REAL SOLUTIONS FOR REAL NEW YORKERS

Health Care Bureau Annual Report 2016

Health Care Bureau Helpline

(800) 428-9071

NEW YORK STATE OFFICE of the ATTORNEY GENERAL

HEALTH CARE BUREAU

REAL SOLUTIONS FOR NEW YORKERS 2016

This report briefly describes highlights of the work of the Attorney General's Health Care Bureau ("HCB") for the period of January 1, 2016 through December 31, 2016. 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 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 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 by going to the HCB website at the link provided above. Instructions for submitting a complaint form by mail are also provided on the website.

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 for registering and resolving consumer healthcare-related complaints.

In 2016, the HCB Helpline handled 5,690 cases. Of these cases, the Helpline investigated and resolved **2,917** consumer complaints and provided another **2,773** 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.

RESTITUTION

IN 2016, THE HCB HELPLINE SAVED HUNDREDS OF NEW YORKERS ALMOST THREE MILLION DOLLARS.

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

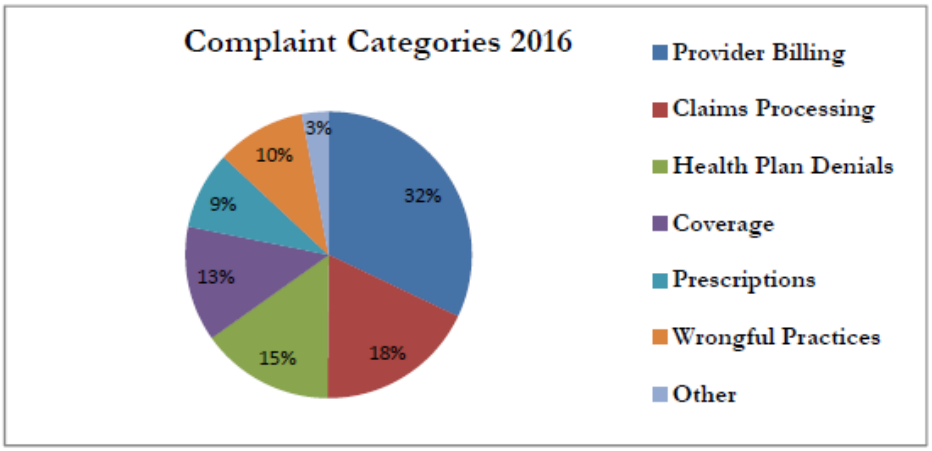
2016 YEAR AT A GLANCE

Benefits to Consumers Across New York State. During 2016, 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 $2,910,000 for consumers in restitution and savings resulting from (i) incorrect medical billing; (ii) wrongful rejection of health insurance claims; and (iii) health plans' 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
- Obtain reinstatement of 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, Health Plan Denials, Insurance Coverage, Prescription Drugs, and Wrongful Practices.

- Data for 2016 compared with 2015 show that "provider billing" continues to be the top issue prompting New Yorkers to contact the HCB. The number of these types of complaints has remained fairly consistent, increasing from 31% of all complaints in 2015 to 32% in 2016. In both years, the majority of these complaints (62% in 2015 compared to 70% in 2016) 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 also remained fairly consistent during the past two years with no more than a one or two percentage point difference in each category.[2]



- As depicted above, after provider billing, New Yorkers' complaints in 2016 fell into the following categories: health plan claim processing/payment complaints, which include health plan mistakes in preparing, processing, or paying claims (18%); health

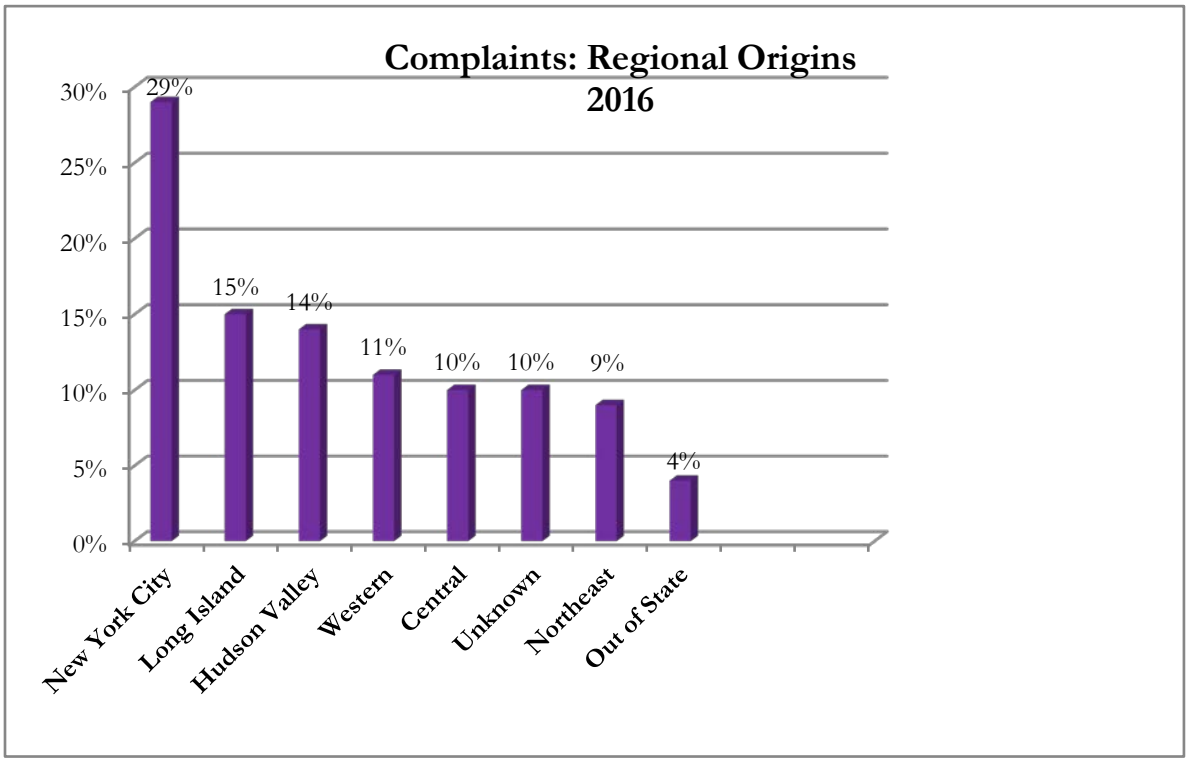
[2]

	2015
Provider Billing	31%
Claims Processing	18%
Health Plan Denials	15%
Coverage	12%
Prescriptions	10%
Wrongful Practices	9%
Other	5%

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 (13%); problems accessing prescription medications (9%); and wrongful practices (10%).

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

Similar to 2015, during 2016, the largest percentage of complaints originated in the New York City region. In 2016, a total of 29% of all Helpline complaints originated in New York City, with the Long Island region also the source of many complaints (15%). See below for regional origins of complaints received by the Helpline during 2016.[3]



[4]

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

[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, 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 (32%) 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.

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 as part of a planned hospital procedure (*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 decreased by 55% in 2016 when compared with 2014.

Notable HELPLINE Resolutions:

- **Improper Balance Billing.** A participating provider of oxygen supplies billed a consumer more than $600 after receiving a denial of coverage notification from the health plan (for failure to receive preauthorization). The consumer had unsuccessfully called the provider several times to attempt to resolve the problem. A Helpline advocate contacted the provider and it became apparent that the health plan had advised the provider that it was improper to bill the consumer, but nevertheless, one month after the health plan's notification, the provider billed the balance back to the patient. As a result of the Helpline advocate's intervention, the provider adjusted the account and sent a letter confirming a zero balance to the consumer. The matter was also recalled from collection.

- **Improper Claim for Services Not Received.** A consumer wrote to the Helpline about a dental claim submitted to the health plan by the provider for treatment on a particular

date in 2016 because the consumer indicated that treatment was not received on that date, and the claim was being counted towards the consumer's annual dental benefit maximum. When the consumer saw the claim on the health plan's website, she contacted the dental office and was informed that the bill actually represented an outstanding balance for treatment provided three years before – in 2013. The consumer advised that no billing statements were received from the office for past services and that the office submitted the claim without the consumer's knowledge. The health plan paid the claim in the amount of $820 to the dental office and issued an Explanation of Benefits. A Helpline advocate contacted the health plan and advised that treatment was never provided. When the health plan contacted the dental office, the health plan was advised that the claim was submitted in error. The claim was voided, the health plan received a refund from the dental office in the amount of $820, and the benefits were reinstated to the consumer's annual dental benefit maximum.

PROVIDER BILLING

THE HELPLINE HAS IDENTIFIED AND RESOLVED HEALTH PLAN ERRORS THAT RESULT IN CONSUMERS RECEIVING PROVIDER BILLS THEY SHOULD NOT PAY.

(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, 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.

Notable HELPLINE Resolutions:

- **Underpayment of Air Ambulance Claim.** A consumer's daughter suffered a head injury and was flown from one hospital to another for emergency treatment. The out-of-network air ambulance company billed the consumer more than $45,000 and the health plan covered less than $6,000. After a Helpline advocate intervened, the health plan and air ambulance agreed to an amount of about $21,000 in satisfaction of the claim. The consumer responsibility was about $2,000.

- **Erroneous Calculation of Secondary Insurance Benefits.** A consumer complained that her secondary insurance was not paying any out-of-network mental health claims.

The health plan advised that as secondary, it did not have to pay more than the primary insurer's allowed amount. The Helpline advocate contacted the secondary insurer and advised that it should be paying based on the secondary insurer's allowed amount, not what the primary insurer allowed. Ultimately, the health plan acknowledged its error. The secondary insurer's allowed amount for the procedure code was $140; the primary insurer's allowed amount was $65. The consumer's claims were adjusted and paid. Savings to the consumer totaled $2,125.

- **In-Network/Out-of-Network Confusion.** A consumer with stage 4 cancer had been seeing an oncologist/hematologist with offices in two locations for about five years. During the five-year period, medical care was covered by his health plan, until the plan suddenly indicated that the consumer's doctor was not a participating in-network provider. A Helpline advocate inquired with the health plan and discovered that the doctor was in-network at one office but not at the other office. The health plan said that it would contact the doctor's office to see if the doctor would apply for in-network status for the one office and that in the meantime, the plan would reprocess the three visits that the consumer made to the out-of-network office as in-network. Savings to the consumer amounted to $2,187.

- **Preauthorization Date Error Results in Denial for "No Preauthorization."** A consumer underwent a medical procedure to have kidney stones removed. She thought that the procedure had been pre-approved, but the health plan denied coverage based on the consumer's failure to obtain preauthorization. The consumer's account was sent to collection by the anesthesiologist and the ambulatory surgery center where the procedure was performed. The plan also denied coverage of the in-network doctor. A Helpline advocate sent an inquiry pointing out that it was the consumer's understanding that the procedure had been pre-approved. After review, the health plan found that it had authorized the procedure, but for a different date. The actual procedure took place a month earlier, which caused the errors in the processing. As a result of the Helpline's intervention, the health plan reprocessed the claims and paid all parties a total of $6,307, leaving the consumer responsible only for the amount of her copayment – about $17.

CLAIMS PROCESSING

THE HELPLINE HELPS CONSUMERS WITH COMPLEX HEALTH PLAN CLAIMS PROCESSING ISSUES, UNTANGLING VARIED PROBLEMS INCLUDING OUT-OF-NETWORK DOCTOR REIMBURSEMENTS.

(3) Health Plan Denials of Coverage for Care

Approximately 15% of all HCB consumer complaints involve health plan denials of coverage for care. Such denials most often occur based on claims that the care was not medically necessary (59%) or that the care provided was not a covered benefit (30%).

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.

Notable HELPLINE Resolutions:

- **Denial of Out-of-Network Exception for Neurosurgeon Reversed.** A consumer contacted the HCB after receiving a denial from a health plan for an exception to use an out-of-network neurosurgeon. A Helpline advocate explained to the health plan that the consumer had called the health plan at the beginning of June 2016 to request an out-of-network exception for the doctor, whereupon the health plan assured the consumer that she didn't need one because the doctor was in-network. The consumer had a pre-surgery consultation with the surgeon later in June and neurosurgery was scheduled for July. During the consultation, the doctor's office again informed the consumer that the doctor was out-of-network. The consumer called the health plan again, but was now told that the doctor was out-of-network. She again requested an out-of-network exception, which was verbally denied. Instead of providing the consumer with a list of participating neurosurgeons, the health plan referred her to a specific medical center. The consumer called the medical center's neurosurgery department and was advised that there were two in-network surgeons who could perform the surgery, but the type of surgery required did not fall into either physician's area of expertise. Moreover, the consumer would not be able to be seen for a pre-surgery consultation for 30 days, placing her health in jeopardy. The Helpline advocate then requested that the health plan reach an agreement with the neurosurgeon to cover both the June pre-surgery consultation and the scheduled July surgery. The health plan heeded the Helpline advocate's request and negotiated "single-case agreements" (so that the doctor was not out-of-network for the consumer) with the surgeon for both the pre-surgery consultation and the surgery.

- **Medical Necessity Denial Reversed After Appeal.** A consumer called for assistance in obtaining preauthorization for back surgery. The health plan denied the surgery as not medically necessary after a "peer to peer" (doctor to doctor) review, and an appeal was pending. A Helpline advocate provided the plan with the doctor's letter of medical necessity, a statement from the physical therapist that physical therapy was not working, and a statement from the employer that the consumer had been out of work for six weeks because of pain. The Helpline advocate asked for the matter to be reviewed on a priority basis. The plan approved the surgery and the consumer was able to undergo the procedure recommended by her doctor.

- **Health Plan Denial of Dental Reconstruction After Accident Reversed.** A consumer's son fell with such force that the impact resulted in major damage to his teeth and gums, necessitating surgery on the bone and requiring implants. The dental plan denied all claims indicating that the claim was more than dental because of the reconstruction required, so the medical plan was responsible for the bills. The health plan, however, denied coverage, on the basis that it did not cover dental care. The Helpline advocate reviewed the benefit book from the health plan and pointed out to the health plan that the medical benefits extend to dental work when natural teeth are damaged in an accident. The denial was reversed.

- **Health Plan Amends Coverage for Gender Reassignment Surgery.** A consumer contacted the Helpline after receiving a denial of coverage from a health plan for bilateral mastectomy as part of gender reassignment surgery. The health plan had determined that the surgery was cosmetic and not medically necessary because it was requested as one of the steps to change gender. The plan indicated that the surgery was only needed when there was a medical cause, such as injury, cancer or birth defect. The HCB submitted an inquiry to the plan and requested that the plan reconsider the denial because the exclusion of coverage was not consistent with the requirement that health plans provide coverage for the medically necessary treatment of gender dysphoria. As a result, the health plan reversed the denial and amended its policy to cover mastectomy for the diagnosis of gender dysphoria as part of sexual reassignment surgery.

Enforcement Actions[5]

- **Enforcement of Mental Health Parity Laws Against HealthNow.** An investigation conducted by the HCB followed the receipt of a number of consumer complaints alleging that HealthNow had improperly denied outpatient mental health coverage for treatment by requiring preauthorization for all outpatient behavioral health counseling after members reached a 20 visit per year threshold, and by excluding coverage for nutritional counseling for eating disorders. The HCB uncovered the wrongful denial of thousands of claims for outpatient psychotherapy and more than one hundred claims for nutritional counseling for eating disorders since 2012. The wrongful denials totaled more than $1.6 million in patient claims. Under an agreement, Buffalo-based HealthNow (which includes BlueCross BlueShield of Western New York and BlueShield of Northeastern New York) will no longer require prior authorization for behavioral health counseling after a member's 20th visit, will cover nutritional counseling for eating disorders, and will reimburse members for their out-of-pocket expenses for the wrongfully denied claims. The investigation was launched under New York's mental health parity law, known as Timothy's Law, which was enacted in 2006 and requires that health plans provide mental health coverage at least equal to coverage provided for other health conditions, and the federal Mental Health Parity and Addiction Equity Act,[6] which provides similar protections to consumers. HealthNow also paid $60,000 to the Attorney General's Office as a civil penalty.

[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.

[6] The federal mental health parity law was enacted in 2008.

- **Nine Health Plans Revise Criteria for Coverage of Hepatitis C Treatment.** The HCB investigated the basis for health plan restrictions on Hepatitis C treatment medication, including restrictions based on fibrosis level, and alcohol or drug use. One investigation concluded by filing a lawsuit against Capital District Physician's Health Plan (CDPHP), which was resolved by a court settlement with the plan agreeing to lift the restrictions. The investigation also resulted in agreement with eight other health insurance companies: Affinity Health Plan, Empire BlueCross BlueShield, Excellus Health Plan, HealthNow, Independent Health, UnitedHealthcare/Oxford, MVP Health Plan, and Crystal Run Health Plans. The nine plans agreed to revise their coverage policies for chronic Hepatitis C treatment. As a result of these agreements, nearly all commercial health insurance plans in New York State cover treatment for chronic Hepatitis C without requiring members to develop advanced disease, such as liver scarring, and will not deny coverage because the member uses alcohol or drugs, or because the authorizing physician is not a specialist. In addition, CDPHP was required to pay costs to New York State in the amount of $25,000. Prior to the agreement, seven of the nine health plans limited chronic Hepatitis C coverage to members with advanced liver scarring or other complications; five of the health plans denied coverage for treatment based on the members' use of alcohol or other drugs; and five of the health plans only permitted specialists to authorize treatment.

(4) Wrongful Practices

About 10% of consumer complaints are based on an assertion of a wrongful or fraudulent business practice. Most of this category of consumer complaints (76%) include false advertising and predatory lending/health care financing.

Notable HELPLINE Resolutions:

- **Laser Therapy Rebate Denial Reversed.** A consumer contacted the HCB about an advertised rebate program. As an incentive to receive laser treatments for psoriasis, a company advertised a rebate program for refund of copayments if treatment was received with one of their laser therapy machines at a provider referred by the company. The consumer was referred to a particular dermatology group for evaluation and received ten treatments with a laser therapy machine. When the consumer submitted his rebate request, he received a letter indicating that he was no longer eligible because the office where he was treated no longer used the company's laser therapy machines for their patients. The consumer advised that he had concerns about the rebate early in the treatment process but had been assured by the company representative that he qualified. As it turned out, the medical practice where he received the laser treatment only used the company's laser in one office and the consumer received treatment in the other office with a device manufactured by a competitor. The Helpline advocate contacted the company that advertised the rebate and the company agreed to reimburse the consumer for the $260 in out-of-pocket expenses that he incurred.

- **Deceptive Credit Card "Sign Up" Practices.** A consumer contacted the HCB when a vision center encouraged him to sign up for a credit card to cover the cost of eyeglasses, without the consumer having been told the price. Also, the consumer did not understand at the time that he was signing a credit card contract. When the consumer found out the price

of the eyeglasses before leaving the building, he was told that the transaction had already gone through and that there was a no refund policy. Although he called the credit card company to cancel the card and he never received the eyeglasses, the credit card company continued to bill the consumer for $550. After being contacted by a Helpline advocate, the credit card company credited the card for the full amount of $550.

Enforcement Actions

- **Deceptive Marketing of Opioids.** The HCB launched an investigation of Endo Health Solutions Inc. and Endo Pharmaceuticals Inc. (collectively, "Endo") as a result of concerns regarding the role of the companies' marketing practices for their long-acting opioid painkiller Opana ER. The HCB also examined the role that drug company promotion of opioids like Opana ER has played in the opioid epidemic. The HCB investigation found that Endo improperly marketed Opana ER as designed to be crush resistant, when Endo's own studies showed that the pill could be crushed and ground. The investigation also showed that Endo improperly instructed its sales representatives to diminish and distort risks associated with Opana ER, including serious dangers involving addiction. In addition, Endo had no meaningful program in place to ensure that its sales representatives were not encouraging health care providers engaged in abuse and diversion to write more prescriptions for Opana ER. The investigation also revealed that Endo made unsupported claims comparing Opana ER to other opioids, and failed to disclose accurate information regarding studies addressing the effects of Opana ER. The settlement agreement includes requirements that Endo cease all misrepresentations regarding the properties of Opana ER; accurately describe the risk of addiction to Opana ER; and summarize studies regarding Opana ER on its website. Endo must also create a program that will prevent its sales staff from promoting this powerful narcotic painkiller to health care providers who may be involved in the abuse and illegal diversion of opioids. Endo was required to pay a $200,000 penalty for its unlawful conduct.

- **Inadequate Jail Health Services**. The HCB brought a lawsuit against Armor Correctional Health Medical Services ("Armor"), a Florida-based prison health services company, alleging that the company failed to provide proper medical services to inmates as required by its $11 million yearly contract with Nassau County. The lawsuit alleged that Armor either failed to perform or egregiously underperformed many of its obligations. After Armor agreed that for a period of three years Armor would not bid on or enter into any contract to provide jail health services in New York State, the lawsuit was settled. Armor was required to pay $350,000 in penalties and contract reimbursements.

- **Misrepresentations About Indoor Tanning.** A lawsuit filed by the HCB concerning misrepresentations of the health effects of indoor tanning was resolved by a court-ordered settlement with Portofino Spas, LLC, a New York company that provides indoor tanning services at five Manhattan locations. The agreement prohibits Portofino from making misleading health claims and ensures the company will comply with New York State and New York City tanning regulations. Portofino agreed to pay $300 per day for any future health misrepresentations and for each future violation of New York tanning laws. Despite the consensus opinions of the scientific and medical communities about the dangers of indoor UV tanning, Portofino used its website and social media outlets to make claims that

falsely minimized or denied the link between tanning and increased cancer risk; misrepresented health benefits of vitamin D and indoor tanning; and misrepresented the safety of indoor tanning compared to tanning outdoors. In addition, the investigation revealed that Portofino violated New York State tanning laws by failing to provide current tanning hazards and consent forms, as well as failing to post the New York State-required warning signs near all tanning devices. The Portofino lawsuit was handled by the HCB, in conjunction with the Environmental Protection Bureau and the Consumer Fraud and Protection Bureau.

(5) Obtaining and Keeping Coverage

Thirteen percent of consumer complaints involved issues relating to obtaining and keeping coverage. Of these complaints, 18% are due to health plan error and 15% are due to employer error.

Notable HELPLINE Resolutions:

- **Coverage Terminated Due to Consumer Error.** A consumer contacted the HCB after learning that his health plan terminated his coverage effective January 31, 2016, for non-payment of premiums. Once he discovered that he had been terminated, he contacted the health plan, and was informed that he had not selected the automatic payment feature as he thought he had done. Accordingly, money was not withdrawn from his account and he had not monitored his bank account to verify that payments were withdrawn. After an inquiry by the Helpline advocate, the health plan first advised that it was not willing to make an exception; however, after a second inquiry, the health plan agreed to reinstate with no gap in coverage and the consumer paid all of his back premiums.

- **Coverage Terminated Due to Employer Error.** A consumer contacted the HCB when she learned that her health insurance was terminated. She advised the Helpline advocate that she had worked for 12 years as a home care worker for a particular company and received health insurance through a union fund. It was her understanding that she had to work 100 hours a month to qualify for health insurance and she believed that she met that requirement. A Helpline advocate made an inquiry with her employer, who advised that her hours had been incorrectly reported and coverage was reinstated.

COVERAGE TERMINATION

LOSING HEALTH PLAN COVERAGE IS A FRIGHTENING EVENT – THE HELPLINE HAS HELPED CONSUMERS KEEP THEIR COVERAGE.

MEDICATION DENIALS

THE HELPLINE RECEIVED DOZENS OF COMPLAINTS REGARDING ACCESS TO COVERAGE FOR HEPATITIS C MEDICATION THAT FORMED THE BASIS FOR AN ENFORCEMENT ACTION RESULTING IN HEALTH PLANS REMOVING THE PREVIOUS RESTRICTIONS.

(6) Access to Prescription Drugs

HCB consumer complaints concerning access to prescription medication constitute about 9% 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 preauthorization 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 brick and mortar 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:

- **Denial Based on Experimental Finding Reversed.** A consumer's son had been diagnosed with a particular form of encephalitis. The prescription drug Rituximab, which is used primarily for leukemia patients, but had recently been found to be effective for encephalitis victims, was prescribed by his physician. The consumer's son received four infusions over a four-month period, and his condition improved. Nevertheless, the health plan denied coverage, finding that the medication was experimental/investigational. A Helpline advocate submitted an inquiry to the plan and provided support for an appeal, referring to information indicating that the infusions were found to be effective treatment, that the son's condition had improved as a result of the infusions, and that the alternative would have been to pay for treatments that were not working. The health plan responded that the medical director had reviewed the case and based on language in the plan, it would consider approving the use of FDA approved drugs to treat conditions that the drug was not designed to treat where, as here, the drug had showed promise in limited studies. As a result, the plan paid nearly $22,000 for the four infusions.

- **Mail Order Pharmacy Requirements.** A consumer contacted the Helpline seeking assistance in obtaining a specialty prescription drug hardship exception for mail order delivery of Norvir, Prezista and Intellence. A Helpline advocate made an inquiry based on

criteria set forth in the health plan's policy. The consumer lived in an unsecured building where there was a privacy concern; there was a risk that packages left at the door would be stolen; and the unattended packages posed a risk to others. The health plan approved all three medications to be picked up at his local pharmacy.

Enforcement Actions

- **Requirement for Prior Authorization for Medication-Assisted Treatment is Removed by Cigna.** After receiving consumer complaints, the HCB investigated Cigna's prior authorization requirement for medication-assisted treatment ("MAT") drugs for opioid use disorder. MAT drugs, which can be prescribed in doctors' offices, are vital tools in combatting the opioid epidemic and saving lives. Cigna required prescribers of these drugs – who had already received specific training regarding MAT and certification from the federal Drug Enforcement Administration – to answer numerous questions about patients' current treatment and medication history in order to obtain authorization. This process in some instances took several days, and resultant delays placed consumers' health at risk. In settlement of the investigation, Cigna agreed to end its policy of requiring prior authorization for MAT.

CONCLUSION

The HCB has worked to protect the rights of health care consumers in New York since its inception two decades ago. With many changes forecast for the future of health care, including potential significant changes to the Affordable Care Act, the HCB Helpline will continue 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 as illustrated in this report. In addition, the HCB will continue to analyze the Helpline's consumer complaints to identify systemic health care problems; work to correct deficiencies; and hold those entities that engage in fraudulent, misleading, deceptive, or illegal practices in the health care market accountable through all means available, including initiating investigations and bringing enforcement actions where necessary.

Health Care Bureau Helpline

(800) 428-9071

NEW YORK STATE OFFICE
of the
ATTORNEY
GENERAL