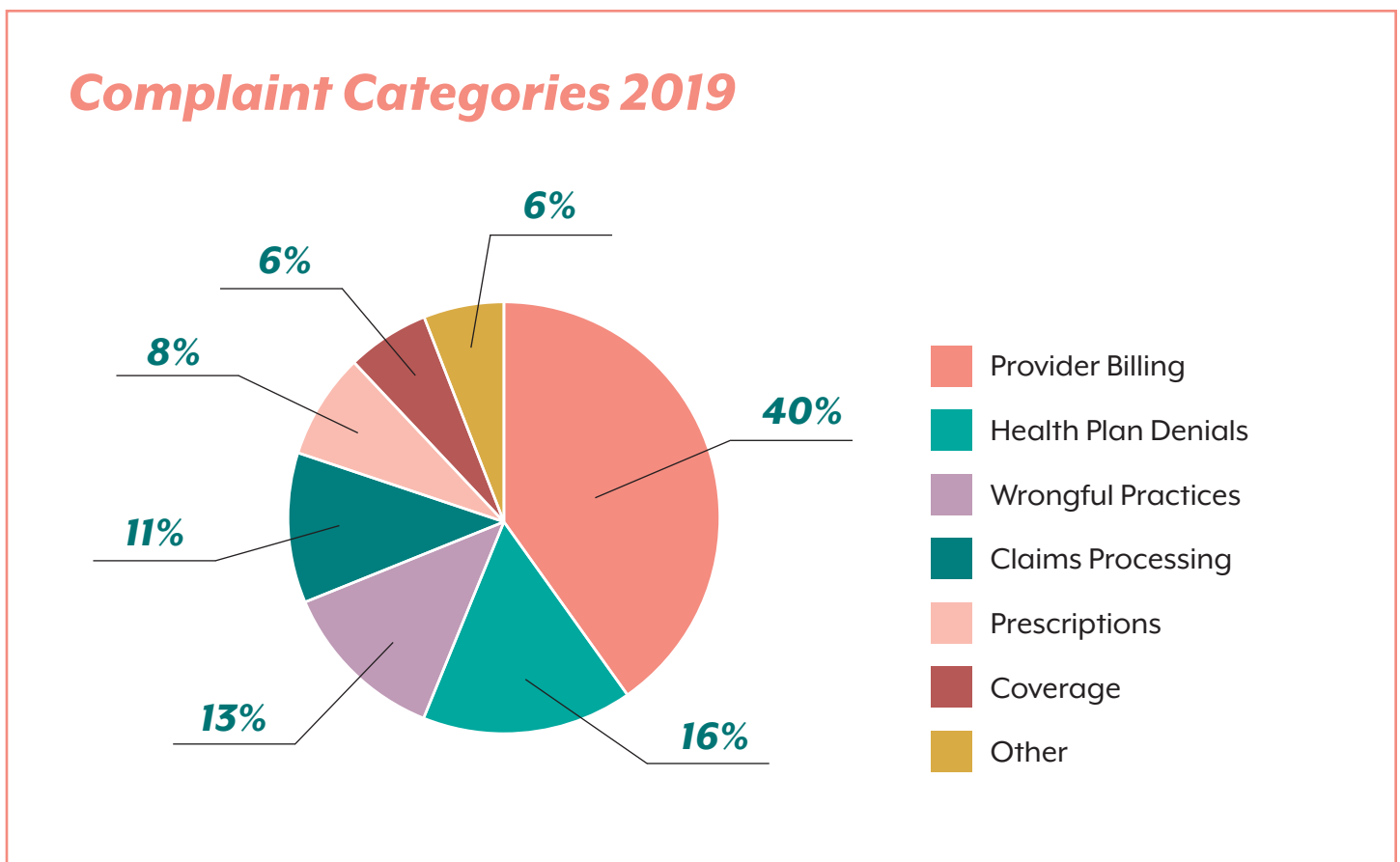
Incorrect billing has been the number one issue raised by New Yorkers since 2011.

Main Health Care Issues Facing New Yorkers

Complaints to the Helpline fall into six general categories: provider billing, health plan denials, wrongful practices, claims processing, prescription drugs, and insurance coverage.

Most complaints to the Helpline (40 percent of all complaints) were about incorrect medical billing (including private physician practices and hospitals). These issues typically include when a patient is incorrectly “balance billed,”² when a provider fails to, or incorrectly, submits claims to an insurance company, or duplicate billing.

Incorrect billing has been the number one issue raised by New Yorkers to the Helpline since 2011. The graph below shows the breakdown of complaints.



² “Balance billing” occurs when a provider bills a patient for the difference between the amount charged and the amount that the patient’s health plan paid. When a provider is in-network, there is an agreement to accept the insurance payment as payment in full, and the provider is not permitted to balance bill the patient (except] for coinsurance, copayment, and deductible). Balance billing is not improper, however, if the provider is not in the health plan’s network.

How the OAG has Helped New Yorkers

Provider Billing Practices

A significant number of consumer complaints (40 percent) raised concerns about provider billing practices. Erroneous provider bills are, unfortunately, not uncommon and can be costly, and even lead to collection agencies getting involved, or legal judgments. Were it not for Helpline intervention, New Yorkers in these instances might have faced these kinds of consequences. Improper billing also often takes an emotional toll on individuals, especially when they try to resolve the situation without success. Some of the successful cases this year include:

- **Refund Secured for Incorrect Billing of Forensic Rape Examination.** A consumer contacted the Helpline after learning that she should not have been billed for a forensic rape exam. The exam was in 2006, and at the time she had paid the hospital bill. The OAG intervened and the hospital refunded her for its erroneous bill.
- **Improper Urgent Care Bill Removed from Collection.** A consumer's son injured himself in April 2016 and went to an urgent care center. The consumer paid a \$50 copayment at time of service. It was not until one year later that the consumer received a letter from the hospital stating that her insurance plan indicated she had no coverage on the date of service. The consumer knew this was wrong and called the insurance company and was told the problem was resolved. After another year, she received another bill, and again called the insurance company, and was again told the claim was paid. The consumer applied for a mortgage loan in March 2019 and discovered that her credit score was low because the urgent care bill had been sent to a collection attorney. The OAG contacted the insurance company, and determined that while the claim had originally been paid, then adjusted and denied, it had been paid in full in 2017. The OAG then ensured that the record with the collection firm was corrected. The bill was canceled and negative information from credit reports was removed.
- **Hospital Billing Error of Almost \$12,000 Corrected.** A consumer was admitted three times to an in-network medical center for a series of strokes in June 2016. When he received a bill from the medical center in 2019 for \$11,985 for the second series of strokes, he contacted the OAG. The OAG investigated the incident and determined that the insurance plan had made all the proper payments, and that the hospital bill had been sent in error. After OAG intervention, the hospital issued a zero-balance statement.
- **Durable Medical Equipment Provider Rescinds Improper Bill.** A consumer contacted the Helpline on behalf of her husband. Hospitalized for six weeks after having a stroke, he was prescribed an air mattress to help address bedsores, when he was discharged from the hospital. The medical supplier, an in-network participating provider, did not obtain proper authorization for the air mattress and billed the family \$800. After the consumer reached out, the company reduced the bill to \$200, but refused to waive the remainder notwithstanding that the supplier was in-network. The OAG intervened and worked with both the insurance company and the supplier, and the bill was rescinded.

• **Hospital Corrects Accounting Error and Improper Billing.** A consumer gave birth to twin girls in October 2018. She paid the bills for their birth in December 2018, but \$15 was incorrectly applied to the wrong daughter's account, causing an overpayment of \$15 on Baby A's account, and an underpayment of \$15 on Baby B's account. For five months, she received monthly bills for the \$15 underpayment. She called the billing department each time she received a bill, and was repeatedly told that they would transfer the money, and she should not receive any more bills. She ultimately called the OAG, which was able to get the hospital to correct the record and issue a zero-balance statement.

Health Plan Denials of Coverage for Care

Approximately 16 percent of all HCB complaints involved health plan denials of coverage for care. Such denials most often occurred based on the health plans' determinations that the care was not medically necessary (despite a health care provider stating otherwise). A denial of coverage can result in a bill of thousands or tens of thousands of dollars. The OAG is frequently able to assist New Yorker in reversing these denials.

• **Plan Reverses Denial of Coverage for Aortic Valve Replacement.** A consumer's insurance company denied coverage for a trans-catheter aortic valve replacement (TAVR). The insurance company denied coverage because its criteria required that in order to be approved for TAVR, he had to be medically determined to not be a candidate for open heart surgery. Although he was a good candidate for open heart surgery, his doctor recommended the TAVR because it was less invasive and involved much less recovery time (one to two weeks versus three months). The consumer met every other element of the medical necessity criteria. His doctor was appealing the denial, when the consumer reached out to the OAG for extra assistance. The OAG advocated on the consumer's behalf to the insurance company, which ultimately approved the procedure.

• **Plan Reverses Denial of Coverage for Out-of-Network Specialist.**

A consumer was on a business trip in Michigan when he fell ill with pain behind his eye. He went to an ophthalmologist and was diagnosed with a rare cancer, choroidal melanoma. He immediately returned home and was seen by an in-network ophthalmologist who recommended three out-of-network specialists as being the only appropriate doctors to treat this cancer. His health plan denied the necessary out-of-network authorization to cover the cost. He appealed the denial, and also contacted the OAG. The OAG intervened and was able to get the insurance company to not only reverse its denial the next day, but also authorize continuing care.



MEDICATION DENIALS

Helpline advocates have helped many New Yorkers obtain medication deemed medically necessary by their physicians.

• **Denial of Coverage for Treatment of Rare Disease Reversed After External Appeal.** A consumer has a rare disease, Ehlers-Danlos Syndrome (EDS), which affects her joints, skin, and tissue. She had tried and failed with conservative treatments, and her physician recommended a cranial cervical fusion (a complex skull surgery). Without the procedure, she risked stroke, neurological injury, or even death. Her insurance provider denied coverage of the procedure. She appealed, and was still denied. She filed an external appeal with the New York State Department of Financial Services, and the OAG submitted a letter in support. The denial was reversed on appeal and the insurance provider was directed to cover the life-saving procedure.

• **Health Plan Reverses Denial of Coverage for Mental Health Treatment.** A consumer's health plan notified her that it would no longer cover her once-a-week outpatient mental health treatment, and instead it would only cover treatment once every other week going forward. She appealed, but her health plan upheld its denial, referencing its internal guidelines for outpatient mental health. She reached out to the OAG, who advised that a letter from her health care provider stating the medical necessity of the treatment may help. OAG also wrote a letter to the health plan, and the denial was overturned.

• **Health Plan Reverses Denial of Coverage for Rehabilitation Facility.** A consumer had been in the intensive care unit (ICU) for over 40 days due to an intracerebral hemorrhage (a brain bleed), and was ready to be discharged from the ICU within two days. His medical team recommended a "disorder of consciousness program" at a rehabilitation facility, but his health plan denied the request, finding no medical necessity. The OAG intervened, and determined that the health plan had denied the request based on outdated information. The OAG worked with the hospital to submit an expedited appeal, which successfully overturned the health plan's decision, and he was transferred to the rehabilitation facility.

Access to Prescription Drugs

Complaints concerning access to prescription medication constituted about 8 percent of all cases handled by Helpline advocates. These complaints included problems with formularies,³ problems with mail-order drugs (including delays and non-deliveries), and denials of preauthorization for high-cost specialty drugs.

• **Health Plan Approves Coverage of Harvoni After Delay.** A nurse practitioner contacted the OAG on behalf of a patient who was having difficulty getting approval for coverage of Harvoni, a medication used for the treatment of chronic hepatitis. The patient's health plan had twice denied appeals for coverage for the Harvoni medication based upon medical necessity, and wanted the patient to use another medication. Even once the appeal was successful, the nurse practitioner continued to have problems getting the medication approved, and spent hours advocating for her patient. The OAG intervened, and within one day, the health plan approved, processed, and paid the claim.

³A formulary is a list of prescription drugs covered by a prescription drug plan or an insurance plan offering prescription drug benefits.

• **Denial of Coverage for Narcolepsy Drug Is Reversed.** A patient’s doctor prescribed Modafinil to treat his condition and contacted the OAG after his health plan denied coverage of the medication. The doctor had provided a letter of medical necessity, indicating that he was experiencing excessive daytime sleepiness, and was having concentration, memory, coordination and other cognitive difficulties. His health plan wanted him to try other drugs on its preferred drug list first and denied coverage of Modafinil. The OAG intervened with the consumer’s health plan, and secured coverage of the drug for one year.

• **Consumer Receives HIV Medication After Initial Denial.** A consumer contacted the Helpline after not being able to obtain his HIV medication, Bictarvy, for about two months due to insurance paperwork errors. First, the pharmacy plan administrator lost his prior authorization paperwork, which caused delays through November and December, and in January a new pharmacy plan administrator took over and did not have the paperwork. The OAG intervened with the pharmacy plan, and was able to secure approval for the Bictarvy within days.

• **Health Plan Adds Coverage for Medical Formula to Benefits.** A consumer contacted the Helpline because her ten-year-old daughter was diagnosed with phenylketonuria (PKU), who needed dietary medical formula that had been denied by her health plan. According to her daughter’s doctor, the only proven treatment for PKU is prescribed medical formula, which consists of safe dietary protein. The health plan covered the formula for approximately four months and then rescinded payment and the consumer received a bill for \$6,148.80. The OAG intervened with the health plan, and ultimately was able to get the claim paid and additional coverage to all on the health plan for dietary medical formula.

⁴Phenylketonuria is a rare, inherited disorder that causes an amino acid called phenylalanine to build up in the body. If untreated, it can lead to serious issues, including seizures, intellectual disability, and behavioral problems.

Wrongful Practices

About 13 percent of complaints were based on an individual's assertion of a wrongful or fraudulent business practice. These complaints included improper refund processes, general inefficiencies, and false advertising. Cases described under the wrongful practice category may also fit into one of the categories above, but have an added element of deception and/or fraud.

• **Provider Honors Free Consultation Offer and Rescinds Bill.** A consumer heard an advertisement for a free consultation for a non-invasive permanent weight loss procedure. She contacted the company and was told that she did not qualify for the advertised procedure because her body mass index (BMI) was not high enough. After hearing another ad for a free consultation and similar service she contacted the company again. This time, they told her she would qualify for the procedure and scheduled the free consultation. She then went to the free consultation and the doctor quickly told her that due to her BMI, her insurance would not cover the procedure, and it would cost \$10,000-\$40,000. She had provided her health insurance information for the consultation, and she later received an explanation of benefits and a bill for \$390. When she contacted the provider to dispute the charges, the provider defended the bill and stated that they never told her it would be a free consultation. After receiving a series of bills for the consultation she contacted the Helpline. The OAG intervened with the provider, who agreed to withdraw the charges and issued a zero-balance statement.

• **Provider Ceases Billing Consumer Who Relied on Telehealth Advertisement.** A consumer used telehealth for two appointments after he received an advertisement from the hospital stating that his health plan covered telehealth and that his cost for a virtual urgent care visit would be similar to an in-person office visit, “depending on his individual benefit plan.” His health plan denied his claims and he was billed the full cost by the hospital. The Helpline advocate sent an inquiry to the health plan with a copy of the hospital's ad, the bill, and the EOBs. The health plan responded that this particular plan was a self-funded plan, and per plan documents, they do not cover telemedicine rendered by providers who are not specifically contracted with the health plan as telemedicine providers. The provider in question, while in-network, was not contracted with the health plan as a telemedicine provider so the claims were correctly denied. Nevertheless, as a result of the OAG inquiry, the health plan's provider relations department reached out to the provider and the provider ceased billing.

Claim Processing and Payment Problems

Eleven percent of all HCB consumer complaints related to claim processing and/or payment errors. These issues included health plan errors, such as a plan's failure to pay claims, processing errors, payment of incorrect amounts, or deductible and/or copayment errors. Some of the most common complaints relating to health plan claim and payment processes include:

- » Health plan failure to process claims in a timely manner and other failures in the processing system; and
- » Health plan lack of clarity about out-of-network coverage/reimbursement, and consumers' lack of understanding about out-of-network provider reimbursement rates and out-of-pocket liability for seeing an out-of-network provider.

• **Erroneous Processing of Surprise Bill⁵ Claim as Out-of-Network Corrected.** A consumer fell in her home and sustained multiple injuries including a broken nose and hand, cuts on her face, and an exposed nose bone, requiring stitches. She was brought by ambulance to the emergency room of an in-network hospital. However, the only plastic surgeon who was on call at the time, and the one who ultimately operated on her, was out-of-network with her plan. Her health plan erroneously processed the claim as out-of-network, and she received a bill in the amount of \$10,499.00. OAG intervened with the health plan, arguing that this should be treated as a “surprise bill,” and that she should not be responsible for the cost. After the OAG intervened, the health plan reprocessed the claim, paid the provider, and issued a new explanation of benefits with zero patient responsibility.

• **Claim Processing Error Concerning Tax Identification Number Error Is Corrected.** A consumer had severe depression and her doctor ordered 36 sessions of Transcranial Magnetic Stimulation. Although the provider was out of network, she sought and received prior authorization from the health plan. Despite this pre-approval, her health plan denied the claims for all 36 sessions stating that the services lacked prior authorization. She attempted to appeal to the health plan and work with her doctor but had no success. She reached out to the Helpline, and OAG intervened with the health plan. The problem with the claim processing was initially stated to be that the provider’s tax identification number did not match the authorization, but upon further review, there was no error that prevented the processing of the claim. The claims were reprocessed and paid with interest, to the consumer for \$8,057.

• **Health Plan Reprocesses and Pays for Emergency Mental Health Treatment.** Another consumer contacted the Helpline after receiving a \$64,308 bill from a hospital where she had received emergency mental health treatment. She believed that the hospital was in-network with her health plan. She had received different explanations as to why her health plan had denied the claim. The OAG intervened, and the health plan discovered that there was an error in claim processing as a result of new rates that were not yet entered in the computer. As a result, the health plan reprocessed and paid the claim.



CLAIMS PROCESSING

The helpline has experience with uncovering health plan errors in the processing of claims that may otherwise remain undiscovered.

⁵ The New York State Emergency Medical Services and Surprise Bills Law (“Surprise Bill”) became effective on March 31, 2015.

Obtaining and Keeping Coverage

Six percent of consumer complaints involved issues relating to obtaining and keeping coverage. Of these complaints, 28 percent were due to health plan error and 15 percent were due to employer error.

• **Employer Reinstates Coverage for Employee's Spouse.** A consumer was attempting to enroll his wife in his health plan. His employer contracted with a company to handle the document verification requirements for enrollment. One of the requirements for enrollment was a certificate of marriage. He and his wife had been married in Costa Rica and their certificate of marriage was in Spanish. The couple had a scanned copy of an English translation of the certificate, which they submitted to the company with a certification to verify its authenticity. The company rejected the documents because the certificate was a translation, and because the certification listed only one of the parties. The company directed the health plan to terminate his wife's coverage. The consumer began working with an attorney to get a new certificate from Costa Rica. At this point he contacted the Helpline for additional assistance because his wife was without health insurance coverage. The OAG intervened with the health plan, and the plan agreed to continue his wife's coverage while they continued working to secure appropriate documentation.

• **Health Insurance Is Reinstated Retroactively.** A consumer retired in December 2018 after 28 years working at her employer and paid for COBRA⁶ insurance coverage until August 2019. However, in May 2019, she received a letter indicating that her COBRA coverage was terminated as of March 31, 2019. She contacted the Helpline for assistance. The OAG intervened with the health plan and determined there had been an error on the part of the consumer's former employer, resulting in termination of her coverage. The OAG worked with the health plan and employer to successfully reinstate retroactive coverage to when she was first enrolled in COBRA.

⁶ The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a health insurance program that allows former employees, retirees, spouses and dependents to obtain continued health insurance coverage at group rates.

About the OAG Health Care Bureau

The HCB is part of the Social Justice Division⁷ in the New York State Office of the Attorney General. The principal mandate of the HCB is to protect and advocate for the rights of health care consumers statewide through:

- **Operation of the Health Care Bureau Helpline.** This toll-free telephone Helpline (800-428-9071) serves as a direct line between consumers and the Office of the Attorney General. The Helpline is staffed by intake specialists and advocates trained to assist New York health care consumers. Assistance ranges from providing helpful information and referrals to investigation of individual complaints, and mediation of disputes to help protect consumers' rights within the health care system. Consumers can also receive assistance from the Helpline by submitting a complaint form online or by mail. The online complaint form is easy for consumers to submit and can be accessed on the HCB website. There are also instructions for submitting a complaint form by mail on the website.
- **Investigations and Enforcement Actions.** The HCB conducts investigations of and litigates against health plans, health care providers, and other individuals and business entities that engage in fraudulent, misleading, deceptive or illegal practices in the health care market. The HCB also includes a specific section focused on tobacco compliance and enforcement ("TCE"). TCE has continued steadfast efforts to reduce tobacco consumption in New York State through monitoring compliance with and enforcement of the Tobacco Master Settlement Agreement. In addition, TCE is responsible for implementing and enforcing numerous state laws and policies, such as the requirement that all cigarettes sold in New York be fire-safe. TCE also enforces certain federal laws relating to cigarettes, such as the Contraband Cigarette Trafficking Act, the Prevent All Cigarette Trafficking Act and the Jenkins Act.
- **Consumer Education.** Through outreach and dissemination of information and materials, the HCB seeks to inform New Yorkers about their rights under state and federal health and consumer protection laws.
- **Legislation and Policy Initiatives.** The HCB promotes legislative and policy initiatives to enhance the rights and well-being of consumers and their ability to access high quality and affordable health care in New York State.

⁷In addition to Health Care, the Social Justice Division includes the following bureaus: Civil Rights, Labor, Environmental Protection, and Charities, each of which enforces the relevant laws to protect consumers in New York.

Conclusion

New Yorkers are understandably frustrated with a health care system that is complicated, and in some cases virtually impossible to sort out. These frustrations prompt many consumers to turn to the Health Care Bureau and its knowledgeable and dedicated team of advocates, attorneys, and support staff for help in sorting out the mysteries of medical billing and health insurance decision-making. Medical care and insurance claim denials by health plans, indecipherable medical bills and fraudulent practices are some of the issues that prompt consumers to contact the HCB. Once a complaint is taken, consumers can expect a prompt response from a Helpline advocate, who will work to resolve a consumer's problem where possible and to help a consumer understand the health care system where there is no error or violation. If warranted, an advocate will go further, escalating an issue for higher-level review and possible investigation. Many of the OAG's investigations in the health-care realm started with a consumer complaint. We thank the individuals who brought important matters to our attention in 2019. We look forward in 2020 to bringing our skills and energy to bear championing the rights of consumers and enforcing the laws and regulations governing the health care industry.