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# REAL SOLUTIONS FOR REAL NEW YORKERS

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## Health Care Bureau Annual Report 2018

Health Care  Bureau Helpline  

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**(800) 428-9071**



NEW YORK STATE OFFICE  
of the

**ATTORNEY  
GENERAL**

# HEALTH CARE BUREAU

## REAL SOLUTIONS FOR NEW YORKERS 2018

This report briefly describes highlights of the work of the Attorney General’s Health Care Bureau (“HCB”), with a particular focus on the work of the HCB Helpline, for the period of January 1, 2018 through December 31, 2018. 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<sup>1</sup> in the New York State Office of the Attorney General. The principal mandate of the HCB is to protect and advocate for the rights of health care consumers statewide through:

**Operation of the Health Care Bureau Helpline.** This toll-free telephone Helpline (800-428-9071) serves as a direct line between consumers and the Office of the Attorney General. The Helpline is staffed by intake specialists and advocates trained to assist New York health care consumers. Assistance ranges from providing helpful information and referrals to investigation of individual complaints, and mediation of disputes to help protect consumers’ rights within the health care system. Consumers can also receive assistance from the Helpline by submitting a complaint form online or by mail. The online complaint form is easy for consumers to submit and can be accessed on the HCB website. There are also instructions for submitting a complaint form by mail on the website.

**Investigations and Enforcement Actions.** The HCB conducts investigations of and litigates against health plans, health care providers, and other individuals and business entities that engage in fraudulent, misleading, deceptive or illegal practices in the health care market. The HCB also includes a specific section focused on tobacco compliance and enforcement (“TCE”). TCE has continued steadfast efforts to reduce tobacco consumption in New York State through monitoring compliance with and enforcement of the Tobacco Master Settlement Agreement. In addition, TCE is responsible for implementing and enforcing numerous state laws and policies, such as the requirement that all cigarettes sold in New York be fire-safe. TCE also enforces certain federal laws relating to cigarettes, such as the Contraband Cigarette Trafficking Act, the Prevent All Cigarette Trafficking Act and the Jenkins Act.

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<sup>1</sup> 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 health care – making it easy for New York consumers to notify the Attorney General’s office about their health care concerns by submitting complaints for review and resolution by the Helpline’s team of advocates.

### RESTITUTION

IN 2018, THE HCB  
HELPLINE SAVED  
HUNDREDS OF NEW  
YORKERS MORE  
THAN TWO MILLION  
DOLLARS.

**In 2018, 4,350 consumers contacted the HCB Helpline for assistance.** During the year, Helpline advocates handled **1,961** consumer complaints and the Helpline provided another **2,389** consumers with information or referrals to the agency most appropriate for the inquiry. The complaints handled by the Helpline highlight the challenges faced by New Yorkers and are an important means of identifying systemic problems in New York’s health care system. In addition, these complaints 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 uncertain 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 legitimate denial of care, 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

## 2018 YEAR AT A GLANCE

### Benefits to Consumers Across New York State.

During 2018, the HCB Helpline’s efforts yielded significant results benefitting thousands of individual consumers across New York State, including securing more than \$2.3 million 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.

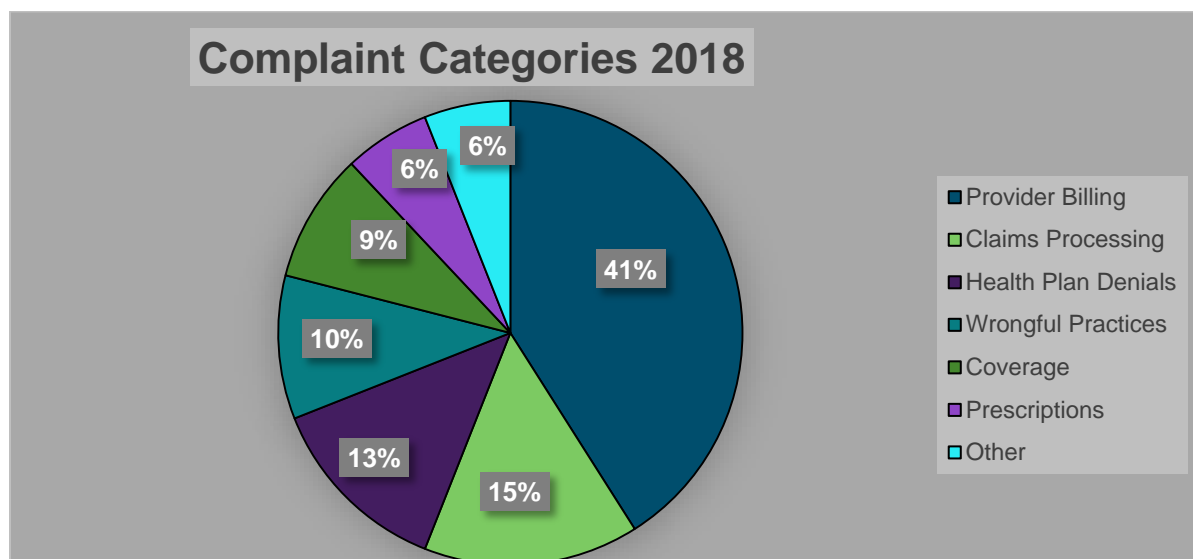
**Issues Raised by Consumers and Resolved by the HCB Helpline.** A review of the HCB complaint data for 2018 shows that Helpline complaints fall into six general categories: Provider Billing, Claims Processing, Health Plan Denials, Insurance Coverage, Wrongful Practices, and Prescription Drugs.

- **Provider billing** concerns captured the highest percentage of New Yorkers’ Helpline complaints in 2018 at 41%.
- After provider billing, health plan claim processing/payment complaints, which include **health plan mistakes** in preparing, processing, or paying claims represented 15% 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 13% of total Helpline complaints.
- **Wrongful practices, including misleading advertising and other business deceptions**, represented 10% of total Helpline complaints.

### 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.

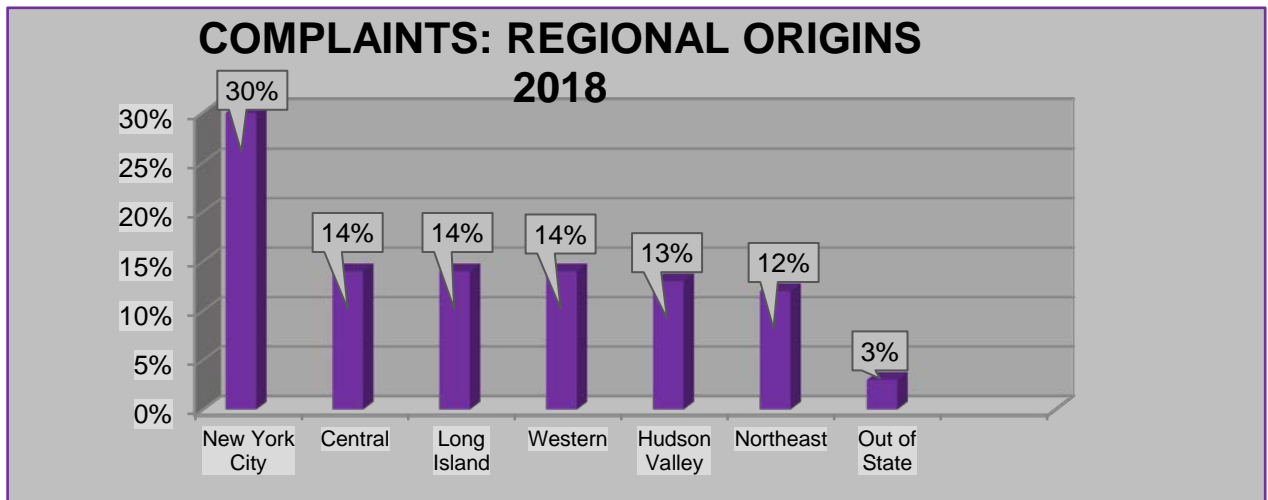
- **Problems obtaining and keeping health insurance coverage** represented 9% of total Helpline complaints.
- **Problems accessing prescription medications** represented 6% of total Helpline complaints.



### HCB Helpline Complaints – Where They Originate.

During 2018, as in 2017, the largest percentage of complaints originated in the New York City region (30% in 2018). In 2018, the Long Island region, Central and Western New York tied for second place at 14%. See below for regional origins of complaints received by the Helpline during 2018.<sup>2</sup>

<sup>2</sup> 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) 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, and false advertising.

### Notable HELPLINE Resolutions:

- Provider Delivers Repaired Wheelchair Improperly Withheld from Consumer.** A consumer contacted the Helpline because she sent her wheelchair to a company for repair more than five months earlier, and the company refused to return the chair to the consumer, claiming that her health plan had not paid for the repair. The consumer was essentially rendered homebound. The Helpline advocate contacted the health plan, and found that there was a dispute between the repair company and the health plan regarding alleged double billing by the provider for other unrelated claims. The health plan explained that while it had paid for the repair services, the payment was offset by recoupment for the unrelated claims. The health plan contacted the company, an in-network participating provider, and explained that the dispute was not a valid reason to withhold services from any members. The repair company delivered the wheelchair to the consumer less than a week after she contacted the Helpline.

- Provider Refunds Money Improperly Retained from Consumer.** A consumer contacted the Helpline, seeking partial reimbursement for home health aide services that she had prepaid for seven days in November 2017 for a relative. Because her relative was hospitalized, negating the need for home health services, the consumer sought reimbursement for the evening she was taken to the hospital, the next full day, and the following morning. While she received a refund check from the company in May 2018, the bank returned the check for insufficient funds twice. The company failed to respond to the consumer’s request for a certified check. The Helpline advocate sent an inquiry to the home health aide company who assured that the issue would be resolved. As a result of the Helpline advocate’s persistence, the consumer finally received a \$960 refund two months after contacting the Helpline.
- Health Plan Covers Unexpected Consumer Charge Based Upon Incorrect Information About Facility Designation.** A consumer went to what she believed was an ambulatory surgical center for a surgical procedure. Her insurance covered the procedure at an ambulatory surgical center with a member responsibility of a \$100 copayment, but the same procedure performed at an outpatient hospital facility would incur a member responsibility of 20% of the charges. Both when scheduling the procedure, and again the day before the procedure was performed, representatives of the facility told the consumer that her responsibility would be \$100. Upon discharge, she was given written “Ambulatory Surgery Patient Discharge Instructions.” She received a bill and Explanation of Benefits showing a member responsibility of \$248. The Helpline advocate requested that the health plan advise as to the correct designation for the facility, and an explanation of how that designation was determined. The advocate also asked the plan to reprocess the claim if the facility was, in fact, an ambulatory surgical center. Defending its original determination, the plan responded that the facility determines the designation. The advocate persisted, reiterating her request that the claim be processed as an ambulatory surgical center procedure, explaining to the health plan the steps taken by the consumer to inquire, prior to the service, as to what her responsibility would be, and noted the title of the discharge document. The plan acquiesced, explaining that its compliance investigations unit determined the claim should be reprocessed with a member responsibility of \$100.

## Enforcement Actions<sup>3</sup>

- Investigation into Aetna’s Privacy Breach Leads to a Change in Privacy Practices and \$1.15 Million in Penalties.** The HCB opened an investigation in July 2017 following Aetna’s July 28 mailing to 2,460 New York Aetna members with HIV. The mailing was sent in envelopes with a large transparent window designed to allow the recipient’s address to be printed on the paper contained within, and in this case, could easily reveal the members’ HIV status, which was noted in the enclosed letter. As part of the HCB’s investigation into the HIV member mailing, the HCB discovered an

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<sup>3</sup> “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.

additional privacy breach. On September 25, 2017, Aetna sent 163 New Yorkers a mailing containing materials related to a research study regarding atrial fibrillation (AFib), an irregular heartbeat condition that can lead to stroke, heart failure, and other heart-related complications. Aetna's mailing to members with AFib used envelopes that displayed the logo of the research study, "IMACT-AFIB," easily viewed by third parties – which could have been interpreted as indicating that the recipient member had an AFib diagnosis. As part of a settlement of this investigation, Aetna was required to pay a \$1.15 million civil penalty; develop and maintain enhanced operating procedures with regard to privacy protections of personal health information and personally identifiable information in mailings; and hire an independent consultant to monitor and report on the settlement's injunctive provisions.

Note: New York State Public Health Law Section 18 requires that patient information, such as the information at issue here, be revealed only with written authorization from the patient. Federal law, pursuant to the Health Insurance Portability and Accountability Act (HIPAA), prohibits the disclosure of protected health information, except in very limited circumstances.

- **Pfizer Inc. Removes Deceptive Advertising Used in “Pay No More Than” Drug Copayment Card Program and Pays \$500,000 to NYS.** The HCB opened an investigation into Pfizer's marketing of its copayment coupons to New York consumers following the receipt of a complaint from a consumer who obtained an Estring copayment coupon. The coupon included the deceptive language “PAY NO MORE THAN \$15” in large bold print. However, when this consumer presented the coupon at the pharmacy register, she had to pay \$144.62. Pfizer's copayment coupons for Estring and other prescription drugs stated in large, clear print that eligible consumers would “PAY NO MORE THAN” a specific dollar amount. In fact, consumers frequently paid significantly more than the “PAY NO MORE THAN” amount that appeared on the relevant Pfizer copayment coupons because of limits on total savings that were not prominently disclosed. The other prescription drugs included in Pfizer's copayment coupon program were Quillivant XR and Quillichew ER (“Quillivant”), and Flector Patch. The settlement resolved allegations that Pfizer deceptively marketed its copayment coupon program for these prescription drugs to consumers without clearly and conspicuously disclosing the material terms and conditions. As part of the settlement, Pfizer agreed to change the language of the Estring, Quillivant, and Flector Patch copayment coupons to explain that patients could “pay as little as” a specific amount, a process Pfizer completed as of early 2018. Pfizer is also required to pay more than \$200,000 in restitution for New York consumers, plus \$500,000 in penalties, fees, and costs.
- **Ageless Men's Health, P.C. Changes Misleading Practices Used in Diagnosing and Treating Low Testosterone.** The HCB initiated an investigation into misleading practices by Ageless Men's Health, P.C. (“Ageless”). Ageless and its affiliates provide Testosterone Replacement Therapy (“TRT”) to men, ostensibly to treat low testosterone levels, at 36 clinics across the United States, including three in New York City. HCB's investigation revealed many of Ageless' misleading practices including (1) featuring a misleading “Low T Quiz” on its website; (2) failing to follow medical guidelines



regarding recommended time of day for testing and number of tests to confirm a diagnosis of low testosterone before starting TRT; (3) offering TRT to men whose diagnostic testosterone levels were above the thresholds for treatment set out in medical guidelines without informing patients of that fact; and (4) failing to inform patients that decreased fertility is a scientifically established side effect of TRT. The HCB found that in diagnosing low testosterone and addressing potential side effects of treatment, Ageless failed to follow evidence-based practices recommended by leading medical organizations. Under the settlement agreement, Ageless is required to make complete and accurate

disclosures to its patients and prospective patients concerning the diagnosis of low testosterone and the risks associated with TRT. Ageless has specifically committed to (1) remove the misleading “Low T Quiz” from its website; (2) inform patients that according to medical guidelines, blood tests for purposes of diagnosing low testosterone should be performed in the morning, and two morning tests should be performed before starting TRT; (3) inform patients about the thresholds for treatment set out in the relevant medical guidelines; and (4) inform patients in writing about the fertility-related side effects of TRT.

## (2) Health Plan Denials of Coverage for Care

**Approximately 13% 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 (42%). While a relatively small percentage of Helpline complaints fall into 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:

- **Health Plan’s Denial of Coverage for Out-of-Network Second Opinion for Cancer Diagnosis Is Reversed.** A consumer contacted the Helpline because he had recently been diagnosed with a rare form of cancer and his provider gave him only one treatment recommendation. The consumer wanted

a second opinion from an out-of-network physician, but his health plan denied coverage. The Helpline advocate sent an inquiry to the health plan explaining the situation and asking that they reconsider the denial. The health plan approved three visits with the out-of-

## 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.

network provider, and advised that the provider would have to submit a request for each specific test/treatment. The consumer reported that the health plan had approved all requests made by the out-of-network provider.

- **Health Plan’s Denial of Coverage for Implanted Heart Monitor Device Is Reversed.** A consumer’s cardiac specialist recommended she have a loop recorder implanted in her chest to monitor her heart. The consumer reported that the cardiac specialist assured her that insurance would cover the costs. After surgery, her health plan indicated patient responsibility for the recorder was \$11,878, deeming the recorder experimental/investigational. When the Helpline advocate inquired, the health plan explained that it initially denied coverage of implantation of the recorder and the recorder itself, but then decided to allow coverage for implantation of the recorder only. The Helpline advocate asked the health plan to explain why it approved the implantation, but not the recorder itself, thus prompting the health plan to reverse its denial of coverage for the recorder, reducing the consumer’s responsibility from \$11,878 to a \$30 copayment.
- **Health Plan’s Denial of Coverage for Walking Boot Is Reversed.** A consumer contacted the Helpline regarding a bill for a walking boot, needed to protect his foot/ankle after an injury, in the amount of \$320. The Helpline advocate ascertained that the health plan had denied coverage for the walking boot as a non-covered benefit. The Helpline advocate sent an inquiry to the health plan asking that it review the denial, and if it was determined that the denial was appropriate, provide the plan document(s) indicating the walking boot is a non-covered benefit. The health plan responded that orthotic devices were not covered and pointed to a particular exclusion: “We will not pay for any services not specifically described in this Plan as a covered benefit.” The Helpline advocate then requested the Durable Medical Equipment (“DME”) and Orthotic Devices sections of the contract. While the health plan indicated that there was no Orthotic Devices section of the contract, it provided the DME section of the contract. Based on the DME section of the contract, the Helpline advocate argued to the health plan that (1) braces and crutches are listed under DME as being covered; (2) braces and crutches, like walking boots, are orthotic devices; (3) walking boots are not listed as non-covered in the DME section; and (4) a reasonable person would interpret the contract as covering walking boots. Ultimately, the health plan adjusted the claim to pay at the in-network benefit level, and the consumer responsibility on the claim was a \$40 copayment.
- **Health Plan’s Denial of Coverage for Out-of-Network Breast Reconstruction Surgeon Is Reversed.** A consumer contacted the Helpline because she had an imminently scheduled mastectomy and breast reconstruction, and her health plan denied reconstruction with her out-of-network surgeon (mastectomy surgeon and facility were both in-network). The health plan indicated that it had three in-network surgeons, all with one surgery group, who it claimed could perform the DIEP flap reconstruction. However, the health plan could not confirm whether the in-network surgeons were authorized to perform the DIEP flap reconstruction at the in-network hospital where the surgery was scheduled because they had never performed that specific surgery at that hospital. In response, the Helpline advocate argued to the health plan that even if it was determined that the in-network surgeons could perform the reconstruction at the in-network hospital, the surgeons likely could not do it the next day (the date the mastectomy and reconstruction were scheduled to

be performed). Since the consumer's health continued to be in jeopardy the longer she waited, the Helpline advocate requested an out-of-network exception. The health plan granted the exception.

## Enforcement Actions

- **EmblemHealth Changes Coverage Criteria for Gender Reassignment Surgery and Pays Restitution to Members plus Penalties to State.** The HCB initiated an investigation after receiving a complaint that EmblemHealth improperly denied coverage of gender reassignment surgery to a member based on failure to meet EmblemHealth's unlawful criteria. The investigation by the HCB revealed that EmblemHealth's process of updating criteria for gender reassignment surgery was deficient; that the criteria included in the 2014-2017 Gender Reassignment Surgery Guidelines were outdated and not medically accurate or evidence-based during the time they remained in effect; and that EmblemHealth's review of member requests, including coverage for mammoplasty as part of gender reassignment surgery, was deficient. The investigation found that EmblemHealth provided misleading and deceptive information to plan members indicating that it based its 2014-2017 Guidelines on current clinical information and standard medical guidelines when they were not. As part of the settlement agreement, EmblemHealth has updated its Gender Reassignment Surgery Guideline and will maintain the changes and continue to update its criteria in accordance with formal reviews. The agreement requires that EmblemHealth provide restitution to members who were improperly denied coverage for gender reassignment surgery, and pay \$250,000 in civil penalties to New York State.

### MEDICATION DENIALS

HELPLINE

ADVOCATES

HAVE HELPED

MANY NEW

YORKERS

OBTAIN

MEDICATION

DEEMED

MEDICALLY

NECESSARY BY

THEIR

PHYSICIANS.

### (3) Access to Prescription Drugs

**HCB consumer complaints concerning access to prescription medication constituted about 6% 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:

- Denial of coverage or imposition of higher copayments for prescribed drugs that are not on the insurance plan's formulary or 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 Amyotrophic Lateral Sclerosis (“ALS”) Medication Is Reversed.** A consumer contacted the Helpline because his health plan denied coverage of a new drug, Radicava, for treatment of ALS, as not medically necessary. His doctor had prescribed Radicava because the drug has been shown to slow the decline of symptoms of ALS. The health plan would not cover the drug because the patient’s lung capacity was less than eighty percent, deeming the member too sick to benefit from the drug. The consumer’s physician had filed a second-level appeal and shortly thereafter, the member sent a letter of medical necessity and progress notes from a different doctor in support of that appeal. The health plan upheld the appeal fewer than two weeks later. The Helpline advocate persisted, and requested that the health plan review the denial again. The Helpline advocate highlighted the physician’s opinion that the lung capacity was irrelevant to the inquiry, and that Radicava was needed to preserve the members’ strong muscles. The Helpline advocate added that the FDA had approved the drug for all patients diagnosed with ALS, clearly stating “although there are some reasons to believe that [Radicava’s] efficacy may decline with increasing disease severity, this is by no means established, and the indication should not limit use to a particular level of disease severity” and “the basic premise – that patients with less severe disease are able to benefit from [Radicava] whereas those more severely affected are too sick to benefit – is not supported by the totality of the data.” The health plan overturned the denial and approved the medication.
- **Denial of Coverage for Anti-Cancer Drug Is Reversed.** A consumer was diagnosed with Hodgkin’s lymphoma (cancer of the immune system) and was receiving aggressive chemotherapy. Due to her young age and the desire to avoid chemotherapy and its side effects, the patient’s oncologist wanted to prescribe brentuximab vedotin, a drug recently approved by the FDA. The health plan denied a preauthorization request, and despite a peer-to-peer review, it denied an expedited first-level appeal as not medically necessary. The consumer contacted the Helpline. The Helpline advocate investigated, and found that the doctor submitted a second-level appeal objecting that a pediatrician and not an oncologist reviewed the case. The Helpline advocate submitted a priority complaint to the health plan asking to join the appeal, and specifically asked that an oncologist review the case. The health plan relented, and, after review by an oncologist, the plan approved coverage of the medication.
- **Health Plan Finds Hardship Exception to Mail Order Requirement.** Consumers, a husband and wife, filed a complaint with the Helpline, requesting delivery of their medications to a pharmacy of their choice instead of mail order, as required by the health plan. The husband was using Methimazole for Grave’s Disease, and the wife was using Synthroid, and Lyothyronine Sodium for thyroid cancer. The consumers were concerned because the mail order pharmacy was delivering their medications at

contraindicated temperatures. The Helpline advocate sent an inquiry to the consumers' health plan citing the FDA recommendations that Methimazole and Synthroid be stored at room temperature and cited the U.S. Library of Medicine to illustrate that Lyothyronine Sodium should be stored at cold temperatures. The health plan agreed to provide a hardship exception for the three medications for one year, allowing consumers to pick up their medications at their local pharmacy.

## Enforcement Actions

- **Accredo Health Group, Inc. Agrees to Address Key Service Issues including Delivery Delays for Life-Sustaining Medication.** Accredo is a specialty pharmacy that dispenses drugs via mail order to health plan members and their physicians. The HCB initiated an investigation after the HCB Helpline received dozens of health care consumer complaints regarding Accredo's services. The consumers often suffered from serious diseases like cancer, rheumatoid arthritis, and HIV. Among their complaints were allegations of delays in mail-order deliveries of life-sustaining medication, privacy concerns with respect to deliveries, prescription errors, billing errors, lack of language access for non-English speakers, and long telephone wait times when calling Accredo for assistance. After an investigation revealed many consumer shortcomings, Accredo entered into a settlement agreement to improve its services by: (1) dispensing an urgent prescription on the day required or facilitating the dispensing of the prescription from a retail pharmacy; (2) adopting the "New York Pharmacy Customer Bill of Rights for Language Services" (to include training and monitoring of pharmacy staff) and a "Language Assistance Policy"; (3) informing patients of their right to free language assistance services; (4) recording all after-hours calls and ensuring that patients who are referred to a pharmacist receive call-backs within two hours; (5) ensuring that RN and LPN counselors are licensed in New York State; (6) recording all patient complaints/queries and auditing resolutions; (7) disclosing to plans, patients, and providers on its website that all patients may not require Accredo "specialty" services; and (8) undergoing an independent audit covering the relief specified in the agreement. Accredo paid \$375,000 to the State of New York as part of the agreement.

Note: While New York insurance law (the "Anti-Mandatory Mail Order Law") requires that plans afford consumers the choice of obtaining drugs at a retail brick and mortar store instead of via delivery, the law only provides that choice to consumers if the retail store offers prescriptions on the same terms and conditions as the mail order company. Because Accredo offers special services that brick and mortar pharmacies usually do not (e.g., 24 hour telephone assistance), consumers may not always be able to avail themselves of the New York law.

### (4) Provider Billing Practices

**A significant number of consumer complaints (41%) raised concerns about provider billing practices.** Although state regulations and many provider health insurance contracts forbid participating in-network providers from "balance billing" consumers,<sup>4</sup> some in-network

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<sup>4</sup> "Balance billing" occurs when a provider bills a patient for the difference between the amount charged and the amount that the patient's health plan paid. When a provider is in-network, there is an agreement to accept the

providers who have agreed to accept the contracted payment from the insurance company nonetheless improperly bill consumers and pursue payment by filing 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 far 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.

- **In-Network Provider Improperly Bills Consumer.** A consumer complained that an in-network ambulance company billed him in the amount of \$268. The bill was improper “balance billing” – a bill for the amount remaining from the initial charge after the health plan’s payment of the “allowed” amount. The consumer had been unable to stop the ambulance company from its improper billing, and the company sent the account to collection. The Helpline advocate sent the complaint to the ambulance company, and the company acknowledged that it was indeed a participating provider with the health plan, and should not have balance billed the consumer. The company canceled the bill and recalled the account from collection.
- **Provider Improperly Codes Preventive Colonoscopy as Diagnostic.** A consumer saw a physician for a colonoscopy, which was preventive in nature and accordingly should have been processed at no cost to the consumer. However, the physician’s office filed a claim with the health plan for a *diagnostic* colonoscopy because the physician found polyps during the procedure. Coding the colonoscopy as diagnostic resulted in the provider billing the consumer \$3,955. The Helpline advocate filed a complaint with the provider, explaining that the discovery of polyps through an initial preventive colonoscopy may not lawfully transform the procedure from preventive to diagnostic. The physician’s office recoded the claim as preventative, and removed the patient balance.
- **Provider Orders Lab Work Specifically Declined by Consumer.** A consumer complained that at his annual physical, the provider asked that he sign consent forms for various tests to be performed. The consumer thought several of the listed tests were unnecessary and told his medical provider that he was consenting only to “standard” lab work, declining some specified tests, including HIV, hepatitis, measles, mumps, and rubella. Notwithstanding the consumer’s decision to decline these tests, the provider

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insurance payment as payment in full (less any co-insurance responsibility), and the provider is not permitted to balance bill the patient. Balance billing is not improper, however, if the provider is not in the health plan’s network.

ordered lab work for approximately twenty different tests, some of which the consumer had specifically declined, and the lab billed the consumer for all tests conducted. The consumer's insurance had approved the claims, but the charges were applied to his deductible. The consumer contacted his medical provider to complain, and despite the provider's acknowledgment that tests may have been improperly ordered, the charges from the lab remained. The Helpline advocate explained the basis of the complaint to the medical provider, noting in particular that the consumer had brought his concerns to the attention of staff prior to receiving services, and that he had not signed consents/authorizations for some of the billed tests. The advocate further asked the medical provider to reach out to the lab to resolve the charges in dispute, and hold the consumer harmless for any unauthorized tests. The medical provider defended the tests as properly ordered based on medical judgment, but acknowledged they did not have authorizations on file, and opted to pay the lab the disputed amount of \$177.

## Enforcement Actions

- **New York Hospitals Pay Restitution to Patients and Change Billing Procedures for Forensic Rape Examinations.** As a result of last year's benchmark settlement with The Brooklyn Hospital Medical Center ("Brooklyn Hospital"), which was initiated after the HCB received a complaint that a survivor of sexual assault was billed seven separate times for a forensic rape examination ("FRE") administered in Brooklyn Hospital's emergency room, the HCB initiated an ongoing investigation into the improper billing practices of New York hospitals for FREs. This ongoing investigation has led to agreements with six New York hospitals and a university to pay restitution to patients and change billing procedures for FREs. The facilities include Brookdale University Hospital Medical Center, Columbia University, Montefiore Nyack Hospital, New York Presbyterian/Brooklyn Methodist Hospital, New York-Presbyterian/Columbia University Irving Medical Center, Richmond University Medical Center, and St. Barnabas Hospital. The investigation found pervasive failures to advise patients of their payment options, and widespread unlawful billing of sexual assault survivors. The ongoing investigation has already revealed at least 200 unlawfully billed FREs at the seven settling hospitals. Under the terms of the agreements, the hospitals will implement written policies to ensure that sexual assault survivors do not receive bills for their FREs, provide full restitution to any improperly billed sexual assault survivors, and pay costs.

Note: 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 cost to private insurance. The purpose of Executive Law 631(13) is to ease payment of FREs by providing for submission of bills to OVS; provide quality exams; and give survivors of sexual assault the ability to choose a means of payment for their FREs, either through the OVS program or their own insurance. Allowing sexual assault survivors to choose to have OVS directly pay for services helps ensure privacy and confidentiality.

## (5) Claim Processing and Payment Problems

**Fifteen 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.

### Notable HELPLINE Resolutions:

- **Health Plan Delay in Updating Credentials Leads to Incorrect Claim Processing.** A consumer was receiving physical therapy services by an in-network provider. From September 2016 to February 2017, the consumer had 25 visits and was required to pay only the \$20 copayment for each of the visits. She resumed services with five visits during July and August 2017, paid the copayment, and then was billed \$1,620 because the health plan at that point indicated the provider was out-of-network. The Helpline advocate contacted the health plan and provider. The health plan responded first, indicating that the physical therapist was in-network until April 2017, and then out-of-network when a new hospital took over the practice, until November 2017, at which time the therapist became in-network again. The provider's practice responded by indicating that the therapist was listed as out-of-network, but was actually in-network along with other employees of the practice because the health plan's credentialing records were not updated until November 2017. This meant the health plan incorrectly processed the consumer's claims as out-of-network, and the health plan then reprocessed the five claims as in-network, holding the consumer harmless.
- **Health Plan Error Delays Payment for Emergency Surgery.** A consumer complained that his health plan was not paying for an emergency appendectomy performed outside of the United States. His health plan covered the facility portion of the charges, but failed to pay the surgeon. The plan had initially requested a provider tax identification number, but since the doctor was located outside of the United States, he understandably did not have one. After two months, the Helpline advocate was

## CLAIMS PROCESSING

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



successful in getting the claim paid, but the plan paid the incorrect amount, paying the claim as an office visit (\$250) instead of surgery, \$1,700 – the amount due. The Helpline advocate persisted, and after three more months, the consumer reported that he received another check, but the payment was still insufficient. Again, the health plan processed the claim as an office visit. The Helpline advocate contacted the health plan again, and it responded that it needed a statement listing the procedure (appendectomy), date of the procedure, and charges for the specific procedure, notwithstanding that the health plan already had all of this information – including a receipt showing the consumer’s payment. The health plan also had an Explanation of Benefits showing the facility payment. Finally, the health plan paid the claim, but paid too much – \$8,000 instead of \$1,700. The consumer returned the difference to the health plan.

- **Health Plan Incorrectly Processes Coverage for Fertility Treatments as Out-of-Network Benefit.** A consumer filed a complaint with the Helpline indicating she had received fertility treatments that her health plan incorrectly processed as an out-of-network benefit. The health plan also gave the consumer contradictory information regarding whether or not the procedures needed pre-authorization, would be processed as an in- or out-of-network benefit, or if an appeal had been filed. Prior to her complaint, the consumer filed a first level appeal, which the health plan denied, then attempted to file a second level appeal, only to be told that her first appeal was never processed as an appeal. The Helpline advocate sent an inquiry with the consumer’s complaint to the health plan. The health plan reversed its determination and reprocessed the claims at the in-network rate. Savings to the consumer totaled \$7,180.

## (6) Obtaining and Keeping Coverage

**Nine percent of consumer complaints involved issues relating to obtaining and keeping coverage.** Of these complaints, 29% were due to health plan error and 11% were due to employer error.

### Notable HELPLINE Resolutions:

- **Health Plan Reinstates Coverage for 216 Consumers.** Several consumers contacted the Helpline because a particular health plan denied their applications for coverage as untimely, but the consumers claimed they submitted their applications by the December 15, 2017 deadline. The health plan explained that it deemed the applications incomplete, and therefore, untimely. Specifically, each application was missing page six, which included only a single question - “Did an agent help you?” The consumers had not returned that page with the application because they believed the health plan required that page six be returned only if the consumer received the assistance of a broker/agent. Even after the health plan agreed to reinstate the coverage of those consumers who had contacted the Helpline, the advocate persisted. The advocate requested that the health plan provide the number of consumers affected by the page six issue. Noting the vagueness of the current application, the advocate requested that the plan provide retroactive coverage to all members affected; discontinue its procedure of delaying/denying coverage when the enrollment application is returned without page six; or revise page six to make it clear that information must be provided even if an

agent/broker did not assist. The health plan conceded that language indicating that all pages of the document were required for processing had been inadvertently omitted from the application form, and agreed to reinstate coverage for 216 affected consumers retroactive to January 1, 2018. Moreover, the health plan changed its policy such that effectively immediately, applications would not be delayed or denied if page six was omitted.

- **One Day Delay in Posting Premium Results in Termination of Coverage.** A consumer submitted a Helpline complaint, explaining that her spouse's health plan unexpectedly and suddenly cancelled his health coverage. The couple had paid the premium by the due date. Adding to the crisis, neither she nor her husband had any advance notice of the interruption, and only discovered the termination when her husband attempted to refill his prescription medication. The Helpline advocate sent an urgent inquiry to the health plan, which immediately reinstated the consumer. The health plan explained that the member paid the required premium payment on the December 10 due date, but the payment did not post to his account until the following day, and as a result, he was terminated effective the first of the month.

## 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 2018, this response included:

- Challenging, along with Minnesota, the U.S. Health and Human Services' (HHS) rescission of \$1 billion in critical federal funding of New York's Basic Health Plan (BHP) – a program that makes affordable health insurance available for low-income New Yorkers, by filing a legal action, *New York v. Hargan* in federal district court. Some months after filing suit, HHS issued a final methodology that resulted in the restoration of approximately \$765 million in BHP funding for 2018 – close to New York's expected BHP funds for that year.
- Challenging, along with 11 other states, the Trump administration's issuance of a final rule allowing for the proliferation of Association Health Plans (AHP) in *New York v. U.S. Department of Labor*. The rule would undo critical consumer protections put into place by the Affordable Care Act (ACA) and unduly expand access to AHPs without sufficient justification or consideration of the consequences. Ultimately, the rule would lead to several million enrollees shifting out of the ACA's individual and small group markets into AHPs with far fewer health benefits and would increase premiums for those remaining in the individual ACA market.
- Challenging the Trump administration's final rule 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 rule.

- Criticizing the Trump administration’s proposed rule that would expand Title X’s prohibition on the use of federal funds in programs where abortion is a method of family planning by submitting critical comments to the draconian rule. Among other things, the “Gag-Rule” would effectively prohibit referrals for abortion services and make it nearly impossible for abortion providers to participate in the critical Title X program.
- Criticizing the Trump administration’s proposed rule to “Protect[] Statutory Conscience Rights in Health Care,” a rule designed to provide additional enforcement of the statutory protections for health care workers who object to providing certain services, including abortion and sterilization procedures, based on their religious beliefs or moral convictions. New York filed a comment letter in opposition to this proposed rule on behalf of 10 states.

## 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 2018, the TCE’s successes included:

- **Tobacco Master Settlement Agreement (“MSA”) Payments.** In 2018, New York State received more than \$650 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 \$126 billion in payments to the States. The litigation that resulted in the MSA was filed in 1998.
- **\$35.4 Million Settlement – FedEx to Retain Consultant for Two Years to Comply with Law and Change Internal Practices.** On the eve of trial, and subsequent to the U.S. District Court for the Southern District of New York ruling that the State and City of New York proved FedEx was liable for its knowing delivery of contraband cigarettes throughout the State of New York thereby violating the federal Contraband Cigarette Trafficking Act (“CCTA”), New York State’s delivery ban statute (“PHL 1399-ll”), and an Assurance of Compliance that the carrier had entered into with the OAG in 2006, FedEx agreed to settle three lawsuits for \$35.4 million. FedEx also agreed to employ a two-year consultant to oversee FedEx's compliance with the settlement agreement in addition to assisting FedEx with implementing internal practices to comply with the law.

- **Comment Letter Urging the FDA to Ban the Use of Flavors in All Tobacco Products.** On March 21, 2018, the FDA issued the Advance Notice in order to solicit information related to the role that flavors play in the use of tobacco products. As part of its rulemaking process, the FDA sought comments, data, research, and other results regarding flavored tobacco and its impact on certain populations. New York lead a bipartisan coalition of nine Attorneys General submitting comments urging the FDA to ban flavored tobacco products. Research has shown that flavored tobacco products are appealing to youth, leading them to begin using the products at a young age. The majority of middle and high school students who use e-cigarettes, cigars, or hookah use flavored products. In addition, use of tobacco products puts youth and young adults at a greater risk for developing coronary artery disease, cancer, and other tobacco-related diseases. Moreover, menthol cigarettes are more likely to pose a greater public health risk than non-menthol cigarettes. Menthol cigarette usage is higher in not only youth tobacco users, but also in minority populations.

## CONCLUSION

Medical insurance and delivery of health care in the United States is complicated and can be daunting for consumers to navigate. The Health Care Bureau's dedicated team of advocates, attorneys and support staff worked diligently in 2018 to resolve New Yorkers' wide-ranging health care-related issues. Denial of services, denial of claims, and billing problems can leave a person frustrated and discouraged, and medically at risk. Our advocates exist to resolve consumers' problems where possible and to help consumers understand the mysteries of the health care system where there is no violation. In a number of cases in 2018, HCB escalated concerns voiced by consumers in Helpline complaints to broader investigations, often resulting in impactful resolutions that benefitted a larger group of individuals. We thank the people who alerted us to these important issues. We will endeavor in 2019 to bring the same vigor to championing the rights of consumers and enforcing the laws and regulations that govern the health care industry.

**New York Attorney General Letitia James acknowledges the work of the Health Care Bureau team and thanks in particular the members of the Health Care Bureau Helpline who so skillfully handle and resolve individual consumer complaints.**

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