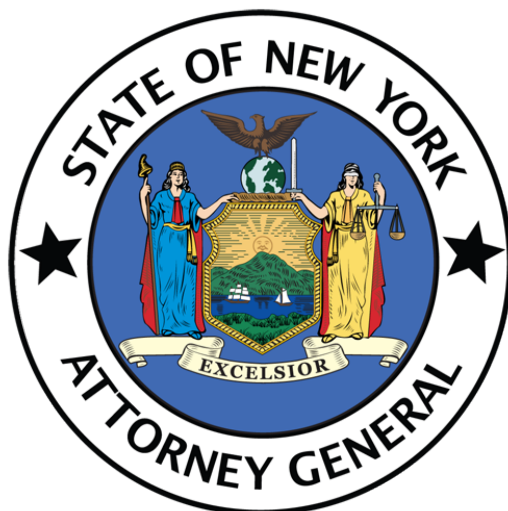
REAL SOLUTIONS
FOR REAL NEW YORKERS

Health Care Bureau Annual Report 2017

(800) 428-9071

NEW YORK STATE OFFICE
of the
ATTORNEY
GENERAL


STATE OF NEW YORK
EXCELSIOR
ATTORNEY GENERAL

HEALTH CARE BUREAU

REAL SOLUTIONS FOR NEW YORKERS 2017

This report briefly describes highlights of the work of the Attorney General's Health Care Bureau ("HCB") for the period of January 1, 2017 through December 31, 2017. For further information about the HCB, including press releases on our most recent work, consumer brochures, and HCB reports, please visit https://ag.ny.gov/bureau/health-care-bureau.

HEALTH CARE BUREAU

The HCB is part of the Social Justice Division[1] 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. Instructions for submitting a complaint form by mail are also provided on the website.
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> **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. In June of 2017, the Tobacco Bureau merged with HCB, forming a new section of HCB, 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 and Jenkins Act.

[1] In 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.

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.

HEALTH CARE BUREAU HELPLINE

The Health Care Bureau Helpline is the Attorney General's front line for registering and resolving consumer health care-related complaints.

RESTITUTION

IN 2017, THE HCB HELPLINE SAVED HUNDREDS OF NEW YORKERS ALMOST TWO MILLION DOLLARS.

In 2017, 5,565 consumers contacted the HCB Helpline for assistance. During the year, Helpline advocates handled **2,515** consumer complaints and the Helpline provided another **3,050** 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 York health care consumers and are an important means of identifying systemic problems in New York's health care system. In addition, these complaints may provide the basis for further investigation and enforcement actions against health plans, providers, and other entities operating in the health care market. Investigations and enforcement actions may in turn result in providing affirmative, systemic relief and helping affected consumers obtain appropriate monetary refunds (known as "restitution").

Many consumers who call the Helpline are confused about (i) their benefits, (ii) the rules to follow to secure coverage for care, (iii) doctor or hospital charges, (iv) appeal rights, or (v) 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 consumers.

HEALTH CARE BUREAU DATA

2017 YEAR AT A GLANCE

Benefits to Consumers Across New York State.
During 2017, the work of the HCB Helpline yielded significant results benefitting thousands of individual consumers across New York State. A review of the HCB complaint data for the year shows that the HCB Helpline secured almost two million dollars for consumers in restitution and savings from resolution of complaints relating to (i) incorrect medical billing; (ii) wrongful rejection of health insurance claims; and (iii) health plans' failure to process insurance claims properly.

In addition, the HCB Helpline achieved invaluable results that are not monetarily quantifiable in two key areas, by helping New Yorkers:

- Obtain medically necessary care or prescriptions where the health plan had previously denied that care or medication, and
- Obtain reinstatement of health coverage that a health plan incorrectly terminated.

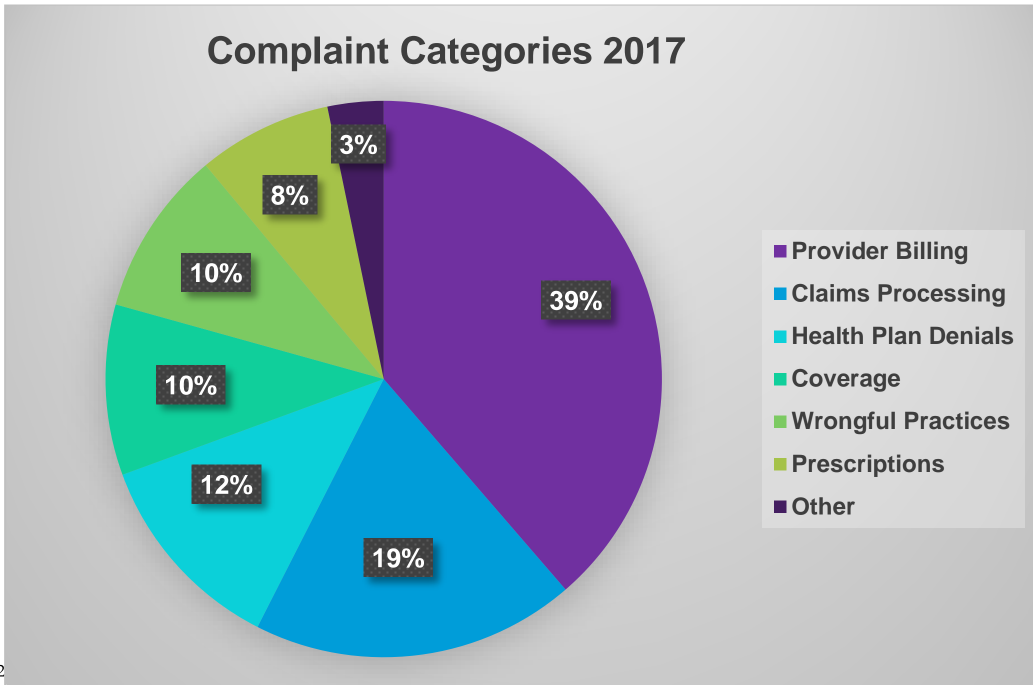
TOP ISSUE RAISED BY CONSUMERS

ERRONEOUS PROVIDER BILLING HAS BEEN THE NUMBER ONE ISSUE RAISED BY NEW YORKERS FOR RESOLUTION BY THE HELPLINE SINCE 2011.

Issues Raised by Consumers and Resolved by the HCB Helpline. A review of the HCB complaint data for 2017 shows that Helpline complaints fall into six general categories: Provider Billing, Claims Processing, Health Plan Denials, Insurance Coverage, Wrongful Practices, and Prescription Drugs.

- Consumer concerns about provider billing captured the highest percentage of New Yorkers' Helpline complaints in 2017 at 39%.
- After provider billing, health plan claim processing/payment complaints, which include health plan mistakes in preparing, processing, or paying claims represented 19% of New Yorkers' complaints.
- Health plan denials of care or coverage, such as denials based on the treatment not being "medically necessary" or the care provided not being a covered benefit ranked third, representing 12% of total Helpline complaints.

- Problems obtaining and keeping health insurance coverage represented 10% of total Helpline complaints.
- Wrongful practices represented 10% of total Helpline complaints.
- Problems accessing prescription medications represented 8% of total Helpline complaints.



[2]

Data for 2017 compared with 2016 show that provider billing continues to be the top issue prompting New Yorkers to contact the HCB's Helpline. The percentage of these types of complaints has increased from 32% of all complaints in 2016 to 39% in 2017. In both years, the majority of these complaints (70% in 2016 compared to 66% in 2017) relate to improper provider billing practices, such as providers improperly balance billing patients or failing to submit claims to insurance companies. The breakdown by percentages of the remaining categories of complaints received by the Helpline has remained consistent during the past two years, with no more than a one to three percentage point difference in each category.[3] The percentage of complaints

[2] Total amount may exceed 100% because individual numbers were rounded up.

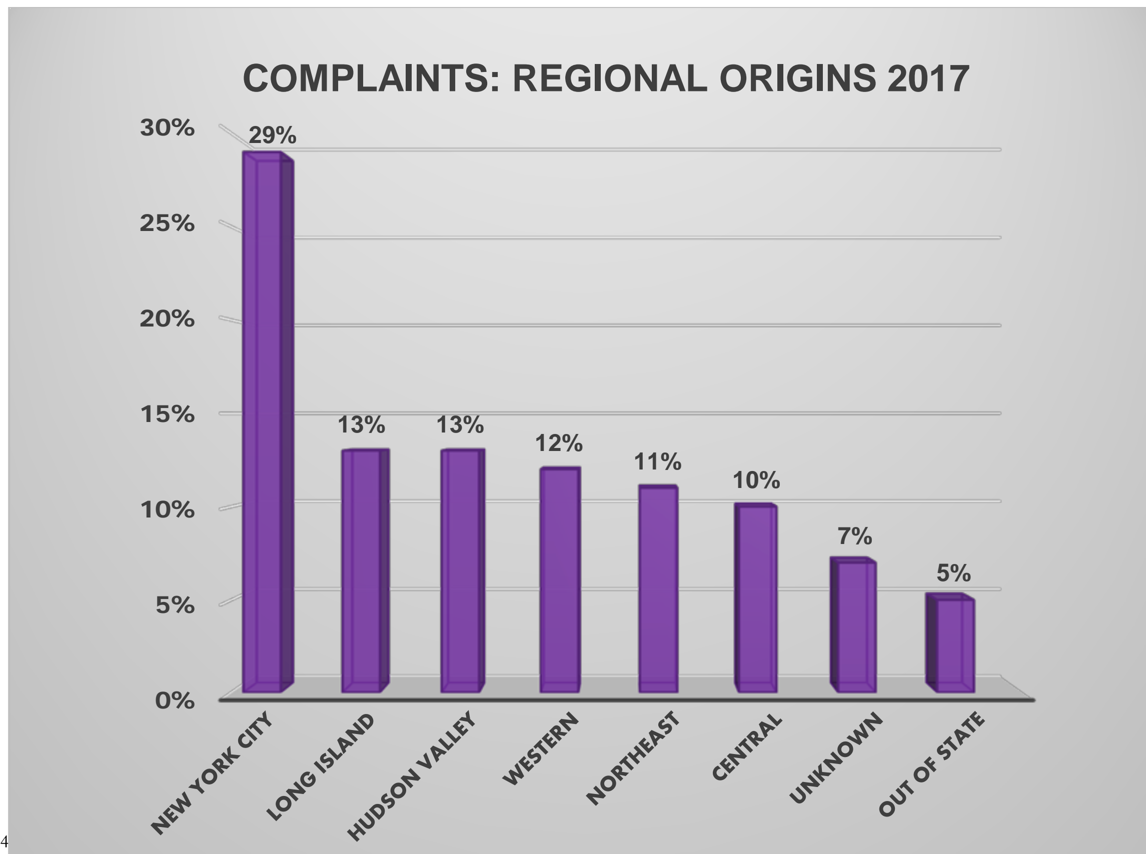
[3]

	2016
Provider Billing	32%
Claims processing	18%
Health Plan Denials	15%
Coverage	13%
Wrongful Practices	10%
Prescriptions	9%
Other	3%

regarding health plan denials of coverage decreased from 15% in 2016 to 12% of all complaints in 2017. Within the category of health plan "denials of coverage" are subcategories that include denials of coverage for care that is "not a covered benefit" and denials of coverage for care that is "not medically necessary." Regarding denials based upon the care not being a covered benefit, there has been a decrease in the percentage of these types of complaints (30% in 2016 compared to 21% in 2017). In addition, there has been a concurrent decrease in the number of complaints received based upon denials of coverage for care based upon medical necessity. In particular, the Helpline received far fewer complaints in 2017 about mental health/substance abuse care, perhaps as a result of the HCB's increased enforcement of mental health parity laws over the past five years.

HCB Helpline Complaints – Where They Originate.

During 2017, as in 2016, the largest percentage of complaints, a total of 29% each year, originated in the New York City region. In 2017, the Long Island region and Hudson Valley region tied for second place at 13%. Although there were some changes between 2016 and 2017, no more than a 3% difference is noted. See below for regional origins of complaints received by the Helpline during 2017.



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[4] New York City includes Bronx, Kings, New York, Queens, and Richmond counties. The Northeast Region includes Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego,

HIGHLIGHTS: HELPLINE RESOLUTIONS, HEALTH CARE BUREAU ENFORCEMENT RESOLUTIONS/ACTIONS, AND OTHER SUCCESSES

The following provides further details on the most common issues prompting consumer calls to the Helpline, specific and notable examples of resolutions achieved by Helpline advocates, as well as resolutions secured by HCB enforcement actions.

(1) Provider Billing Practices

A significant number of consumer complaints (39%) raised concerns about provider billing practices. Although state regulations and many provider health insurance contracts forbid participating in-network providers from "balance billing" consumers, some in-network providers who have agreed to accept the contracted payment from the insurance company nonetheless improperly bill consumers and subject them to collection actions. Other typical complaints related to provider billing include:

- Provider failure to submit claims to the insurance company or submission of claims with errors; and
- Provider billing for services not rendered or duplicate billing.

Notable HELPLINE Resolutions:

The examples set forth below highlight the routine problems – unfortunately way too familiar to many New Yorkers – that consumers face when they receive erroneous provider bills. These errors are not uncommon and can be costly, and even lead to collection agency activity and ultimately legal judgments. Were it not for Helpline intervention, the consumers in these instances might have faced these burdensome outcomes.

- **Provider Fails to Submit Bill to Secondary Insurer.** A consumer contacted the Helpline about a hospital bill for the balance of **$1,300** dating back to 2013 for the labor/delivery of her child. The hospital had sent the bill to a collection attorney. At the time that the charges were incurred, the consumer advised the hospital that she had two insurance plans. The Helpline advocate found, however, that the hospital did not file a claim with the secondary plan in a timely manner after the consumer's primary insurance paid. The advocate provided documents to the collection attorney, asking that the collection be recalled since the hospital was at fault for not filing a claim with the secondary plan. The secondary plan confirmed it would not pay because the claim was not filed timely. Ultimately, the collection attorney obtained consent from the hospital

Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington counties. Long Island includes Nassau and Suffolk counties. Hudson Valley includes Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester counties. The Western Region includes Allegany, Cattaraugus, Chatauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, and Yates counties. The Central Region includes Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, and Tompkins counties.

to drop the collection action and the hospital waived the bill.

- **In-Network Provider Improperly Bills Consumer.** A consumer complained that he was treated by an in-network participating provider, but that the physician was billing him directly in the amount of **$985** for services rendered. The health plan had advised the physician that he had not properly submitted the claim to the plan, and that he needed to resubmit the claim accordingly, but the provider refused to do so. Since this was a participating provider, the Helpline advocate sent the complaint to the health plan, asking that it either require the provider to cease billing the member or that the plan pay the claim as an exception to hold the member harmless. The plan continued to require the physician to submit the claim properly, but when he did not and continued to bill the consumer, the Helpline advocate escalated the case to the compliance director and finally received a response advising that the health plan would pay the claim on an exception basis.

PROVIDER BILLING

IMPROPER CODING BY PROVIDERS OF "PREVENTIVE" CARE AS "DIAGNOSTIC" RESULTS IN INCREASED COSTS TO CONSUMERS.

- **Provider Improperly Codes Preventive Colonoscopy as Diagnostic**. A consumer saw a physician for a colonoscopy, which was preventive in nature and should have been processed without a copayment. However, the hospital submitted the claim as diagnostic, causing the consumer to be burdened with a large financial responsibility due to a high deductible – in the amount of **$2,493**. A Helpline advocate made an inquiry to the hospital as to the reason the claim was submitted as diagnostic. The hospital responded that because polyps were found and removed during this initial colonoscopy, the hospital deemed the procedure a diagnostic procedure. The Helpline advocate informed the hospital that the discovery of polyps through an initial preventive colonoscopy may not transform the procedure from preventive to diagnostic. The hospital reviewed the claim and corrected it, adding a modifier that alerted the insurance company that the procedure began as preventive but became diagnostic due to findings. The insurance plan then reprocessed the claim to pay without cost-sharing to the consumer.

- **Provider Improperly Submits Claim Using Non-Participating Identification.** A consumer had two minimally invasive spinal surgeries where cement was injected into a vertebra to seal fractures. The same participating surgeon did both surgeries on both occasions in May and July 2017 on an outpatient basis. On both occasions, he used the same equipment and same assistants, but **$1,062** was assigned to his out-of-network deductible for the first surgery, while nothing was assigned to the deductible for the second surgery. The consumer had already met his in-network deductible before both surgeries and believed that the surgeon was a participating provider with his health plan. After a Helpline advocate submitted an inquiry, the health plan stated that the provider had incorrectly submitted the first claim electronically using his non-participating

provider identification, which was why it was assigned to the consumer's out-of-network deductible. The second claim was submitted with his correct participating provider identification, and therefore the consumer was not assigned any patient responsibility. Once the error was discovered and corrected, the first claim was reprocessed and the $1,062 was removed from the consumer's deductible.

Enforcement Actions[5]

- **Brooklyn Hospital Medical Center ("Brooklyn Hospital") Pays Restitution to Patients and Changes Billing Procedures for Forensic Rape Examinations.** An investigation conducted by the HCB followed the receipt of a complaint alleging that Brooklyn Hospital had illegally directly billed a sexual assault survivor seven separate times for a forensic rape exam (FRE) administered in the hospital's emergency room. The investigation revealed that between January 2015 and February 2017, Brooklyn Hospital conducted 86 FREs – and in 85 out of those 86 cases, the hospital either improperly billed the patient directly, or billed the patient's insurance plan without advising the patient of the choice of payment options as required by law. Brooklyn Hospital had sent some of these improper bills to collection. New York State Executive Law Section 631(13) provides that when a hospital furnishes certain services – including an FRE – to any sexual assault survivor, it shall provide such services to the patient without charge and shall bill the NYS Office of Victim Services (OVS) directly, or alternatively, the sexual assault survivor may voluntarily opt to assign the costs to private insurance. The AG settlement agreement requires Brooklyn Hospital to pay restitution to improperly billed sexual assault survivors, maintain and properly disseminate a Sexual Assault Victim Policy that prevents improper billing, and pay $15,000 to New York State. The investigation has led to HCB's statewide investigation of improper hospital billing for FREs, which is currently underway.

(2) Claim Processing and Payment Problems

Nineteen percent of all HCB consumer complaints relate to claim processing/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.

[5] "Enforcement Action" refers to action, including investigation, litigation, and resolution, taken by Health Care Bureau assistant attorneys general to address a violation of law and achieve broad relief – injunctive as well as monetary – for consumers.

Notable HELPLINE Resolutions:

- **Health Plan's Denial of Coverage for One Newborn Twin Is Reversed.** A consumer contacted the Helpline stating that she received a **$24,474** bill from a hospital for the 2012 care of one of her twins. She did not contact the Helpline earlier because she believed that her health plan had paid the bill, but recently learned that the amount due was in collection. The consumer gave birth to twins in October 2012 at one hospital and the twins were then transferred to another hospital due to complications. Apparently due to an unspecified error in processing the claims, the health plan only covered the claims for one twin and not the other at the second hospital. A Helpline advocate sent an inquiry to the health plan for review. The response was delayed since the claims were so old that they had been archived. The Helpline advocate eventually received a short written response from the health plan indicating that it paid the full amount billed of $24,474 to the second hospital.

- **Health Plan's Denial of Coverage for In-Vitro Fertilization Is Reversed.** In December 2015, the health plan pre-approved advanced in-vitro fertilization (IVF) benefits for the consumer that were covered under her plan at the time. However, effective January 1, 2016, the health plan eliminated advanced IVF benefits, so the plan denied the consumer's claims citing this change, notwithstanding that approval was made in 2015 when benefits were still available and the consumer had received an authorization letter stating that the treatment was approved from December 2015 through March 2016, during which time the consumer began and ended treatments. The consumer appealed twice and both times the appeals were denied, leaving her with an **$11,810** bill to the fertility clinic. A Helpline advocate submitted the complaint along with the authorization and proof of dates of treatment, and further requesting that the health plan forward to the Helpline advocate the excerpt from the 2015 benefits book that described IVF benefits. The health plan responded by authorizing reimbursement to the clinic in the amount of $7,086. The clinic accepted the amount as payment in full.

- **Health Plan's Denial of Coverage for Emergency Room Care Is Reversed.** A consumer received an Explanation of Benefits (EOB) from a health plan regarding treatment received at a hospital emergency room, indicating that the plan had reimbursed the physician practice. The consumer subsequently received another EOB indicating that coverage of the same services for the same date was denied. The balance of **$286** was then sent to a collection agency by the hospital. A Helpline advocate inquired as to why the health plan first paid, and then denied coverage of the emergency room treatment. The plan responded that there had actually been two visits to the emergency room that day. The second visit was denied incorrectly because the plan thought it was a duplicate

CLAIMS PROCESSING

THE HELPLINE HAS EXPERIENCE WITH UNCOVERING HEALTH PLAN ERRORS IN THE PROCESSING OF CLAIMS THAT MAY OTHERWISE REMAIN UNDISCOVERED.

claim as it billed for the same services and charges. Even after receiving the consumer's records from the hospital, the plan did not catch the error. The response indicated that the plan realized its mistake after the Helpline advocate's inquiry, paid the claim and then called the provider to advise that as participating providers they should have called the plan when the claim was denied, and not have sent the bill to a collection agency. The provider accepted the new reimbursement as payment in full. The matter was recalled from collection.

Enforcement Actions

- **Oxford Health Plans (NY) and Oxford Health Insurance, Inc. (together, "Oxford") Must Ensure Refunds Are Provided to Hundreds of Members for Improperly Denying Claims for Infusion Services.** The HCB conducted an expanded investigation of Oxford after an Oxford health plan member complained to the HCB Helpline that she began to receive bills from a provider of infusion supplies, when the infusion supplies had previously been covered by her plan. Infusion therapy is used as part of a medication treatment plan – usually for chronically ill patients – and is a procedure in which medication is administered intravenously. Infusion therapy is used, for example, to treat serious or chronic infections that do not respond to oral antibiotics and for pain management. Initially, Oxford maintained that its denials of coverage were correct, stating that the consumer's benefits had changed. However, HCB's review of the plan documents did not support Oxford's contention. As a result of the HCB's inquiry, Oxford acknowledged that it had improperly denied hundreds of other members' infusion services claims, as well as claims for nurse home healthcare visits for the administration of infusion medication. After acknowledging its error in the coverage denials and providing assurances that it had corrected the benefit configuration error that resulted in the denials, the HCB discovered (through another consumer complaint) that 277 members continued to receive improper denials because Oxford had failed to fully identify the problem and correct it. Through implementation of the HCB's settlement agreement, Oxford ultimately identified a total of 2,587 claims that were improperly denied, totaling nearly $500,000. Oxford agreed to reprocess the claims and pay providers where payment for claims were outstanding and ensure restitution to consumers who had improperly paid. As set forth in the agreement, Oxford was required to pay $35,000 to New York State.

(3) Health Plan Denials of Coverage for Care

Approximately 12% of all HCB consumer complaints involved health plan denials of coverage for care. Such denials most often occurred based on claims that the care was not medically necessary (61%). While a relatively small percentage of Helpline complaints are in this category, the impact of a denial of what a consumer's health provider deemed medically necessary – and a reversal through HCB advocates' assistance – cannot be overstated.

Notable HELPLINE Resolutions:

- **Denial of Coverage for Transgender Related Care/Medication Is Reversed.** A consumer contacted the Helpline when she was denied coverage for medical treatment, lab work, and prescription medication because of her transgender status. The consumer indicated she had not received a formal written denial, but rather, informal email communications from the health plan. A Helpline advocate requested written determinations of all denials and plan documents, seeking explanation for the non-coverage. The Helpline advocate also requested information regarding the consumer's right to appeal. After receiving a reply from the plan, it appeared as though the letters regarding her right to appeal had been sent to the incorrect address (her former address), and her time to appeal had passed before she had contacted the Helpline. Based upon lack of notification regarding the consumer's right to appeal, the Helpline advocate requested an extension of the deadline to appeal the denials, which the health plan granted. The consumer appealed and the Helpline advocate wrote a letter in support asserting that the specific plan exclusion of coverage did not apply under the facts unique to this consumer's case, and further requesting that the plan review the categorical exclusion for violations of federal law. The plan reversed its prior denials of coverage and amended the plan to eliminate the categorical exclusion.

- **Denial of Coverage for Gender Reassignment Surgery Is Reversed.** A consumer contacted the Helpline because while the health plan agreed to pay in full for the consumer's gender reassignment surgery, the plan only paid half. After a Helpline advocate filed an inquiry, the plan paid in full as agreed. While working on the case, the Helpline advocate discovered that the consumer also had to pay out-of-pocket for electrolysis in preparation for surgery because the health plan had denied coverage as "cosmetic." The Helpline advocate filed a second inquiry asking for coverage due to the medical necessity of electrolysis for surgical preparation. The denial of coverage was reversed. Restitution to the consumer totaled **$9,700**.

- **Health Plan's Denial of Coverage for Midwife at In-Network Rate Is Reversed.** A consumer had out-of-network (OON) benefits and used an OON midwife for home birth. The consumer believed that because there were no in-network midwives willing to do home births in her area, the health plan would automatically pay the entire claim because of network inadequacy. The consumer had called the plan before the birth and the plan explained to her how to file OON claims. The child was born at home with the assistance

HEALTH PLAN CARE DENIALS

THE HELPLINE HAS HELPED HUNDREDS OF NEW YORKERS ACCESS HEALTH PLAN COVERAGE FOR CARE WHERE THEIR DOCTORS HAVE DEEMED THE CARE MEDICALLY NECESSARY.

and oversight of the midwife. The health plan paid the midwife at the OON rate, leaving consumer with a significant balance of over $3,000. The consumer appealed the decision, but her appeal was denied. A Helpline advocate urged her to follow through with a second-level appeal and wrote a letter of support on her behalf. The health plan agreed to reimburse the midwife as an in-network provider because its review found that at the time of patient's initial call, the representative did not explain that the consumer could ask for a "single-case agreement" with the OON midwife. As a result, the health plan reimbursed the midwife an extra **$3,502** in addition to the $1,700 that the health plan had already paid, leaving the consumer with a zero balance.

- **Health Plan's Denial of Coverage for Genetic Testing Is Reversed.** A consumer contacted the Helpline after receiving a bill from a lab for genetic testing for her child. The child tested positive for chromosome disorder and behavioral issues – the test was necessary for diagnosing the disorder and establishing a treatment plan. She called the health plan after receiving the bill and was assured that she was not liable; and that the health plan was continuing to work with the lab to resolve the issue. In December 2016, however, she received a denial from the health plan on the basis that the lab work was experimental/ investigational. The denial indicated that "documentation does not indicate how conventional testing is insufficient to develop a treatment plan." A Helpline advocate sent an inquiry to the health plan asking what coverable conventional test was available to diagnose chromosome disorder. The health plan responded that upon review of the medical records, the service was deemed medically necessary, and the claim was processed and paid in the amount of **$5,121**.

Enforcement Actions

- **Cigna Removes Ban on Coverage for Neuropsychological Testing for Psychiatric Conditions and Autism Spectrum Disorder.** After receiving a consumer complaint about Cigna's written policy for neuropsychological testing, the HCB launched an investigation into Cigna's administration of mental health benefits. The policy stated, "Cigna does not cover neuropsychological testing" for psychiatric conditions and autism spectrum disorder "because such testing is considered educational in nature and/or not medically necessary." Under the terms of the settlement, Cigna agreed to comply with Timothy's Law, which mandates that New York group health plans provide "broad-based coverage for the diagnosis and treatment of mental, nervous or emotional disorders or ailments … at least equal to the coverage provided for other health conditions." The New York law is similar to federal mental health parity laws, which were passed in 2008. The settlement requires Cigna to revise its policies, pay autism claims previously rejected, and pay a penalty of $50,000.

(4) Wrongful Practices

About 10% of consumer complaints were based on the consumer's assertion of a wrongful or fraudulent business practice. These consumer complaints included improper refund processes, general inefficiencies, predatory lending/health care financing, and false advertising.

Notable HELPLINE Resolutions:

- **Misrepresentation Allegation Leads to Refund for Failed Hair Transplant Surgery.** A consumer contacted the Helpline seeking a refund for failed hair transplant surgery, stating that he paid $7,500 to have 3,000 hairs transplanted (Follicular Unit Transplantation). In a follow-up one-year later, it was determined that the consumer only had 1,000 successful transplantations, despite his understanding based upon the contract that he would have 3,000 successful transplantations. The company wanted him to come in for additional surgery. Consumer refused, requesting a refund of $5,000 (2000 hairs @ $2.50 per hair). A Helpline advocate sent the complaint to the company. The company defended its work, claiming, "not all transplanted hairs survive and grow," and added "[f]urthermore, it is virtually impossible to count the number of transplanted grafts a year following the procedure." Nevertheless, after intervention of the Helpline advocate, the company agreed to a **$4,500** refund to the consumer.

- **Fraudulent Billing Allegation Leads to Recall of Physician Bill.** A consumer complained of fraudulent billing in the amount of **$2,114** by an emergency room physician for surgical repair of her daughter's finger tendon because the procedure was actually done by another physician. The consumer provided the medical record from the doctor who actually performed the surgery. The insurance plan had paid both doctors. A Helpline advocate sent an inquiry to both the health plan and the provider group. The health plan advised that its "fraud squad" investigated the claim. The bill was recalled by the provider.

Enforcement Actions

- **Three Mobile Health Application Developers Correct Misleading Marketing And Privacy Practices.** Following a yearlong investigation of mobile health applications (apps), three companies agreed to correct misleading statements, provide enhanced warnings to consumers, and improve privacy policies while also clearly disclosing that their apps are not medical devices and are not approved by the U.S. Food and Drug Administration (FDA). The three popular health-related apps are sold on Apple's App Store and Google Play platforms. Matis, an Israel-based company, sells **My Baby's Beat,** an app that Matis previously claimed could turn any smartphone into a fetal heart monitor, although the "device" had never been approved by the FDA. Although Matis encouraged consumers to use My Baby's Beat rather than a fetal heart monitor or Doppler, it never conducted, for example, a comparison to a fetal heart monitor, Doppler, or any other device that had been scientifically proven to amplify the sound of a fetal heartbeat. Cardiio is an American company that sells the app known as **Cardiio,** which claims to measure heart rate. The developer had not tested its accuracy, however, with users who had engaged in vigorous exercise, despite marketing the app for that purpose. The developer also misleadingly implied that the app was endorsed by the Massachusetts Institute of Technology. Runtastic is an Austria-based company that sells **Runtastic**, an app that purports to measure heart rate and cardiovascular performance under stress. Yet the developer failed to test its accuracy with users who had engaged in vigorous exercise, despite marketing the app for that purpose. Under the HCB's settlements, the developers agreed to provide additional information about

testing of the apps, to change their ads to make them non-misleading, and to pay $30,000 in combined penalties to New York State. Additionally, the developers now post clear and prominent disclaimers informing consumers that the apps are not medical devices and are not approved by the FDA. The developers also made changes to protect consumers' privacy, requiring affirmative consent to their privacy policies for these apps and disclosures that they collect and share information that may be personally identifying. This includes users' GPS location, unique device identifier, and "deidentified" data that third parties may be able to use to reidentify specific users.

- **Molina Health Care of New York (Molina) Eliminates Language And Communication Barriers For Enrollees.** Following the receipt of complaints that Molina, a Central New York health insurer (formerly Total Care of New York) failed to provide important information and notices to Limited English Proficiency (LEP) enrollees, the HCB in conjunction with the Civil Rights Bureau, initiated an investigation of Total Care. The complaints also alleged that Total Care failed to adequately notify and provide communication assistance services to at least one enrollee who was deaf, and that Total Care used notices that did not adequately describe member benefits. These complaints stemmed from Total Care's provision of personal care services through the Consumer Directed Personal Assistance Program (CDPAP) for its Medicaid Managed Care health plans. CDPAP is intended to permit chronically ill and/or physically disabled individuals in need of home care services flexibility and freedom of choice in obtaining personal care services, including affording them an opportunity to hire certain qualifying relatives or friends as caregivers. As a result of the investigation, Total Care agreed, among other things, to revise policies to include interpretation and translation services to meet both state and federal requirements. Specifically, Total Care will require member service representatives to document enrollee's preferred mode and or language of communication and provide a link on its website homepage to inform consumers of the availability of free language assistance services and auxiliary aids for those with visual or hearing impairments. Additionally, Total Care revised its communications to members to describe more accurately who may serve as a personal care assistant for Medicaid enrollees and mailed over 150 corrected letters to members who had received an inaccurate letter. Total Care was acquired by Molina in 2016 and serves more than 35,000 members through its Medicaid Managed Care and Child Health Plus health plans. As part of the agreement, Molina was required to pay a $25,000 penalty to New York State.

- **Two Buffalo-Area Property Owners Agree to Lead Abatement Work Regarding Lead-Based Paint Hazards in Two Buffalo Apartment Complexes.** A joint investigation conducted by the HCB and the Environmental Protection Bureau showed that two apartment complexes, Elmwood Anderson Apartments (33 units) owned by Anderson Apartments LLC; and the Lafayette-Barton Apartments (36 units) owned by Lafayette Barton Apartments LLC, had a history of property code violations issued by the Erie County Department of Health and the City of Buffalo. These violations included several that were related to children who suffered lead poisoning. The investigation further revealed that the vast majority of the apartment buildings' units contained deteriorated lead-based paint – paint that was peeling, chipping, chalking or cracking, or located on a surface that was damaged or deteriorated. As a

result of the investigation, the current property owners agreed to lead abatement work regarding the lead-based paint hazards in the buildings by following a detailed work plan that included replacement of all windows, tight-fitting doors, cabinet drawers, floors, and other "friction surfaces" that contain lead-based paint. The agreement requires that an independent monitor oversee the lead abatement work.

(5) Obtaining and Keeping Coverage

Ten percent of consumer complaints involved issues relating to obtaining and keeping coverage. Of these complaints, 25% were due to health plan error and 18% were due to employer error.

Notable HELPLINE Resolutions:

- **Coverage Terminated Due to Health Plan Error.** A consumer contacted the Helpline because her health plan cancelled her insurance coverage. The consumer advised that the health plan should have been taking the monthly premium payments automatically from her checking account. However, the auto-generated deductions did not occur and the funds were not deducted as scheduled. A Helpline advocate inquired about the issue with the health plan and consumer was reinstated.

- **Coverage Terminated Due to Health Plan Glitch.** A consumer contacted the Helpline because her health plan terminated her coverage due to non-payment despite her having paid her bills electronically, the same way as she always had. She attempted, several times, to find out the root of the problem with customer service and supervisors, to no avail. A Helpline advocate filed an inquiry and after much persistence on the part of the Helpline advocate, it turned out that the plan had changed banks and the new deposit information was not provided to the member. The plan waived the member's January and February premiums due to her lack of access to health care during those two months.

- **Adult Son's Disability Designation Is Approved.** A consumer's 25-year-old son was disabled, confined to a wheelchair, with a serious brain injury. For 10 years, the consumer had gone through the process of certifying health plan coverage for his son as a disabled dependent under his plan. However, in 2017, the consumer found out that his son's coverage was terminated because he, in error, did not fill out a small part of the application. The consumer said that the plan told him that it would send him the additional required forms, but the consumer did not receive them. The consumer called the Helpline because his son had no health coverage and needed critical medication and services. A Helpline advocate inquired to the health plan regarding the coverage denial, and the following day, the advocate was advised that the paperwork was expedited and the son's disability designation was approved for another seven years, permitting him to remain covered under the parents' plan.

(6) Access to Prescription Drugs

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

MEDICATION DENIALS

HELPLINE ADVOCATES HAVE HELPED MANY NEW YORKERS OBTAIN MEDICATION DEEMED MEDICALLY NECESSARY BY THEIR PHYSICIANS.

- Denial of coverage or imposition of higher copayments for prescribed drugs that are not on the insurance plan's formulary or which are on a higher tier; and
- Disputes with health plans relating to receiving medications through mail-order pharmacies instead of preferred neighborhood brick and mortar retail pharmacies.

Notable HELPLINE Resolutions:

- **Medical Necessity Denial of Coverage for ADHD Medication Is Reversed.** A consumer contacted the Helpline on behalf of her son who was taking a particular ADHD medication (Quillivant XR) that, after trying other medications, was the only medication that successfully treated the son's ADHD. The consumer's request was urgent because the health plan had denied continuation of the prescription as not medically necessary, and the child had been without medication for almost two weeks. The child's physician filed an appeal and a Helpline advocate sent an inquiry to the health plan. The denial was overturned and the **medication was approved.**

- **Denial of Coverage for Brand Drug is Reversed Where Generic Is Contraindicated.** A consumer contacted the Helpline in need of the medication Valtrex, which treats infection. The Helpline advocate handled the case as a priority because the consumer had run out of medication. The health plan required prior approval and step therapy – meaning that the member must try alternative(s) and provide documentation of their failure. The consumer's physician provided medical records that indicated the member had tried and failed the generic version. A Helpline advocate submitted an inquiry with the health plan and the **medication was approved.**

- **Denial of Coverage for Medication Needed In Time for Trip Is Reversed.** A consumer contacted the Helpline for assistance in obtaining her medication, Zoloft, a

drug used to treat depression, when the pharmacy told her they could not fill her prescription and she only had three days of her medication left. The consumer had just recently switched her insurance and the new plan was requiring prior approval for the medication, but the doctor was away for ten days. The health plan told the consumer that a supervisor would contact her within three to five business days, but the consumer had arrangements to be out of the area by that time and needed the medication within two days. After a Helpline advocate contacted the health plan, a supervisor was able to ensure that the consumer would be **able to obtain her medication that evening.**

Enforcement Actions

- **Requirement for Prior Authorization for Medication-Assisted Treatment Removed by Anthem.** Following an agreement with Cigna in 2016, Anthem, the second largest health insurer in the country, agreed to end its policy of requiring prior authorization for medication-assisted treatment (MAT) for opioid use disorder. MAT drugs, which can be prescribed in doctors' offices, are vital tools in treating opioid addiction, and in turn combatting the opioid epidemic and saving lives. The agreement also includes Anthem's New York affiliate, Empire BlueCross BlueShield (BCBS), which insures over 4 million New Yorkers. This policy change will apply not only to most Anthem members in New York, but also to members nationally as well. Before the agreement, Anthem required providers to obtain preauthorization for MAT coverage requests, which required the providers – who had already received specific training regarding MAT and federal authorization to prescribe these drugs – to answer numerous questions about the patient's current treatment and medication history. This unnecessary administrative burden often resulted in missed opportunities to assist patients struggling with addiction. In fact, the HCB's investigation revealed that Empire BCBS denied nearly 8% of the overall requests for coverage of MAT in 2015 and the first half of 2016. This also caused significant delays in patients obtaining treatment for addiction – or patients never obtaining the treatment at all. While Empire BCBS does not require prior authorization for the majority of drugs it covers for medical conditions, it maintained a policy of rigorous preauthorization for MAT. Indeed, Empire BCBS does not require prior authorization for powerful opioids, including fentanyl, morphine, tramadol, and oxycodone, when prescribed for pain. This disparity is inconsistent with the New York and federal mental health parity laws, which require health plans to cover mental health and substance use disorder treatment the same way they cover treatment for physical conditions. The agreement also requires Empire BCBS to implement an initiative to expand access to MAT for members in its New York service area, including conducting provider outreach and education regarding the benefits of MAT, and informing qualified health care providers how they can become certified to prescribe buprenorphine and buprenorphine/naloxone as part of MAT. Empire BCBS will provide the HCB with a list of MAT providers who have joined its network.

  Note: The HCB has aggressively enforced laws that require parity in health plan coverage of mental health and addiction treatment, reaching agreements with six companies, including Anthem, MVP Healthcare, EmblemHealth, Excellus, Beacon

Health Options, and HealthNow. The HCB has also reached agreements with Purdue Pharma and Endo Pharmaceuticals Inc. to ensure that these opioid makers engage in responsible and legal marketing.

Defending Access to Quality Health Insurance

The federal Affordable Care Act (ACA) enabled New York to expand access to quality affordable health insurance to millions of New Yorkers. Where the federal government has waged an attack on the ACA, the HCB has swiftly responded to this assault in an effort to maintain New Yorkers' access to quality health care. In 2017, this response included:

- Intervening in *House of Representatives v. Price*, a legal challenge brought by the U.S. House of Representatives to block billions of dollars in ACA subsidies that reduce co-payments, deductibles, and other out-of-pocket costs for low-income New Yorkers.

- Challenging as co-plaintiffs in *California v. Azar* the Trump administration's decision to stop paying cost-sharing reductions mandated by the ACA to ensure consumer affordability of health insurance and access to care.

- Challenging the Trump administration's issuance of interim final rules restricting women's access to birth control coverage without cost-sharing by

    - filing a lawsuit as co-plaintiffs in *California v. Trump* to prevent the administration from implementing the unconstitutional rules; and

    - leading a coalition of 16 Attorneys General in filing comments with the federal Department of Health and Human Services opposing the rules.

Tobacco Compliance and Enforcement

The Tobacco Compliance and Enforcement ("TCE") section engages in monitoring and enforcement of existing agreements, as well as state and federal law, with the ultimate goal of improving public health through decreased tobacco use in New York State. In 2017, the TCE's successes included:

- **Tobacco Master Settlement Agreement ("MSA") Payments.** In 2017, New York State received more than $617 million in payments resulting from a landmark settlement of litigation brought by the State, along with many other jurisdictions, against the five largest tobacco companies. The payment was apportioned among the State, City, and Counties of New York. The MSA imposed significant restrictions on cigarette companies' advertising, marketing, and promotional activities including forbidding participating cigarette manufacturers from advertisements targeting youth; and banning the use of cartoons, transit advertising, and most forms of billboard advertising, sponsorships, and free product sampling. The MSA also required the tobacco companies to contribute billions of dollars each year to the Settling States and

jurisdictions. To date, the tobacco companies have made more than $119 billion in payments to the States. The litigation that resulted in the MSA was filed in 1998.

- **$247 Million Judgment and Penalties Awarded Against UPS for Knowingly Delivering Contraband Cigarettes.** On May 25, 2017, the U.S. District Court for the Southern District of New York issued a formal decision and final judgment in a lawsuit filed in 2015 by the State and City of New York against the common carrier United Parcel Service, Inc., for its knowing delivery of contraband cigarettes throughout the State and City of New York. The State and City's complaint alleged several claims, including the carrier's violation of the federal Contraband Cigarette Trafficking Act, the Prevent All Cigarette Trafficking Act, New York State's delivery ban statute (N.Y. Public Health Law section 1399-*ll*), and an Assurance of Discontinuance that the carrier had entered into with the OAG in 2006. The Court's decision in favor of the State and City followed a two-week bench trial in September 2016. See *New York v. UPS*, 253 F. Supp. 3d 583 (S.D.N.Y. May 25, 2017). The award was the largest trial verdict recorded in New York State for 2017. The Court's decision is currently the subject of a pending appeal.

- **Cigarette Manufacturer King Mountain Enjoined From Selling Contraband Cigarettes in New York State.** On September 5, 2017, the U.S. District Court for the Eastern District of New York entered a final judgment in favor of the State, granting the State's request to enjoin a cigarette manufacturer from selling and delivering contraband cigarettes into New York State for resale to a number of Native American-owned retailers. The judgment prohibits Mountain Tobacco Company, doing business as King Mountain Tobacco Company, Inc. (King Mountain), a cigarette manufacturer based on the Yakama Indian Reservation in the State of Washington, from continuing to sell its cigarettes to persons not otherwise licensed as a stamping agent of the State. For a number of years, King Mountain had sold and delivered contraband cigarettes into New York State for resale to a number of Native American owned retailers. The State's complaint alleged a number of claims against the manufacturer, including violations of the Contraband Cigarette Trafficking Act and several New York State laws governing the sale, receipt, stamping, and reporting of such cigarettes. The Court's judgment and other orders entered by the Court are currently the subject of a pending appeal.

CONCLUSION

The HCB was active in 2017 working to protect the rights of health care consumers in New York. While the forecast for the future of the U.S. health care system remains uncertain, New York consumers can continue to count on the HCB to advocate both on behalf of individuals and communities statewide, and to ensure that the rights of New York health care consumers are protected. The HCB will continue to help individual consumers and to analyze the Helpline's consumer complaints to identify systemic health care problems; work to correct deficiencies; and hold accountable those entities that engage in fraudulent, misleading, deceptive, or illegal practices in the health care market through all means available, including robust investigations and enforcement actions.

https://ag.ny.gov/bureau/health-care-bureau

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