REAL SOLUTIONS FOR REAL NEW YORKERS

Health Care Bureau 2015 Annual Report

Health Care Bureau Helpline

(800) 428-9071

NEW YORK STATE OFFICE *of the* ATTORNEY GENERAL

HEALTH CARE BUREAU

REAL SOLUTIONS FOR NEW YORKERS 2015

This report briefly describes the work of the Attorney General's Health Care Bureau ("HCB") for the period of January 1, 2015 through December 31, 2015. For further information about the HCB, including press releases on our most recent work, consumer brochures, and HCB reports, please visit http://www.ag.ny.gov/bureau/health-care-bureau.

HEALTH CARE BUREAU

The HCB is housed within 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 provide assistance to New York health care consumers. Assistance ranges from providing helpful information and referrals, 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.

Investigations and Enforcement Actions. The HCB conducts investigations and litigation 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.

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.

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

HEALTH CARE BUREAU HELPLINE

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

In 2015, the HCB Helpline handled 5,444 cases. Of these cases, the Helpline investigated and resolved **2,836** consumer complaints and provided another **2,608** 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").

RESTITUTION

INDIVIDUAL RESTITUTION AND SAVINGS RANGE FROM LESS THAN $100 TO OVER $155,557.

HEALTH CARE BUREAU DATA

2015 YEAR AT A GLANCE

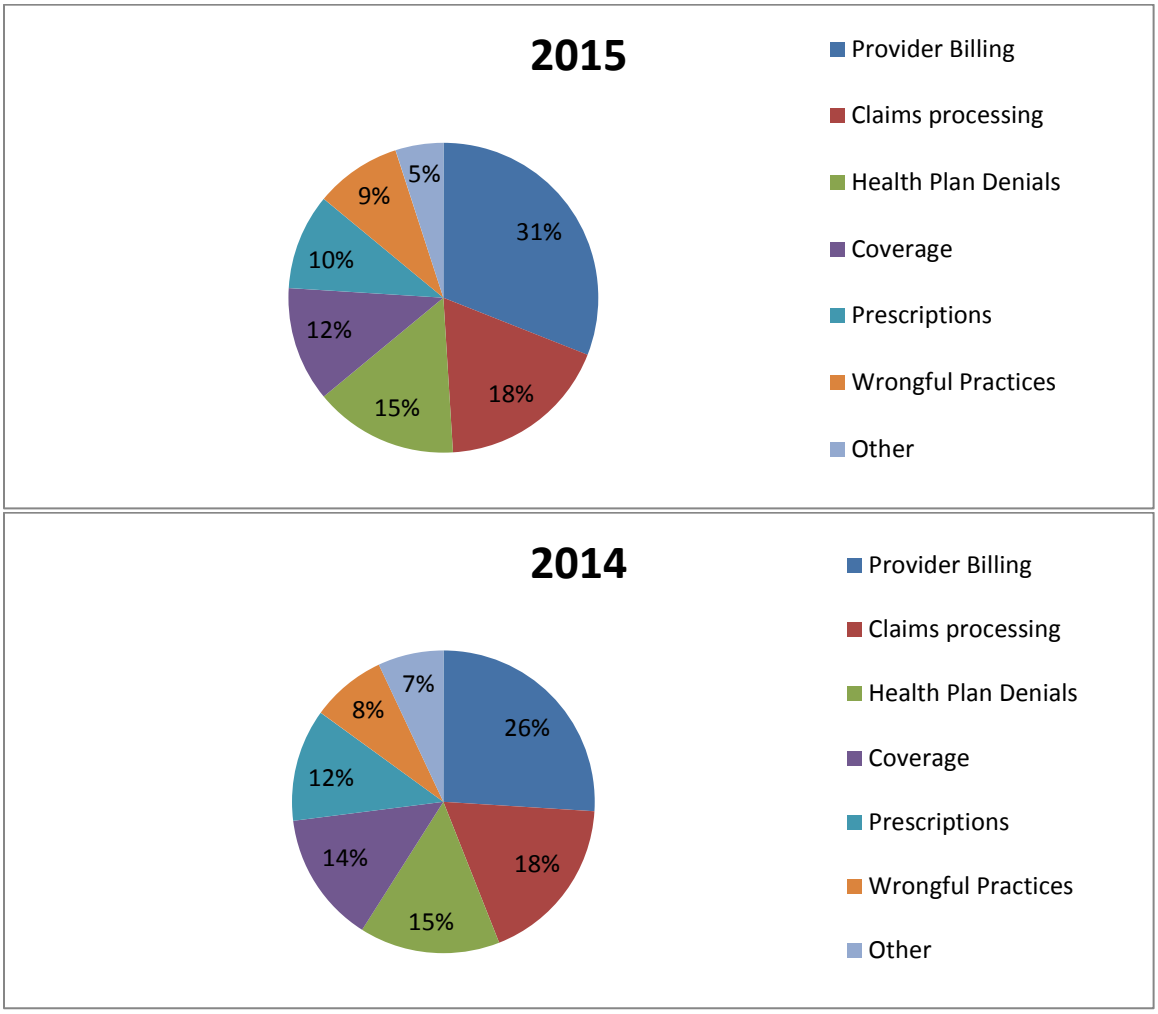
Benefits to Consumers Across New York State. During 2015, the work of the HCB Helpline yielded significant results benefitting thousands of individual consumers across New York State. A review of the HCB complaint data for the year shows that the HCB Helpline secured approximately $2,781,000 for consumers in restitution and savings resulting from (i) incorrect medical billing; (ii) wrongful rejection of health insurance claims; and (iii) the health plan's failure to properly process insurance claims. In addition, the HCB Helpline achieved invaluable results that are not quantifiable, by helping New Yorkers

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

Issues Raised by Consumers and Resolved by the HCB Helpline. A review of the HCB complaint data shows that the types of cases handled by the Helpline can be classified into six general categories: Provider Billing, Claims Processing, Insurance Coverage, Health Plan Denials, Prescription Drugs, and Wrongful Practices.

- Data for 2015 compared with 2014 shows that "provider billing" continues to be the top issue prompting New Yorkers to contact the HCB. The number of these types of

complaints has increased from 26% of all complaints in 2014 to 31% in 2015. In both years, the majority of these complaints (62% in 2015) (59% in 2014) relate to improper provider billing practices, such as the improper balance billing of patients and the failure of providers to submit claims to insurance companies. The breakdown by percentages of the remaining categories of complaints received by the Helpline has remained fairly consistent during the past two years with no more than a two percentage point difference in each category.



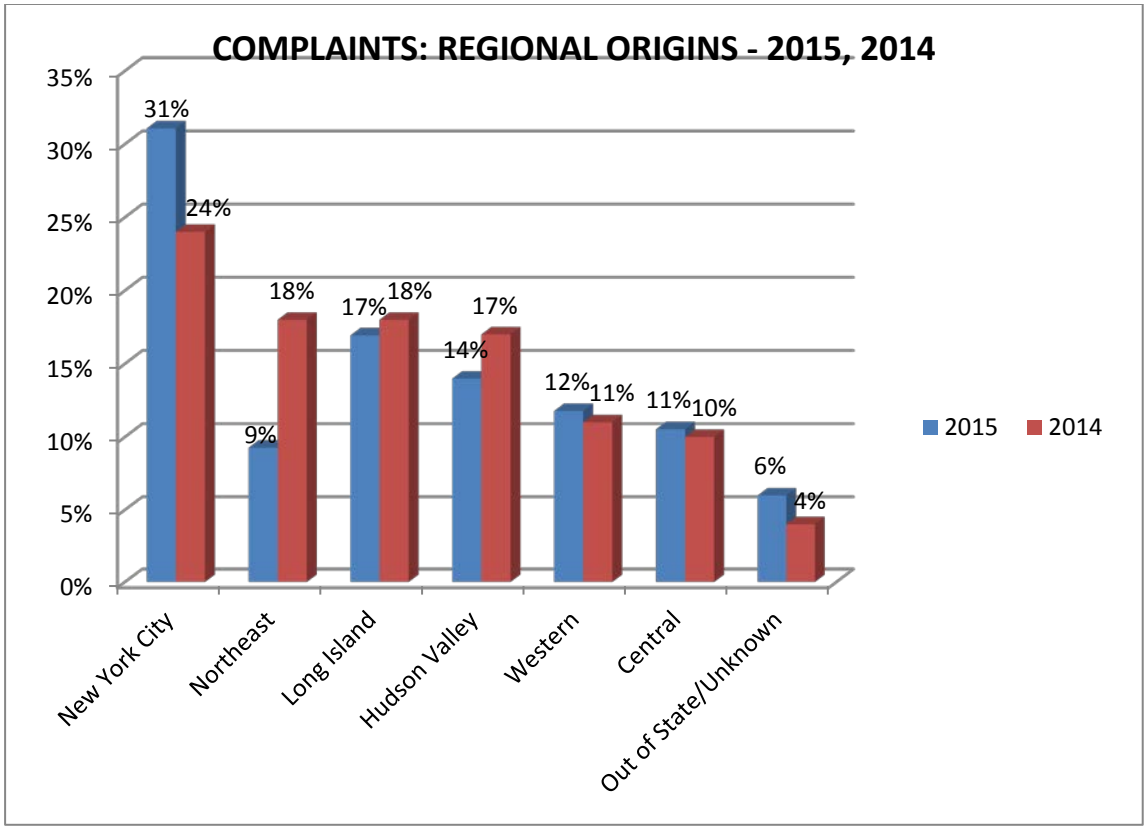
- As depicted above, after "provider billing," New Yorkers' complaints in 2015 fell into the following categories: health plan claim processing/payment complaints, which include health plan mistakes in preparing, processing, or paying claims (18%); health plan denials of care or coverage, such as denials based on the treatment not being "medically necessary" or the care provided not being a covered benefit (15%); problems obtaining and keeping health insurance coverage (12%); problems accessing prescription medications (10%); and wrongful practices (9%).

- 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.

HCB Helpline Complaints - Where They Originate. A review of the Health Care Bureau complaint data shows the following:

During 2015, the largest percentage of complaints originated in the New York City region. In 2015, a total of 31% of all Helpline complaints originated in New York City, with the Long Island region also the source of many complaints (17%). See below for regional origins of complaints received by the Helpline during the past two years.[2]



[3]

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

[3] 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, 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.

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 (31%) 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.
- Provider billing for services not rendered or duplicate billing.

  Note: Previously, a typical provider billing complaint included bills by an out-of-network provider who participated in the consumer's care - often to the surprise of the consumer who either received services in the emergency room by an out-of-network provider, or in the context of a planned hospital procedure, did not know that the provider was part of the medical team providing services (*e.g.,* out-of-network anesthesiologists or radiologists providing care at an in-network hospital). However, in light of the New York State Emergency Medical Services and Surprise Bills Law ("Surprise Bill Law"), which became effective on March 31, 2015, complaints to the Helpline about "surprise" bills have markedly decreased.

Notable HELPLINE Resolutions for "Provider Billing" Complaints

- **Improper Out-of-Network Bill Issued by In-Network Provider.** A consumer complained that a physical therapy office incorrectly advised him that it was out-of-network and correspondingly required that he pay over $5,000 for services. The physical therapy office then submitted claims to the insurer, and the insurer paid the claims to the physical therapy office as in-network. The physical therapy office refused to refund the consumer for the overpayment. Since this was a participating provider, an advocate sent the complaint to the insurer requesting that it require its in-network provider to reimburse the consumer. The insurer advised that the provider refused to issue a refund, but as a result of the Helpline's intervention, the insurer cancelled the physical therapy office's contract as a participating provider and refunded $5,175 to the consumer directly, so that the consumer would be held harmless.

- **Improper Bill Due to Provider Claim Submission Error.** A consumer went to a hospital emergency room for a broken ankle but when she arrived, the hospital admitted her for other health reasons, including a cardiac condition. The consumer was treated in the hospital for ten days, but the insurance company did not cover her entire stay because the hospital submitted a claim solely for the broken ankle. The consumer faced a bill of over $150,000. The consumer's prior appeal of the insurer's denial was not successful. An advocate filed an inquiry with the hospital and the hospital subsequently filed a corrected claim. Upon receipt of the corrected claim, the insurance company issued payment to the hospital.

PROVIDER BILLING

SINCE 2011 "PROVIDER BILLING" HAS CONSISTENTLY RANKED AS THE NUMBER ONE ISSUE RAISED BY CONSUMERS FOR RESOLUTION BY THE HCB HELPLINE.

- **Improper Bill Due to Provider Coding Error.** A consumer received a collection agency hospital bill for over $3,000 for a routine colonoscopy that, pursuant to the Patient Protection and Affordable Care Act (ACA), was to be covered without copayment, deductible or co-insurance. After an advocate made an inquiry with the insurance company, it was discovered that the doctor's office had submitted the claim with a coding error, resulting in a denial by the insurer and issuance of a bill by the provider. After the provider submitted a corrected claim identifying the procedure as a routine instead of diagnostic colonoscopy, the claim for the colonoscopy was reprocessed, alleviating the out-of-pocket costs for the consumer.

- **Improper Provider Bill for Services Not Received.** A consumer had undergone open heart surgery and was directed by his cardiologist to wear a heart monitor for one week following the procedure. The consumer complained that he was improperly billed $4,500 by the provider of the cardiac monitor for one month of cardiac monitoring even though he only used the monitor for a week. Upon the Helpline's request for an explanation of the bill, the provider responded that the patient had been billed in error due to a failure in the provider's "processing." As a result, the company adjusted the bill to reflect a zero balance.

Enforcement Actions[4]

- **Urgent Care Center Surprise Out-of-Network Bills.**
    - Four consumers contacted the Helpline reporting that they received "surprise" bills from **WorkFitMedical, LLC**, a provider of urgent care services, when they believed that the provider was in-network with UnitedHealthcare/Empire Plan

[4] "Enforcement Action" refers to action, including investigation, litigation, and resolution, taken by Health Care Bureau assistant attorneys general to address a violation of law.

at the time that services were rendered. Upon investigation, it was determined that for approximately 15 months, WorkFit represented to patients that it was in Empire's network at a time when WorkFit did not yet have a contract with them. As a result of being out-of-network, WorkFit balance billed 325 Empire Plan members in the amount of approximately $197,000 more than the member responsibility would have been if WorkFit had actually been in-network. In an Assurance of Discontinuance (AOD)[5] entered into on December 23, 2015, WorkFit agreed to provide nearly $17,000 in restitution and adjustments to zero of outstanding bills for those members whose accounts reflected a current outstanding balance. WorkFit also agreed to pay $12,500 in costs and penalties. In addition to restitution and adjustment to patient accounts, the AOD requires WorkFit to strengthen disclosures about its network participation. The WorkFit agreement is part of the continuing work of the HCB to ensure health care providers clearly and accurately disclose critical information to consumers.

- Also in 2015, the HCB entered into separate agreements with **four urgent care centers** to improve disclosures to consumers of participating insurance plans. The HCB entered into agreements with: **181st Street Urgent Care** in Manhattan; **Brookdale Urgent Care**, affiliated with Brookdale Hospital; **New York Doctor's Urgent Care** with two locations in Manhattan; and **Cure Urgent Care**, with three locations in Manhattan and Long Island. The agreements require, in part, that providers disclose through their website the health care plans in which the provider participates. In addition, fee information must be made available to consumers so that they know in advance which providers participate in the health plan's network, and the cost of services if the provider is out-of-network.

(2) Claim Processing and Payment Problems

Eighteen percent of all HCB consumer complaints arise from claim processing/payment errors. These issues include health plan errors, such as the 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.

- 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] An "Assurance of Discontinuance" is a settlement document that the Attorney General may accept in exchange for "discontinuing" an ongoing investigation instead of filing a civil lawsuit in any case for which a person or entity has engaged in acts or practices that are in violation of the law.

Notable HELPLINE Resolutions for Claim Processing/Payment Error Cases

- **Health Plan System Error.** A health plan denied a consumer's medical claims due to the plan's "system error." The system failed to delete previous insurance information and the plan continued to deny the claims based on the consumer having other insurance. While the consumer had provided a Certificate of Creditable Coverage showing the other insurance had terminated and the plan acknowledged that he had no other insurance when he called, the system kept denying the claims anyway. An advocate sent the complaint to the insurance company requesting that its system be corrected and claims reprocessed. The insurance company took affirmative action to correct the problem and the system was correctly loaded - all claims were reprocessed and paid.

- **Health Plan Claim Processing Error.** A consumer's health plan denied coverage for the consumer's hearing aids, the cost of which was covered under his plan. The plan's denial letter stated, incorrectly, that he was ineligible for coverage due to being 26 years old and a dependent when in fact his age was not relevant because he had his own individual policy. An advocate filed an inquiry and the insurance company reprocessed the claim, allowing the contracted rate of $6,000.

- **Health Plan Pays Less Than Verbal Telephone Representation.** A consumer complained that she was advised by an insurance plan customer service representative that out-of-network breast reconstruction surgery would be paid based on UCR (usual, customary and reasonable). On the strength of that information, the consumer used the out-of-network surgeon. Instead of UCR reimbursement, the claim was paid under the MRC reimbursement (maximum reimbursable charge) method, which is the health plan's language to describe payment as a percentage of the Medicare rate. As a consequence, the plan paid only 10 percent of the cost, leaving the consumer with a large balance bill to pay out of her own pocket. An advocate sent an inquiry to the plan, requesting review of the telephone records and, if it was determined that the consumer was misinformed, that the plan pay the additional cost. The insurer responded that the consumer was given wrong information by customer service, and, as such, it paid the surgeon $33,025 as represented.

- **Contraceptive Coverage - No Cost-Sharing**. During 2015, the HCB learned of complaints relating to access by women enrolled in health plans whereby some insurers were violating ACA contraceptive coverage requirements by improperly imposing cost-sharing for some methods of contraception and related services. In some instances, plans were requiring that women pay hundreds of dollars for the contraceptive option recommended by their physicians. On May 7, 2015, the HCB sent an inquiry to 11 health plans requesting information about imposition of cost-sharing regarding FDA-approved methods of birth control for women as well as services related to follow-up and management of side effects, counseling for continued adherence, and device removal. Subsequently, the NYS Department of Financial Services joined in the OAG inquiry and on June 17, 2015, a similar joint inquiry was sent to 12 additional health plans. Although the focus of the inquiry shifted because of new guidance issued by the U.S. Department of Health and Human Services (HHS), as a result of the inquiries,

many insurers provided restitution after their self-audit that uncovered claim processing/payment errors, with an estimated amount **of restitution provided to consumers in excess of 200,000.** In addition, 16 out of 23 plans agreed to an earlier compliance date (than required by the new guidance) of October 1, 2015 for provision of no-cost sharing contraceptive coverage.

(3) Health Plan Denials of Care or Coverage

Approximately 15% of all HCB consumer complaints involve health plan denials of care or coverage for care. Such denials most often occur based on claims that the care was not medically necessary (52%) or that the care provided was not a covered benefit (25%), and in 19% of the complaints the denial was due to health plan error.

HEALTH PLAN CARE DENIALS

THE MAJORITY OF HEALTH PLAN DENIALS FOR CARE OR COVERAGE FOR CARE ARE BASED ON A FINDING THAT THE CARE IS NOT MEDICALLY NECESSARY.

Notable HELPLINE Resolutions for Health Plan Denial of Care or Coverage Cases

- **Coverage Denial Reversed Due to Erroneous Appeal Information.** A consumer's daughter had a history of substance abuse and was admitted to an inpatient rehabilitation program. The health plan paid for the daughter's first 12 days of inpatient treatment, but at the end of the 12 days the health plan determined that the daughter had progressed and no longer needed inpatient treatment. The insurer did agree to continue covering the daughter's treatment under the partial hospitalization program, which constituted a lesser level of care. However, to ensure that his daughter would be safe and remain sober, the consumer paid to continue the inpatient level of care. The father later complained that the insurer gave him incorrect information about his appeal rights regarding denial of the continuation of the inpatient program. The insurer told him by letter that his internal appeals had been exhausted after only one internal appeal and that he did not have a right to an external appeal. An advocate contacted the insurer and asserted that the denial should be reversed because of the incorrect appeal information. The insurer reversed its denial based on that argument, noting that the plan was a fully funded plan, and the information provided to the consumer was for self-funded plans.

- **Medical Necessity Denial Reversed After Appeal**. A consumer was diagnosed with cancer in one breast and her physician recommended that she have both breasts removed because the particular form of breast cancer inevitably spreads to the other breast. The insurer only approved removal of one breast and DIEP flap reconstruction. The insurer also denied benefits for an out-of-network plastic surgeon. An advocate contacted the insurer in support of an appeal, and after another "peer-to-peer" review, the plan reversed its denial on medical necessity grounds. However, since the plan was

an ERISA self-funded plan the next hurdle was for the consumer's employer to approve a single-case agreement and to negotiate an amount with the plastic surgeon. The parties successfully negotiated an agreement and a $217,000 bill was reduced to $100,000.

- **Medical Necessity Denial Reversed After Further Review.** A consumer sought assistance in obtaining approval for inpatient admission to a drug treatment rehabilitation center. The consumer indicated that he was a heroin addict, and had tried to admit himself for treatment but was denied by his insurer. He was not currently under the care of a doctor and did not have a treatment professional to recommend the inpatient care. An advocate contacted the insurer and was advised that the requested inpatient stay was denied because clinical information supplied by the treatment center did not meet clinical criteria for the requested service. Further review was requested and the insurer obtained additional clinical information, including information resulting from a "peer-to-peer" review, and the services were approved.

Enforcement Actions

- **Enforcement of Mental Health Parity Laws Against Excellus.**[6] An investigation conducted by the HCB uncovered widespread violation of mental health parity laws by Rochester–based Excellus Health Plan, and revealed that Excellus denied inpatient addiction treatment services at least twice as often as inpatient medical services between 2011 and 2014, including nearly seven times as often in 2012. Findings of the investigation also included that many of Excellus' inpatient substance use disorder rehabilitation denials were the result of its requirement that members fail outpatient treatment multiple times before accessing such care, which conflicts with New York State guidelines and is not applied by Excellus to medical care. The investigation also showed that some of these denials appeared arbitrary and wrongly decided, and that Excellus did not cover residential treatment for behavioral health conditions in its standard contract. As part of an AOD executed with Excellus in March 2015, the health insurer was required to cover residential treatment for behavioral health conditions and reform its procedures for evaluating behavioral health treatment claims. The settlement also required Excellus to provide notice of a new appeal right to 2,700 members whose requests for inpatient substance use disorder rehabilitation and eating disorder residential treatment were previously denied during 2011 through 2014, and pay $500,000 in fees and costs. The restitution process is ongoing, but Excellus has so far reimbursed 10 members a total of $55,000 for out-of-pocket expenses for treatment they received but the plan had not previously covered.

- **Enforcement of Mental Health Parity Laws Against ValueOptions, Inc.** An investigation conducted by the HCB uncovered widespread violation of mental health parity laws by ValueOptions, Inc., revealing that ValueOptions issued denials twice as

[6] New York's mental health parity law, known as Timothy's Law, was enacted in 2006, and requires that insurers provide mental health coverage at least equal to coverage provided for other health conditions. The federal Mental Health Parity and Addiction Equity Act, enacted in 2008, prohibits health plans from imposing greater financial requirements or treatment limitations on mental health or substance use disorder benefits than on medical or surgical benefits.

often for behavioral health claims as insurers did for other medical or surgical claims and four times as often for addiction recovery services.

In 2014, the HCB entered into settlements with two major New York health insurers, MVP Health Care and EmblemHealth, which use ValueOptions as a vendor for administering behavioral health benefits. Under those settlements, MVP and EmblemHealth have reimbursed 215 members a total of $1.2 million for out-of-pocket expenses for treatment they received but the plans had not previously covered. As a result of the AOD executed with ValueOptions in March 2015, in addition to the MVP and Emblem settlements, extensive reforms are required in ValueOptions' claims management procedures, and the company is required to cover residential treatment and charge the lower, primary care copayment for most outpatient visits to mental health and substance use disorder treatment providers. In addition, ValueOptions has agreed to overhaul its behavioral health benefits. As part of the settlement agreement, ValueOptions will also post parity disclosures on its website, file regular compliance reports with the Attorney General, and pay a $900,000 penalty.

- **Enforcement of No Cost-Sharing Preventive Screening Procedures.** An investigation conducted by the HCB uncovered the wrongful denial of coverage of anesthesia services provided in connection with preventive colonoscopies by **EmblemHealth, Inc.** The ACA requires that health plans cover recommended preventive services, including colonoscopies, without member cost-sharing. Because colonoscopies necessitate the administration of anesthesia, anesthesia services provided in connection with preventive colonoscopies must be covered without member cost-sharing. As part of an AOD executed with EmblemHealth in March 2015, the insurer was required to send reimbursement checks to members of certain Emblem plans whose claims for anesthesia performed in connection with an in-network preventive colonoscopy were processed subject to member cost-sharing. Reimbursements totaled approximately $400,000. In addition, the agreement provides that Emblem will train its employees, and pay a penalty.

(4) Wrongful Practices

About 9% of consumer complaints are based on an assertion of a wrongful or fraudulent business practice. Most of this category of consumer complaints (71%) include false advertising, outdated provider directories, and predatory lending/health care financing.

Notable HELPLINE Resolutions for Wrongful Practice Cases

- **High Interest Credit Card Medical Debt.** A consumer opened a high interest credit card account for medical debt in 2006. She made payments regularly until 2009 when she was diagnosed with cancer and became unemployed. The account was eventually sold to a debt collector. Consumer maintained she was pressured into signing up and inadequately informed regarding the interest-free promotional period. An advocate sent the complaint to the debt collector, explaining consumer's position and asking for relief

on the debt. The account was recalled, credit reports wiped clean and balance reduced to zero.

- **Unauthorized Credit Account Opened for Cosmetic Surgery.** Consumer complained that she was provided financing for an elective procedure that she did not authorize and did not receive. The company, a cosmetic surgery company based in Florida, opened up an account in the consumer's name in the amount of $5,000 on the basis of a contract that was sent to her but never executed. The case began when the consumer contacted the company about possibly having a cosmetic procedure done and asked them about financing options. As part of that query, she provided personal information including her Social Security number. The company sent her a contract and credit application. She did nothing with it. An advocate contacted the credit company who determined that someone from the cosmetic surgery company opened the $5,000 account without consumer consent. The charge was removed and the account was closed.

- **Premium Increase Without Notice.** Three consumers contacted the Helpline when they did not receive notice of a premium increase effective January 1, 2015 for their health plan with **HealthNow New York, Inc.** They indicated that if they had been given notice, they would have changed their insurance to a different carrier. The members had been given the option of signing up for a new plan beginning February 2015, but the issue of the increased rate for January 2015 remained unresolved. Investigation determined that there was confusion as to who was responsible for the late notification, and the plan agreed to refund the difference between the previous rate and the increased rate to the plan members who paid the premium for the month of January 2015, and for those plan members who had not yet paid the January premium, issue a credit to their account for the difference between the previous rate and the increased rate**. A total of 140 refunds/credits were issued to plan members for a total amount of $28,030.** Regarding the contractual agreement between the plan and the plan administrator, and the lack of clear language designating responsibilities for premium notification, the plan agreed to implementation of specific contractual language governing the designation of the responsibilities and obligations of each party.

Enforcement Actions

- **Unauthorized Corporate Practice of Medicine.** An investigation by the HCB began as the result of over 300 complaints lodged with the Helpline concerning Aspen Dental offices across New York State. The findings of the investigation by the HCB revealed that **Aspen Dental Management, Inc. ("Aspen")** had essentially developed a chain of dental practices technically owned by individual dentists but which, in violation of New York law, were subject to extensive control by Aspen. That control included sharing individual clinic profits with the management company and the marketing by the management company under the shared Aspen Dental trade name. Through business practices, Aspen routinely made business decisions for the clinics that directly impacted patient care. Those practices included incentivizing and otherwise pressuring staff to increase sales of dental services and products, implementing revenue-oriented patient scheduling systems, and hiring and oversight of clinical staff. The investigation

also showed that Aspen exercised undue control over the clinics' finances. As part of an AOD executed in June 2015, Aspen agreed to end the practice of exercising any control over dental practices' clinical decision-making. In addition, Aspen agreed not to share in the dental practices' fees for professional services rendered and to keep the practices' finances separate. The agreement requires Aspen to pay $450,000 in civil penalties.

- **Enforcement of Restrictions on Opioid Product Promotion Against Purdue.** An investigation conducted by the HCB uncovered that in certain instances, **Purdue Pharma, L.P. ("Purdue"),** a pharmaceutical manufacturer of the long-acting opioid, OxyContin, may have failed to take the necessary steps to ensure that its sales representatives (1) properly flagged all professionals who were potentially involved in the abuse and diversion of opioids, and (2) stopped dealing with providers on the company's "no-call" list. The investigation further found that Purdue's unbranded pain management website, www.inthefaceofpain.com, suggests that its content is neutral and unbiased, but that many advocates appearing on the site were paid by Purdue. In an AOD entered into with Purdue in August 2015, Purdue agreed to strengthen and make permanent an internal Purdue program aimed at preventing its sales staff from promoting OxyContin to health care providers who may be involved in abuse and illegal diversion of opioids. The agreement also requires Purdue to disclose financial relationships with any individuals, including doctors and other health care professionals, who appear on the company's "unbranded" websites that endorse the benefits of pain treatment. In addition, the company will provide information on these sites about the risks of opioids, including addiction. As part of the settlement, the company will pay $75,000 in penalties and costs.

- **Violation of Child Resistant Packaging Requirement for Liquid Nicotine.** An investigation conducted by the HCB uncovered that liquid nicotine companies were selling liquid nicotine in New York in violation of a law requiring that it be sold in child resistant packaging. As part of AODs executed in the summer of 2015, agreements were entered into with **Henley Vaporium**, headquartered in Manhattan; **Beyond Vape**, a California-based seller with three store fronts in New York City; **Rocket Sheep,** an e-liquid manufacturer; **ECig Distributors, Inc.**, a corporation that also does business as eCigDistributors.com, ejuices.com, and eliquid.com; and **Charlie's Chalk Dust, Inc.**, a Delaware corporation with its principal office located in California. The agreements require the companies to remove from all their distributors and retail purchasers any liquid nicotine sold in packaging that does not meet child-resistant standards. They are also required to refund consumers who purchased liquid nicotine in improper packaging. In addition, the retail stores must train their staff on the requirements of the New York legislation, in particular that bottles containing liquid nicotine be sold in child-resistant packaging, and that any knowledge of bottles being sold without proper packaging be reported to the Attorney General's Office. This was a joint investigation by the Tobacco Compliance Bureau and the HCB. Total penalties due from the companies under the settlements are $100,000.

- **Enforcement Action to Stop Prohibited "Direct Access Testing."** An investigation by the HCB showed that **Direct Laboratories LLC ("DirectLabs")** and

Laboratory Corporation of America ("LabCorp") enabled New Yorkers to undergo clinical laboratory testing without a licensed medical provider's involvement, as required by New York State law. Investigation further showed that DirectLabs sold requisitions for a wide range of tests, and these requisitions were automatically generated with a licensed chiropractor's name – who had never seen or spoken with the patients – in exchange for a $24 "access fee" payment. Consumers could then take those requisitions to a LabCorp patient service center to have the testing performed at reduced prices negotiated between LabCorp and DirectLabs. Under the AODs executed in December 2015, DirectLabs will no longer operate in New York and must refund all customers with requisitions that have not yet been presented to a laboratory for testing to be performed. Also, LabCorps patient service centers in New York will no longer accept specimens for examination pursuant to requisitions generated by DirectLabs or any similar company. In addition, LabCorp agreed to ensure that requests for laboratory testing submitted by health care providers are within the provider's scope of practice as set forth by the New York State Education Department and that the providers' licenses are current. DirectLabs is required to pay a $24,500 penalty; LabCorp is required to pay a $225,000 penalty.

- **Excessive Copays Charged by Excellus Health Plan.** An investigation conducted by the HCB began when an Excellus member complained to the HCB Helpline that his provider billed him a specialty care copayment ($25) after visiting his primary care physician to whom he had already paid the primary care copayment of $15. The amount billed reflected the amount on the Explanation of Benefits issued by Excellus to the member. Excellus acknowledged that it issued the Explanation of Benefits erroneously and explained that certain providers affiliated with the University of Rochester Medical Center (URMC) had changed their tax identification numbers without informing Excellus. When the providers' claims were submitted to Excellus after the tax identification number change, the Excellus claim processing system could not match the claims to the primary care provider and instead defaulted to the higher copayment. As part of the January 2015 agreement, Excellus agreed to update the URMC provider tax identification information in its systems, so that primary care claims will be correctly processed; review its claims data to identify each member who saw his/her primary care physician and was assessed additional copayments for specialty services; mail letters to affected members; and implement and monitor a full refund process.

(5) Obtaining and Keeping Coverage

Twelve percent of consumer complaints involved obtaining and keeping coverage. Of these complaints, 39% are due to health plan error and 25% are attributable to the New York State of Health Marketplace/Exchange enrollment problems.

Notable HELPLINE Resolutions for Coverage Cases

- **Failure to Apply Federal Tax Credit Causes Premium Billing Error.** A consumer was about to transition to Medicare as of December 1, 2015, and had an insurance plan that he had purchased on the Exchange that had been effective since March 1, 2015. After he informed the Exchange of this information, he received a bill for November in the amount of $484.60 rather than the amount of his regular payment of $250. There was no reason given, and he needed to keep his plan in effect for November because he had medical bills for that month. After much back and forth between the advocate and insurance plan, it turned out that the Exchange failed to apply his federal tax credit, resulting in the consumer being billed the full premium amount. The insurance plan had to go to the Exchange and request that it apply the credit, which it finally did, and the insurer issued a new statement.

- **Consumer's Clerical Error Results in Termination.** A consumer's health insurance coverage was terminated after she had mistakenly written her husband's member identification number on the memo line of the premium payment checks instead of her own identification number. Although her husband had been set up with auto-debit for many years to pay his premiums, once his wife's checks were applied to his account, the insurer stopped auto-debiting his account, so his account was current (no credit) and hers was delinquent. An advocate faxed an urgent inquiry to the insurer explaining the situation and asking for immediate reinstatement with no lapse. The insurer agreed, and advised how much was owed on the wife's account to bring it current. The consumer was able to pick up medication that she needed the next day.

COVERAGE

THE NUMBER OF IMPROPER INSURANCE TERMINATION CALLS INCREASED FROM 9% IN 2013 TO 14% IN 2014. IN 2015 THESE COMPLAINTS DECREASED TO 12%. THIS STILL REPRESENTS A SIGNIFICANT ISSUE FOR THOSE AFFECTED. IT IS HOPED THAT THIS NUMBER WILL CONTINUE TO DECLINE AS IMPLEMENTATION OF THE ACA CONTINUES.

MEDICATION DENIALS

DURING 2014 THE HELPLINE RECEIVED ONE COMPLAINT REGARDING ACCESS TO MEDICATION FOR HEPATITIS C. DURING 2015, THE HELPLINE RECEIVED MORE THAN 20 COMPLAINTS. ADVOCATES HAVE HANDLED THESE CASES ON AN INDIVIDUAL BASIS, AND IN A NUMBER OF INSTANCES HAVE SEEN HEALTH PLAN REVERSALS.

- **Premium Payment Posted to Wrong Account.** A consumer was concerned about a pending termination of his daughter's policy due to non-payment. His daughter was a college student and he routinely paid the premiums for her policy. The consumer verified that the payment check had been cashed; however, despite having provided this information to the plan, he was unable to have this matter resolved on his own. An advocate filed an inquiry with the insurer. The insurer responded that the premium payment had indeed been cashed, but had been incorrectly posted to another subscriber's contract.

(6) Access to Prescription Drugs

HCB consumer complaints concerning access to prescription medication constitute about 10% of all cases handled. These complaints include 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 include:

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

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

Notable HELPLINE Resolutions for Prescription Drug Access Cases

- **Erroneous Cancellation of Medication Shipment.** A consumer had been taking a medication to reduce preterm labor. The shipment of medication that she needed was unexpectedly not delivered - no explanation was given to her. An advocate made an inquiry with the insurer and was notified that the fulfillment agent cancelled her order in error. The agent mistakenly identified the medication as temperature-sensitive (normally sent with cold packs), which could not be sent on Friday for delivery on Monday and this error was not corrected on Monday. When the insurer was alerted that the order had not been received, it arranged a shipment on the same

day for overnight delivery.

- **Mail Order Pharmacy Requirements.** A consumer's insurer required her to receive her specialty medication from Accredo. She had a history of problems with the delivery of the medication, and the insurer had previously granted retail pharmacy overrides on a one-time basis to resolve those issues. An advocate faxed an inquiry to the insurer detailing the delivery issues and requesting a more permanent retail pharmacy override. The insurer granted a retail pharmacy override for the life of the plan.

- **Unexpected Prior Authorization Requirements.** A consumer contacted the Helpline in the late afternoon because she went to her local pharmacy to fill her prescription and was told by the pharmacist her insurance company now required a prior authorization. The consumer was a recovering drug addict and needed the prescription drug to manage her addiction. She was concerned about the pain and discomfort she would face as a result of not having the medication. The advocate contacted the insurer and a supervisor authorized an override for one month's supply in order to allow the consumer time to work with her doctor to obtain the authorization. The consumer was able to fill her prescription.

CONCLUSION

The Health Care Bureau is at the forefront of efforts in New York State aimed at protecting the rights of health care consumers, both on an individual level as well as on a larger systemic scale. The HCB's Helpline has proven to be an invaluable resource for consumers in New York State as advocates ensure that consumers understand their rights within the health care system and work to protect those rights across the broad range of issues highlighted in this report. Additionally, the Health Care Bureau analyzes the Helpline's consumer complaints to identify systemic health care problems, and will take appropriate affirmative steps to address these systemic problems, including initiating investigations and bringing enforcement actions where necessary.