

State of New York
Office of the Attorney General
Health Care Bureau

2003 Health Care Helpline Report



-Complaint Patterns-
-Consumer Tips-
-Reform Recommendations-



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Acknowledgments

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This report is dedicated to the Health Care Bureau Helpline's staff. Their compassion, commitment, and perseverance inspire us all.

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EXECUTIVE SUMMARY

HEALTH CARE HELPLINE

Staff of the Health Care Helpline of the Attorney General's Health Care Bureau (HCB) handled 7,745 cases between July 1, 2002 and June 30, 2003, an increase of 30% in the number of cases handled in the previous twelve month period. Of these 7,745 cases, 2,578 were consumer complaints resolved by Helpline staff and 4,508 were consumer inquiries to which Helpline intake staff responded by providing information or referrals to other agencies. Complaints from providers accounted for the remaining 659 cases.

This report:

- analyzes the 2,578 individual consumer complaints that were investigated by HCB staff;
 - these complaints involved: (1) claims processing and payment problems; (2) denials of care or coverage by health plans; (3) problems gaining access to specialty care and out-of-network care; (4) problems getting and keeping health insurance coverage; (5) billing errors by providers; and (6) access to prescription drugs;
- describes investigations and enforcement actions against health plans, providers, pharmaceutical manufacturers and other entities operating in the health care market;
 - the HCB's objective in these enforcement actions has been to protect consumers' health care rights, to rectify systemic problems, and to provide restitution to affected consumers;
- provides tips to consumers about how to protect their rights and maximize their health care coverage; and
- proposes reform recommendations to address systemic problems.

Helpline staff assisted consumers in recovering \$3.9 million in additional care or coverage for care from health plans, providers and other entities. In Calendar Year 2003, the HCB's enforcement actions generated \$862,475 in

restitution to consumers in New York and \$344,500 in costs and penalties to the state.

Our Findings

An analysis of Helpline complaints reveals:

- that claims processing and payment problems, denials of care or coverage by health plans, and problems gaining access to specialty care and out-of-network care account for 65% of all consumer complaints received by the Helpline during the 12-month period covered by the report;
- that many consumers who call the Helpline are confused about their benefits, about the rules to follow to secure coverage for care, about doctor or hospital charges, about appeal rights, or about where to get help with some other aspect of health care; and
- some trends in 2003 Helpline complaints as compared to complaints analyzed in our 2002 report. Complaints about:
 - denials of care or coverage by health plans decreased from 23.2% to 17.4% of all complaints; and
 - retrospective denials of emergency care declined from 1.2% to 0.6% of all complaints.

CONSUMER COMPLAINTS AND HCB ENFORCEMENT ACTIONS: HIGHLIGHTS

Claims processing and payment problems

25% of all HCB consumer complaints arose from provider or health plan mistakes in preparing, processing or paying claims, and over half of these mistakes (16% of all consumer complaints) are made by health plans. The most common complaint relating to health plans' claims and payment processes (8% of all consumer complaints) is that health plans do not process claims at all or do not process them in a timely manner.

Reform Recommendations

- Mandate use of a model claim denial notice by all health plans to address inadequate and confusing denial notices.
- Fully fund New York's Managed Care Consumer Assistance Program to ameliorate widespread confusion on the part of consumers and their frequent inability to protect their rights and access benefits. This program was established in New York to fund local organizations to provide consumers with assistance and education regarding managed care issues.
- Provide statutory penalties for violations to better address non-compliance by plans and providers of the Managed Care Consumer Bill of Rights, which provides managed care consumers with rights to certain coverage information, an appeal and grievance process and other protections.

Health plan denials of care or coverage for care

17% of all HCB consumer complaints involved health plan denials of care or coverage for care. Medical necessity determinations (generally called Utilization Review or UR) that resulted in denials of care or coverage by health plans accounted for 7% of all consumer complaints.

Enforcement Actions

- Two years of monitoring six plans' UR practices reveals that the plans are in substantial compliance with the terms of settlement agreements with the Attorney General. These agreements required (i) denial notices to include the clinical findings relied upon in denying care and (ii) notice that failure to meet statutory deadlines for processing an appeal would result in an automatic reversal of the denial.
- The Attorney General entered into an agreement with BlueCross BlueShield of Western New York and BlueShield of Northeastern New York, divisions of HealthNow, to remove language from member identification cards that failed to properly inform consumers about their rights to obtain emergency care.
- Mutual of Omaha and two divisions of Excellus Health Plan corrected their contracts and/or denial notices that contained incorrect or incomplete definitions of "pre-existing condition," and reviewed 156 claims and 16,621 claims, respectively, that were denied since 1997. As a result, approximately \$400,000 in restitution was paid to consumers.

Access to specialty and out-of-network care

22% of all HCB consumer complaints involved problems accessing or paying for specialty medical care. The majority of these complaints concerned health plans' inadequate "usual and customary" reimbursement of non-participating providers, which leaves consumers with a hefty portion of the bill. Other complaints demonstrated consumer confusion about specialist referral or pre-authorization processes and health plan errors in administering these processes.

Complaints from HMO consumers who were denied coverage for out-of-network services that they believed were necessary because no similarly qualified in-network providers existed highlight a flaw in the UR appeals process. Because such denials are considered to be coverage denials rather than medical necessity denials, they can only be challenged through a plan's internal grievance process, with no right to an external review.

Reform Recommendation

- Allow consumers access to the external appeals process to review disputes about denials of out-of-network referrals to specialists.

Getting and keeping coverage

17% of consumer complaints involved getting and keeping coverage. Employers are frequently responsible for loss of coverage. Consumers complain that some employers terminate coverage without informing employees, neglect to pay premiums (even when employees have paid their share of the premiums), and refuse to allow employees to continue coverage as required by state and federal law (commonly referred to as COBRA).

Enforcement Actions

- In resolving consumer complaints, the HCB found that Health Insurance Plan of Greater New York (HIP) had improperly terminated and Health Net of the Northeast (Health Net) had threatened to improperly terminate the individual health insurance policies of members when they reached age 65 and allegedly became eligible for Medicare even though federal and state law allowed members to renew these policies at their option. Settlement agreements signed with both plans provide for reinstatement and other restitution to affected members.
- Attorney General Eliot Spitzer and State Superintendent of Insurance Gregory V. Serio sued an Albany health plan, Universal Value Care, sold by Millennium Business Association of America, Inc., for operating an unlicensed insurance business, engaging in deceptive business practices, and failing to demonstrate adequate reserves from which to pay promised benefits. The court granted an immediate temporary restraining order to stop operation of the plan and later approved a settlement that provided for a \$100,000 fund to pay claims and other restitution to consumers.

Billing errors by providers

13% of HCB consumer complaints were prompted by a provider's improper or illegal billing of consumers. Although state regulations and many

participating provider contracts prohibit providers from billing consumers in most instances, some providers illegally bill consumers and subject them to collection actions.

Enforcement Actions

- The HCB began an investigation of Quest Diagnostics, Inc., the nation's largest diagnostic laboratory, after receiving complaints from consumers that it had balance billed them. The HCB found that Quest was improperly balance billing consumers by billing them for the entire balance of the bill when it had submitted a claim to the consumer's health plan but received no response from the plan. Quest agreed to cease billing consumers in this situation and to provide restitution to consumers who were improperly billed in the past.
- After investigating complaints from consumers, the HCB found that Atria Communities, Inc, one of the nation's major operators of senior living facilities and adult homes, charged New York residents a mandatory, non-refundable "Community Fee" of up to \$5,000 for supplemental services beyond those required to be provided by state law. The Attorney General's settlement with Atria requires it to revoke the community fee, not impose any other mandatory fee for services unless the fee complies with applicable law, and refund all or part of the fee to certain former residents of Atria's facilities.
- The HCB continued to survey nursing home admission contracts and found that many contained inaccurate, misleading and, in some cases, illegal language requiring third-party guarantees. The contracts also stipulated arbitrary grounds for discharging residents. Six nursing homes across the state, joining nine others that settled with the HCB in June 2001, agreed to change their admission contracts by eliminating (1) third-party guarantees that impose financial obligations on families as a condition of admission and (2) vague language that allowed wide latitude to discharge residents involuntarily (although none of the homes had billed third parties or involuntarily discharged residents illegally).

Access to prescription drugs

5% of HCB consumer complaints were about access to prescription drugs. With drug costs rising precipitously, health plans are moving to limit such costs, primarily through the use of formularies – lists of covered medications.

Consumer complaints about prescriptions involved the use of formularies and “switching” – the practice of switching consumers from a brand-name medication to a generic one or from one brand-name drug to another that the plan “prefers” (usually because it saves the plan money through price reductions or rebates). Other complaints involved the health plan or pharmacist cutting the number of pills dispensed per visit and difficulties with prescription mail order returns and reimbursement.

Enforcement Action

- The Attorney General sued GlaxoSmithKline, Pharmacia and Aventis for conducting elaborate illegal schemes to inflate the price of prescription drugs for consumers and government health plans. The ongoing lawsuits focus on the companies' reporting of the "average wholesale price" that Medicare, Medicaid and EPIC use as the base for reimbursement for drugs. The companies are alleged to have reported an inflated average wholesale price in relation to the lower price charged to doctors, pharmacists and other health care providers. The companies exploit this "spread" to market their drugs, improperly inducing doctors to prescribe drugs and thereby increasing the companies' market share. This litigation is still pending.

Introduction

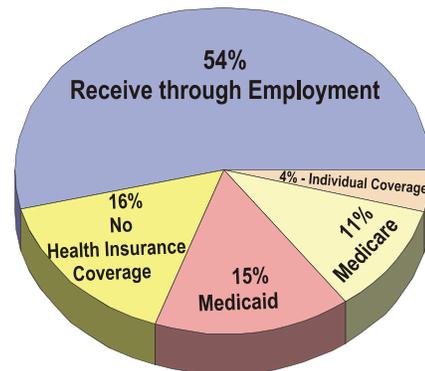
Health Care INSURANCE IN NEW YORK STATE

Consumer Confusion: A Maze of Coverage Options and Benefit Eligibility Rules

New Yorkers with health insurance coverage receive it from a variety of sources – 54% receive health coverage through employment, 15% have coverage through Medicaid, 11% have Medicare, 4% have individual direct-pay insurance contracts with private insurers, and 16% have no health insurance coverage at all.¹

Within the health insurance marketplace consumers are given a choice of coverage options. For convenience, we use the term “health plan” in this report to refer to the many variations of health insurance and managed care plans, except when we discuss a specific type of plan. Listed below are various types of health plan options.

Health Insurance Coverage Sources for New Yorkers



- Network-model Health Maintenance Organizations (HMOs) create a “network” by contracting with a variety of hospitals and physicians to provide services. “Classic” or “pure” HMOs require patients to have pre-authorizations for certain services and referrals to see specialists, and generally do not pay for services received from an “out-of-network” or “non-participating” provider.
- HMO-Point of Service (HMO-POS) plans are a more flexible version of the Network HMO. They provide some level of coverage for members to go out-of-network and may not require pre-authorizations and referrals.
- Preferred Provider Organizations (PPOs) are networks of doctors, hospitals and other providers that are individually contracted with the PPO to provide services. In PPOs, consumers typically have more flexibility to choose their doctors and are not limited to doctors in one particular group. In general, PPO members do not have to get a referral to see a specialist.

- Fee-for-service means that the doctors and hospitals are paid a fee for each service provided to a health care consumer. Consumers are not restricted to any particular doctor or hospital.

New Yorkers with No Health Insurance

Approximately 2.9 million New Yorkers lack any kind of health insurance.² Most of the uninsured are working adults and nine out of ten uninsured workers do not have access to employer-sponsored coverage.³ Many of these workers are not eligible for government subsidized coverage (or if they are eligible but they do not know about it) and cannot afford individual coverage available in the market.⁴ Uninsured consumers frequently avoid seeking medical care or struggle to pay high bills once they do get care. Further, the uninsured are vulnerable to scams that involve unlicensed health insurers or unscrupulous medical discount card offerings that promise low premiums and great savings on health costs – promises that are often too good to be true (See Chapter 4).

Consumer Rights

New York health care consumers enjoy a range of rights and protections. Both Medicare and Medicaid provide an array of grievance and appeal rights, while most consumers with private health plans receive three primary areas of protection under New York's Managed Care Consumer Bill of Rights (MCCBOR):⁵

- the right to contest certain health plan decisions through mandatory grievance and utilization review appeal procedures;
- the right to access specialty, out-of-network and emergency care; and
- the right to obtain a range of information about the health plan in which the consumer is enrolled or would like to enroll.

In addition, New York's general consumer protection laws that forbid deceptive business practices, fraud and false advertising protect both insured and uninsured consumers from the illegal practices of entities that operate in the health care marketplace - health plans (licensed or not), hospitals, doctors, laboratories, or pharmaceutical manufacturers.

Helping to ensure that consumers are made aware of these rights, understand how to exercise them, and receive any necessary help for such

exercise constitutes a core function of the Attorney General's Health Care Bureau (HCB).

THE HEALTH CARE BUREAU AND THE HEALTH CARE HELPLINE

The HCB is part of the Division of Public Advocacy in the Office of the New York State Attorney General. The HCB protects and advocates for the rights of all health care consumers statewide through:

- **Operation of the Health Care Helpline.** Staff on this toll-free telephone helpline assist consumers by providing helpful information and referrals, investigating individual complaints, and attempting to find a resolution that will help to ensure that each consumer obtains access to the health care to which the consumer is entitled.
- **Investigations and enforcement actions.** These activities target health plans, providers, pharmaceutical manufacturers, and other individuals and entities that engage in fraudulent, misleading, deceptive or illegal practices in the health care market.
- **Consumer education.** Through education initiatives, the HCB seeks to acquaint New Yorkers with their rights under the MCCBOR and other health and consumer protection laws.
- **Legislation and policy initiatives.** Such projects are aimed at enhancing the rights of health care consumers and their ability to obtain good quality, affordable health care in New York State.

Health Care Helpline

The HCB Health Care Helpline is the Attorney General's front line in registering and resolving consumer complaints regarding health care. The HCB handled 7,745 cases between July 1, 2002 and June 30, 2003 (see Table on page 5 for a breakdown of consumer complaints). Of these 7,745 cases, 2,578 were consumer complaints resolved by Helpline staff and 4,508 were consumer inquiries to which Helpline intake staff responded by providing information or referrals to other agencies. Complaints from providers accounted for the remaining 659 cases.

The work of the Helpline can be divided into three critical consumer assistance functions:

- helping consumers to challenge a denial of care or coverage for care by health plans. In the period covered by this report, Helpline staff assisted consumers in recovering \$3.9 million in additional care or coverage for care from health plans, providers and other entities;
- helping consumers to correct mistakes by providers or health plans that led to denials of care or coverage for care and a range of claim, billing and payment problems; and
- helping consumers to understand how to obtain benefits through their health plans or to understand the limitations inherent in the health care system.

Helpline staff play a pivotal role in both the functioning of the Helpline and the identification of systemic problems that become the focus of the HCB's enforcement actions. First and foremost, Helpline staff assist consumers with complaints by gathering information, helping consumers and their health plans identify the exact nature of particular disputes, putting each dispute in a legal context, and then moving the parties towards a resolution.

If a Helpline staff person, in consultation with an HCB Assistant Attorney General, identifies a pattern of conduct that suggests a provider or health plan is violating federal or state law by, for example, acting in a fraudulent or deceptive manner, the HCB may decide to investigate the matter further and may ultimately bring an enforcement action. Thus, the complaints and inquiries received by the Helpline provide invaluable information about the problems affecting New York's health care consumers and, in some instances, uncover illegal activity that the HCB can address through its enforcement actions.

The day-to-day experience of Helpline staff reveals the need for additional resources to assist health care consumers. Of all the players in the health care system, it is individual consumers who know the least about how the system works. Because New Yorkers are forced to navigate a maze of procedures, rules, rights, and remedies, often without the benefit of any prior experience or organized support, additional funding for expansion of the New York State Managed Care Consumer Assistance Program (MCCAP)⁶ and other consumer assistance organizations is clearly warranted.

THIS REPORT

The 7,745 cases handled by the HCB Health Care Helpline between July 1, 2002 and June 30, 2003 exemplify the experience of the state's health care consumers and indicate some stress points in the state's health care system.

The 2,578 consumer complaints in which HCB staff intervened on behalf of the consumer, involved six general areas: (1) claims processing and payment problems; (2) denials of care or coverage by health plans; (3) problems accessing specialty and out-of-network care; (4) problems getting and keeping health insurance coverage; (5) billing errors by providers; and (6) access to prescription drugs. Each of these categories is discussed in a separate chapter in the report. We note that three issues – claims processing and payment problems, denials of care or coverage by health plans, and problems accessing specialty and out-of-network care – account for 65% of all consumer complaints received during the 12-month period covered by the report.

Included in each chapter are descriptions of Helpline complaints that illuminate both the nature of the issue under discussion and the kind of assistance the Helpline provided to individual consumers.⁷ In addition, side-panels describe enforcement actions pursued by the HCB regarding that particular issue, offer tips to consumers on how to deal with problems or questions more effectively and present recommendations for reform of various systemic problems identified by the HCB through its work. Finally, we have highlighted certain trends and differences in complaints reported in this report and the 2002 Health Care Helpline Report. In reporting these trends, we note that the sample size is limited and that the 2003 report covers a shorter period of time (12 months) than the 2002 report (18 months).

| Helpline Cases by Type and Issue | | No. of Helpline Cases | % of Consumer Complaints |
|----------------------------------|--|-----------------------|--------------------------|
| Table | Consumer Complaints – Issue | | |
| 1 | Claims processing and payment problems | 652 | 25.3 |
| 2 | Denials of care or coverage by health plans | 449 | 17.4 |
| 3 | Access to specialty care and out-of-network care | 565 | 21.9 |
| 4 | Getting and keeping coverage | 438 | 17.0 |
| 5 | Billing errors by providers | 340 | 13.2 |
| 6 | Access to prescription drugs | 134 | 5.2 |
| | <i>Sub-total - Consumer Complaints:</i> | 2,578 | 100.0 |
| | Provider complaints | 659 | |
| | Referrals and information | 4,508 | |
| TOTAL | | 7,745 | |

The report does not analyze the 4,508 consumer referral and information inquiries identified in Table above (cases in which HCB staff provided information or a referral).

THE HELPLINE DATASET

All calls by the public to the Helpline are entered into a Microsoft Access database. The fields in the database allow for extraction of cases according to how they were handled (complaint, information, referral), the source of the inquiry (consumer, provider), the issue raised by the inquiry, and a range of other variables.

In general, this report describes consumer complaints in two ways, depending on how far an investigation had progressed by the time the report was written. In many cases, it is possible to determine whether a health plan or provider made a mistake or violated a law. In these cases, it is possible to assign a degree of responsibility for the problems at issue – for example, Table 2 refers to a category of cases with the phrase, “Denials of care or coverage caused by health plan error.”

At other times, however, it is not possible to know whether a dispute arose because of some mistake or violation of the law, or whether the complaint reflects the consumer's frustration with a valid denial of care, a legitimate bill, or simply the inherent imperfections of the health care system. In these cases, all that can be said is that a dispute arose between party A and party B on issue X. These kinds of cases are classified and labeled without denoting fault on the part of any party – such as in Table 2.2, “Covered benefit denials: Plan deems service ‘Custodial’.” Where it was possible to assign responsibility to one party or the other, the language in the report makes this clear; where all that is known for certain is the issue in dispute, the report avoids assigning fault, and no such element should be inferred.

CONSUMER COMPLAINTS – FINDINGS AND RECOMMENDATIONS

1. CLAIMS PROCESSING AND PAYMENT PROBLEMS

Helpline complaint patterns indicate that providers and health plans sometimes do a poor job of managing the claims and payment process. As Table 1 shows, one-fourth of all Helpline consumer complaints (25.3%) arise from provider or health plan mistakes in claims preparation, processing, and payment, and almost two-thirds of these mistakes are attributable to health plans.

It appears that consumers' problems with the health care system tend to begin with the paperwork and electronic transmissions that inevitably follow any doctor-patient encounter. This paperwork consists of providers and consumers preparing and submitting claims, health plans processing those claims, and those same plans issuing payments.

In HMO, HMO-POS plans or PPO plans,⁸ most of this paperwork passes between providers and health plans, increasingly by electronic means. The efficiency and accuracy of the entire claims processing system depend on the diligence of providers and the administrative competence of health plans. Consumers, generally speaking, play a small role and have little expertise.

| Table 1 Consumer Complaints Claims processing and payment problems | No. of Helpline Cases | % of all Consumer Complaints |
|---|--------------------------------------|---|
| Due to health plan errors | 421 | 16.3 |
| Due to provider errors | 230 | 9.0 |
| TOTAL | 651 | 25.3 |

claims, and those same plans issuing payments. In HMO, HMO-POS plans or PPO plans,⁸ most of this paperwork passes between providers and health plans, increasingly by electronic means. The efficiency and accuracy of the entire claims processing system depend on the diligence of providers and the administrative competence of health plans. Consumers, generally speaking, play a small role and have little expertise.

Claims processing and payment problems due to health plan errors

A health plan's failure to process claims at all or not process them in a timely manner accounts for nearly 10% of all Helpline consumer complaints (see Table 1.1 below).⁹

Ms. B called the HCB Helpline to file a complaint against her health plan for non-payment of claims. Ms. B's provider stated that he had submitted this claim four times but the plan had no record of receiving it. After the HCB submitted a copy of the claim with a letter of inquiry, the health plan responded that it had not received the claim until our intervention. The claim, in the amount of \$431, was processed and paid.

The state's "prompt payment" law requires health plans to pay "clean claims" within 45 days of receipt.¹⁰ If the health plan believes in good faith that it is not responsible for paying some or all of a claim, it must notify the consumer or provider in writing within 30 days of receipt of the claim it disputes, providing a specific reason why the plan believes it is not liable or specifying what additional information it needs to determine its liability for the claim. If the health plan does not promptly pay claims, it is subject to fines and must pay interest on late payments.¹¹

| Table 1.1 Consumer complaints Claims processing and payment problems Due to health plan errors | No. of Helpline Cases | % of all Consumer Complaints |
|---|--------------------------------------|---|
| Health plan not processing or paying claims | 247 | 9.6 |
| Health plan paid wrong amount | 28 | 1.1 |
| Health plan overpaid provider | 15 | 0.6 |
| Health plan paid wrong person | 15 | .06 |
| Health plan error regarding deductible or co-payment | 29 | 1.1 |
| Other claims processing or payment problems | 87 | 3.4 |
| TOTAL | 421 | 16.4 |

Payments of the wrong amounts, payments to the wrong person, mistakes in the application of consumers' deductibles, and the imposition of inaccurate co-payment amounts are examples of other processing errors.

| Reform Recommendations |
|---|
| Consumer Assistance and Information Disclosure |
| <ul style="list-style-type: none"> ○ Expand the Managed Care Consumer Assistance Program (MCCAP) through additional funding for existing MCCAP organizations and new MCCAP organizations to serve all of New York's geographic, cultural and linguistic communities.¹² ○ Amend the MCCBOR to prescribe statutory penalties for violations of its provisions. |

Denials of claims due to provider errors

Health plans rely upon the submission of timely, accurate and complete information by providers.

Late filing of claims is the most common provider error, followed closely by failure to submit sufficient clinical information to adjudicate the claim. Medical necessity determinations - or, more generally, "utilization review" - are a key aspect of managed care, and health plans will routinely insist on seeing additional clinical information from providers before approving coverage.

Entering the wrong diagnostic or procedure code on a claim form is the next most common provider error. In most situations where the mistake is typographical, only one or at most

two codes will be wrong, but this will almost always cause a mismatch between the diagnosis and the treatment. Health plan computer systems, which are set up to catch these types of problems, will reject such a claim, typically stating that the health service identified by the (incorrect) code is not medically necessary or is not a covered benefit.

Similar problems arise when a provider fills in the wrong claim form, fills in the correct form improperly, or submits the claim to the wrong health plan.¹³

Ms. T called the HCB after discovering a judgment totaling more than \$7,500 was entered against her by a hospital for services provided to her three years earlier. The hospital submitted its bill to Mrs. T's HMO after the claim filing deadline, so the health plan legitimately denied the claim. The hospital was a participating provider and should have filed an appeal. Instead, the hospital illegally balance billed Ms. T and then sued her when she did not pay. Following intervention by the HCB, the hospital agreed to vacate its judgment, and the HMO made an exception to policy and paid the claim.

| Table 1.2 Consumer complaints Claims processing and payment problems Due to provider errors | No. of Helpline Cases | % of all Consumer Complaints |
|--|--------------------------------------|---|
| Late filing of claim | 46 | 1.8 |
| Insufficient clinical information | 42 | 1.6 |
| Wrong diagnostic or procedure code | 25 | 1.0 |
| Participating provider failed to issue referral or obtain authorization | 19 | 0.7 |
| Other provider error | 98 | 3.8 |
| TOTAL | 230 | 8.9 |

Helpline staff often resolve cases by contacting the provider and asking that corrected information, or additional information, be submitted to the health plan. In many of these cases, the consumer had been making the same request for weeks, if not months, to no avail.

Consumer TipsAvoiding Provider and Health Plan Claims Errors

- Read your health insurance policy carefully to know the extent and limits of your coverage.
- Take special note of the services for which you have to pay – through co-payments, deductibles or co-insurance – and make sure you understand how much you have to pay and when.
- Keep a careful record of all health care expenses that may be applied toward your deductible. Keep receipts showing co-payments and co-insurance payments.
- Check that your provider is using the correct codes for the services you received and your medical diagnosis.
- If you are asked to pay a charge you do not understand, ask your plan or provider to explain the charge and to direct you to the relevant provision of your policy that requires it.

2. HEALTH PLAN DENIALS OF CARE OR COVERAGE FOR CARE

Most requests for coverage of health care services are approved by health plans. Nevertheless, the denial of coverage for health services according to established and legally permissible

criteria is an essential aspect of managed care and of health insurance generally. Health plan denials fall into two broad

categories: medical necessity denials

and covered benefit denials. As shown in Table 2, the HCB found that medical necessity denials are the most common consumer complaint brought to our attention during the period covered by this report.

| Table 2 Consumer complaints Health plan denials of care or coverage for care | No. of Helpline Cases | % of all Consumer Complaints |
|---|--------------------------------------|---|
| Medical necessity denials | 186 | 7.2 |
| Denials due to health plan errors | 135 | 5.2 |
| Covered benefit denials | 129 | 5.0 |
| TOTAL | 450 | 17.4 |

2003 Trends

From 2002 to 2003, consumer complaints to the Helpline about health plan denials of care or coverage for care declined from 23.2% to 17.4% of all complaints.

Medical Necessity Denials

Many health plans spend a significant amount of time and resources deciding whether a service or procedure is medically necessary. A denial of coverage on the ground that the service is not medically necessary is called an "adverse determination." While each plan has its own definition of medical necessity, generally a service is deemed medically necessary if:

- it is appropriate and required for the diagnosis or treatment of the patient's sickness, pregnancy or injury;
- it is safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications; and
- there is not a less intensive or more appropriate diagnostic or treatment alternative that can be used in lieu of the service or supply requested.

The medical necessity decision-making process is known as Utilization Review (UR), and is governed by New York's "UR Law" – Article 49 of the Insurance Law and Article 49 of the Public Health Law. UR can take place at three different stages: in advance of a requested service (known as pre-authorization or precertification), after the service has been delivered (known as retrospective review), and during the delivery of an ongoing service (known as concurrent review).

The UR Law ensures that:

- only medical professionals issue adverse determinations;
- decisions to authorize or deny care are made within a specified period of time (3 days for pre-authorizations, 1 day for concurrent reviews, and 30 days for retrospective reviews);
- consumers and their providers receive timely and informative notice of adverse determinations, including a clear statement of the reasons and clinical rationale, if any, for the denial; and
- consumers and providers have certain appeal rights:¹⁴
 - (1) a standard internal appeal or an expedited appeal, which are conducted by a clinical peer reviewer¹⁵ within the health plan who was not involved in the initial adverse determination;
 - (2) an external appeal to an independent clinical peer reviewer.¹⁶

HCBS Enforcement Action

Utilization Review Reform

Pursuant to agreements settling an enforcement action, the Attorney General monitored the UR practices of six major health plans over a two-year period ending December 31, 2003. Under the terms of each plan's agreement, denial notices had to include the clinical findings and data relied upon in denying health care and notice that failure to meet statutory deadlines for processing an appeal would result in an automatic reversal of the denial. In addition, plans had to send denial notices to doctors and hospitals so that they could exercise their independent right to appeal. The HCB's initial analysis of plan performance during the two-year monitoring period reveals that the plans are in substantial compliance with the terms of the settlement agreements.

Table 2.1 shows the frequency with which New York consumers contacted the HCB Helpline with complaints concerning health plans' UR practices.

| Table 2.1 Consumer complaints Health plan denials of care or coverage for care Medical necessity denials | No. of Helpline Cases | % of all Consumer Complaints |
|---|--------------------------------------|---|
| Pre-authorization denials | 54 | 2.1 |
| Retrospective denials | 17 | 0.7 |
| <i>Denials of emergency care</i> | 16 | 0.6 |
| Concurrent denials | 48 | 1.9 |
| Denials of care as experimental or investigational | 26 | 1.0 |
| Plan considered service to be "cosmetic" | 14 | 0.5 |
| Plan considered service to be "custodial" | 5 | 0.2 |
| Medical necessity - other | 6 | 0.2 |
| TOTAL | 186 | 7.2 |

Pre-authorization denials

As noted in Table 2.1, pre-authorization denials account for 2.1% of all consumer complaints. If a consumer does not get pre-authorization for a service which requires it, the plan may refuse to pay for the service, even if it would have "pre-authorized" the service if the consumer (or the attending doctor) had asked in advance. It may also refuse to pay for follow-up visits for services that were not pre-authorized, even if the consumer requests approval for later visits.

Mr. S received a pre-authorization from his plan for an MRI. However, his radiologist ordered a contrast MRI to determine the cause of his problem and his plan denied pre-authorization for this type of MRI. Mr. S contacted the HCB and was advised to file an external appeal. Mr. S requested an expedited external appeal, with support from his doctor that failure to act quickly would severely compromise Mr. S's ambulatory status. An independent external reviewer overturned the health plan's denial and Mr. S received full coverage.

If the consumer is somehow physically or mentally unable to request pre-authorization, or is prevented by some extraordinary situation, there is a

chance that the plan may excuse the error. In most cases, however, the consumer will pay a financial penalty for not getting pre-authorization.

A few examples of the many types of pre-authorization include: approval before going to a specialist in the network; approval before going to a specialist outside the network; seeking approval a week or two before admission to a hospital or for an operation; 24- or 48-hour notification to the health plan of admission to a hospital straight from the emergency room; and periodic approval for ongoing mental health visits and for additional hospital stays.

Retrospective denials

Retrospective review occurs, by definition, after care has been provided. While the majority of complaints received about such denials concerned emergency care claims, there was a significant reduction in such complaints this year (see box below).

2003 Trends

From 2002 to 2003, consumer complaints to the Helpline about retrospective denials of emergency care declined from 1.2% to 0.6% of all complaints. Such reduction may be linked to the Attorney General's enforcement action and subsequent advisory opinions from the state health and insurance departments clarifying plans' obligations to cover emergency care under the prudent layperson standard.

Under New York law, it is illegal to deny an emergency claim for lack of a physician referral where the presenting symptoms have met the "prudent layperson" standard.¹⁷ Health plans must cover emergency claims when the individual has symptoms that an ordinary, prudent layperson would consider to pose a serious health risk.¹⁸

Consumers are entitled to

coverage for claims that meet the prudent layperson standard even if the final diagnosis is not as severe as the patient originally thought. For example, if a patient with severe chest pains has an ultimate diagnosis of indigestion, the health plan generally must pay for the emergency room services.

Mr. A took his daughter to the emergency room because she was in excruciating pain caused by a cyst which needed to be drained. Mr. A's health plan stated that this was not an emergency and denied coverage. Mr. A was confused about his appeal rights. The HCB advised Mr. A that his time to appeal begins on the date of the denial letter and not from the actual date of service. Mr. A appealed his plan's denial and the claim was paid in full.

A related protection prohibits health plans from insisting that members receive pre-authorization before seeking emergency care.¹⁹ It is also illegal for health plans to require that consumers who have received emergency services notify the plan afterward as a condition for coverage of the care.²⁰

HCB Enforcement Action

Improper Notice of Coverage for Emergency Care

The HCB investigated complaints about some HealthNow member ID cards and found that many of the cards failed to properly inform consumers of their rights to obtain emergency care. For example, some cards instructed members to "contact your Primary Care Physician (PCP)" in the case of an emergency, and only "if not possible" to first contact your PCP, "proceed to the nearest urgent care center or emergency room" This language amounted to a pre-authorization requirement for emergency care, which is strictly prohibited under New York law. HealthNow agreed to issue new cards with improved language and review ER claims to reimburse any consumers who were erroneously denied.

Concurrent denials

Another form of UR that can lead to denial of care is concurrent review. Not all health plans perform concurrent review, but those that do tend to focus their attention on inpatient hospital stays, including inpatient mental health treatment. If a health plan has chosen to conduct concurrent review, it must decide within 24 hours of a request for continuing coverage of a health care service whether or not to approve the request. If the health plan needs additional information and requests it, the 24-hour time period begins when the plan receives that information. Clinical information passes back and forth between the provider and the health plan, and the plan makes a decision about the appropriateness of the care being provided.

Most concurrent review denials state that the patient's condition does not warrant the level of care being provided. This occurs most commonly when a hospital patient's condition has improved to the point where, according to the health plan, the patient can be safely discharged.

Ms. Q suffers from severe leg and back pain and, after trying many different treatments, found chiropractic services have been the only helpful therapy. However, Ms. Q's health plan refused to cover her for the full number of visits that her doctor believes is medically necessary to effectively treat her pain. The HCB wrote to the health plan requesting a review of the case and reconsideration of the number of visits. The health plan reversed its decision and Ms. Q received additional chiropractic visits.

Plan considered service to be “cosmetic” or “custodial”

New York law permits health plans to exclude coverage for cosmetic and custodial services.²¹ Generally, the determination of whether a health service is cosmetic or custodial is a medical necessity determination.²²

Denials of care as experimental or investigational

Most health plans only pay for services that have been proven safe and effective, rejecting those they deem “experimental” or “investigational.” Some providers, particularly specialists at the forefront of their field, may recommend procedures and treatments that have not yet been fully accepted in the broader health profession. Wary of approving a procedure that later turns out to be unsafe or ineffective, some health plans may rely on directories and manuals that list only the most widely used procedures and treatments.

Mrs. G underwent surgery for removal of a tumor in her jaw. She required treatment with Continuous Passive Motion (CPM) equipment, called a TheraPacer, a piece of durable medical equipment, as part of her recovery. The equipment was denied by her health plan as experimental. At Mrs. G’s request, the HCB presented the plan with a letter showing that the equipment was approved for treatment purposes by the Food and Drug Administration in 1993. The plan reversed its decision and paid for the equipment.

Denials Due to Health Plan Errors

Health plans sometimes erroneously issue denials and send bills to members, asserting that a member or a provider has made an error or failed to provide information when, in fact, the plans themselves are to blame for the supposed error or lack of information. Table 2.2 shows the most common types of errors by health plans.

| Table 2.2 Consumer complaints Health plan denials of care or coverage for care Denials due to health plan errors | No. of Helpline Cases | % of all Consumer Complaints |
|---|--------------------------------------|---|
| Coordination of benefits - primary/secondary | 57 | 2.2 |
| Improper “Late filing of claim” denials | 16 | 0.6 |
| Improper “Lack of information” denials | 17 | 0.7 |
| Improper “Not a covered benefit” denials | 38 | 1.5 |
| Other - including computer problems | 7 | 0.3 |
| TOTAL | 135 | 5.2 |

Complaints about incorrect denials also arise from the following situations:

- claims submitted within the required time-frame by both members and providers are not received and processed by the proper health plan staff and the services are therefore denied for “late filing of claim”;
- clinical information submitted by a member or a provider to support a request for coverage is not passed on to the proper department in the health plan, and a denial is issued for “lack of information”;
- health plans sometimes deny as “not a covered benefit” a health service that is in fact covered under the contract;²³
- a plan adjudicates a claim according to the wrong contract terms;
- the health plan enters or uses incorrect provider information, such as a tax ID number, and all claims submitted by that provider (using the correct number) are rejected as coming from a non-participating provider; and
- the health plan enters an incorrect diagnosis or procedure code, causing

Reform Recommendation

Utilization Review Practices: Denial Notices

Health plans should be required to use a standardized state-mandated denial form for all denials. Such a form could be similar to the one required for Medicare denials and, ideally, would include the phone numbers of the local MCCAP office and other consumer assistance organizations.

the claim to be denied.

Coordination of benefits – primary/secondary

Individuals are often covered by more than one health plan (e.g. their own plan and their spouse’s plan). In these situations, health plans need to “coordinate” the benefits being provided to the member. One plan will be primary, meaning that it must pay first. Once the primary plan has paid, it issues an Explanation of Benefits (EOB). The consumer then submits this EOB to the secondary plan, which may then (and only then) issue a payment to discharge its own obligation.

Mr. L retired from his job and became eligible for Medicare. He was also a covered dependent under his wife's health plan. Because his wife's employer employed more than 20 people, her plan was the primary payer for Mr. L's claims and Medicare was secondary. However, when Mr. L underwent a colonoscopy, the claim was incorrectly denied by his plan on the basis that Medicare was the primary payer. The HCB intervened, the plan corrected its records and paid Mr. L's \$1,400 claim.

Covered Benefit Denials

According to HCB Helpline complaints, when health plans deny coverage for a service as not a covered benefit, they often argue that the consumer has reached the benefit maximum under the contract or that treatment involves a "pre-existing condition" (see Table 2.3).

| Table 2.3 Consumer complaints Health plan denials of care or coverage for care Covered benefit denials | No. of Helpline Cases | % of all Consumer Complaints |
|---|--------------------------------------|---|
| Consumer has reached benefit maximum | 53 | 2.1 |
| Pre-existing condition | 41 | 1.6 |
| Denial of durable medical equipment / service considered a convenience | 26 | 1.0 |
| Other covered benefit denials | 9 | 0.3 |
| TOTAL | 129 | 5.0 |

Consumer Tips

Preventing Covered Benefit Denials

- Before receiving care, read your health plan benefits booklet and check with your health plan to make sure the treatment is a covered benefit.
- If the procedure or treatment is not a covered benefit, discuss your needs with your doctor; there may be a similar health service that is covered under your contract.
- Be sure to obtain a pre-authorization if required.
- Keep copies of all documents and notes of all conversations with your plan.
- If you receive a denial, file a grievance with your plan, stating why you think the care is covered. Get help from your doctor or from the Attorney General's Health Care Helpline at (800) 771-7755 (option 3).

Pre-existing condition

The Helpline assisted 41 consumers who were denied coverage for medical care because the care was for an alleged pre-existing condition. State and federal law require that a pre-existing condition be covered unless diagnosis or treatment of the condition was actually recommended or received within the six months prior to enrollment by the consumer in the plan.

If a pre-existing condition does exist, health plans can impose a waiting period before

providing coverage for the pre-existing condition, but the period cannot exceed twelve months after the enrollment date. A waiting period due to a pre-existing condition must be reduced by any amount of time the insured was previously covered under another health plan, as long as there was no break in coverage of more than 63 consecutive days between the end of membership in the prior plan and the start of membership in the current plan.²⁴

HCB Enforcement Action

Covered Benefit Denials: Pre-existing Condition

The HCB began an investigation of Excellus and Mutual of Omaha after receiving complaints that the plans had wrongly denied coverage due to alleged pre-existing conditions. The HCB found that the plans' contracts and/or denial notices contained incorrect or incomplete pre-existing condition definitions, and omitted or incorrectly stated the members' right to be credited with previous health insurance. Excellus and Mutual of Omaha agreed to correct all contracts and reviewed 16,621 and 156 denials, respectively, resulting in restitution of \$400,000 to consumers.

Consumer reached benefit maximum

A benefit maximum is a limit on the amount of benefits a health plan will provide to a given enrollee. This can take the form of limits on how many times a service can be received or how much money can be spent. A few examples of benefit limits are annual or lifetime limits on prescription drugs, out-of-network benefits, mental health care²⁵, and limits on total medical services.

Mr. H paid out-of-pocket for his prescriptions because his health plan claimed that he had reached his benefit maximum. The HCB contacted Mr. H's health plan and was advised that Mr. H has a lifetime maximum through his employer plan of \$50,000. After the HCB's inquiry, the health plan determined that Mr. H had used only \$44,419.16 of his lifetime maximum and accordingly had \$5,580.84 worth of coverage left. The health plan's computer system was corrected and Mr. H received reimbursement for his prescriptions.

Consumer Tips**Appealing Denials of Care**

- Appeal. Very few people who receive denials appeal, but most of those who appeal win more coverage. So, always appeal any denial of coverage for care that you and your doctor think is necessary - the odds are in your favor.
- Get a clear explanation in writing from your health plan of the reason your care was denied. You have a right to this explanation, so demand one if you don't receive it because this will help you prepare your appeal.
- Get your doctor to help you by writing a letter explaining why you need the care. If possible, have your doctor call the health plan's medical director on your behalf.
- Follow the time lines for submitting your appeal - submit it on time, send it by certified mail, and keep calling to find out the status. Keep a paper trail of everything you send to the health plan and a record of every time you call the plan and who you talk to.
- Get help with your appeal. Call the Attorney General's Health Care Bureau at (800) 771-7755 (option 3).

3. ACCESS TO SPECIALTY CARE

Health plans require or encourage their members to receive health care services from “participating” providers who are in the plan’s network of providers and who have agreed to accept the plan’s fixed rates as payment for such services. For example, HMO members generally receive coverage only for services received from participating providers and must have a referral to a provider of specialized care (e.g., a cardiologist) in order for such care to be covered. If HMO members follow these rules, their personal liability for such services is limited to a small co-payment amount, usually between \$5 and \$20.

PPOs encourage members to use participating providers by generally providing full coverage (except for a co-payment) for their services. Generally, PPO members do not need a referral to see a specialist and are usually free to visit non-participating providers, but they pay a much higher share of the cost of such out-of-network care.

| Table 3 Consumer Complaints Access to Specialty and Out-of-Network Care | No. of Helpline Cases | % of all Consumer Complaints |
|--|--------------------------------------|---|
| Consumer disputed plan usual & customary rate payment for out-of-network care | 195 | 7.6 |
| Consumer received out-of-network services w/out pre-authorization | 86 | 3.3 |
| Plan issued improper “No pre-authorization” or “No referral” denial | 29 | 1.1 |
| Plan refused a referral to an out-of-network provider | 53 | 2.1 |
| Consumer received surprise bill from unknown non-participating provider | 69 | 2.7 |
| Plan gave wrong information on the “participating” status of a provider | 38 | 1.5 |
| Consumer received an in-network service without pre-authorization | 54 | 2.1 |
| Access to patient records | 18 | 0.7 |
| Other | 22 | 0.8 |
| TOTAL | 564 | 21.9 |

Some health plans do not always appropriately reimburse consumers for out-of-network care. Moreover, it appears that some consumers do not understand the concept of in-network and out-of-network care and the need for a referral or pre-authorization to access certain types of care from certain types of providers. Further adding to the confusion and trouble for consumers, plans make mistakes in administering provider networks and in processing requests for coverage of specialty care (see Table 3 above).

Consumer disputed a plan's reimbursement of a non-participating provider

Complaints about reimbursement of a non-participating provider come from consumers – generally those with HMO-POS and PPO plans – who see a non-participating provider and call to complain that their plan paid the provider too little, leaving them with a hefty balance to pay themselves. Most plans pay a set percentage of what is often called the “usual and customary rate” (UCR) charged for a particular service,²⁶ and the member is liable for the remainder of the UCR plus whatever balance the provider charges.

| Example: Health plan payment to out-of-network provider (80% of UCR) and the amount left for HMO-POS or PPO member to pay | |
|--|-------------|
| Amount charged by out-of-network surgeon | \$10,000.00 |
| Health plan's "usual and customary rate" for this procedure | \$5,500.00 |
| Health plan pays provider 80% of UCR | \$4,400.00 |
| Balance owed by member | \$5,600.00 |

Plans draw up their own schedules of rates for health services, procedures, treatments, and items of equipment,²⁷ using data purchased from a commercial vendor that presents statistics on providers' charges across the country, broken down by treatment code, ZIP code, and other factors.²⁸ Judging by Helpline consumer complaints, some UCRs set by some health plans are lower than the amount customarily charged by providers in some areas of the state. Thus, some consumers with HMO-POS and PPO plans are shouldering an undue financial burden for using non-participating providers.

In adjudicating an out-of-network claim submitted by Mr. Z, a health plan noted that its UCR rate, based on a standard databank that it relied on for setting allowed charges, was substantially lower than the provider's charge and referred the claim for internal review. The plan determined that the appropriate reimbursement rate was 300% higher than the allowed charges. After contacting the HCB, Mr. Z appealed, still believing that the reimbursement rate was low, and the plan upheld its original determination but again submitted the case for internal review. Such review found that the member was entitled to an additional \$6,000.

Plan wrongly issued a “No pre-authorization” or “No referral” denial

Pre-authorizations and referrals issued by one department in the health plan are often not logged into the health plan’s computer system, resulting in a denial of care or coverage for care.

Plan refused to authorize a referral to an out-of-network provider

New York law provides HMO members with the right to full coverage for care from an out-of-network health care provider if their health plan does not have a participating provider with experience and expertise in the treatment or service needed.²⁹ An out-of-network referral is usually sought when (1) the member’s condition is unusual or unusually serious and (2) the member’s condition calls for either an uncommon medical service or a provider with unusual training and expertise that cannot be found within the health plan’s network.

In recent years, a debate has emerged over whether denials of out-of-network referrals necessarily involve medical judgment, or whether they are administrative in nature. The distinction is important because denials based on judgments about the medical necessity of a health service are governed under the UR Law, which guarantees (1) that all decisions at the initial stage and on appeal are made by medical professionals and (2) the right to an external appeal. Under the current statutory scheme, denials of out-of-network referrals are not deemed to be medical necessity determinations. Appeals of such denials are therefore handled as grievances, which cannot be externally appealed.

Reform Recommendation

Referrals to Out-of-Network Providers

Amend Article 49 of the Public Health Law and Article 49 of the Insurance Law to require that denials of referrals to out-of-network providers be treated as adverse determinations under the UR Law, allowing access to the external appeals process.

Ms. P underwent four separate operations to treat severe nasal blockage. The surgeries were performed by physicians who participated with Ms. P’s HMO. Because Mrs. P’s condition did not improve, her primary care physician referred her to an out-of-network specialist. When her HMO denied authorization for surgery with the non-participating surgeon, the HCB intervened. Eventually, the HMO Medical Director agreed to speak with doctors involved in Ms. P’s care, authorization for coverage of this care was

granted and Ms. P was treated by the out-of-network specialist, with successful results.

Consumer received a surprise bill from an unknown non-participating provider

A health plan member who goes to a participating provider or facility for covered services, is sometimes surprised by receiving a bill weeks later from a non-participating provider who was “brought in” during the procedure or service.

Under New York law, when a consumer in an HMO or an HMO-POS plan obtains a referral from a participating provider to a non-participating specialist, hospital or other facility, the consumer must be “held harmless” (i.e. not be held liable for any more than would be charged by a participating provider: the relevant in-network co-payment).³⁰

Consequently, if a participating provider involved in providing a service decides to “bring in” a non-participating provider, the matter should be resolved between the health plan and the participating provider. Nevertheless, some HMOs erroneously insist that members are responsible for the full cost of services provided by non-participating providers in these situations.

Ms. R underwent a tonsillectomy and began receiving bills from an anesthesiologist who did not participate with her HMO. However, because the surgery was performed by a participating surgeon at an in-network hospital, the \$300 claim should have been paid in full by the health plan. The HCB contacted Ms. R’s health plan and it issued full payment.

Consumer received an in-network service without pre-authorization

As already explained, referrals and preauthorizations are basic to HMOs. Members who want to receive certain specialized health services must first obtain a referral from their primary care physician (PCP) or a pre-authorization directly from the health plan. HMOs have the right to deny coverage for in-network services when a member did not get a referral or a pre-authorization. The 54 complaints on this issue suggest that some HMO members do not sufficiently understand how their health coverage works. They need more education, information, and guidance if they are to avoid unexpected bills.

Mr. V suffered a seizure, went to the hospital and received an MRI from a doctor who did not participate with his primary health plan, but did participate with his secondary plan. Instead of giving information on both plans, Mr. V only gave insurance information on the secondary plan because he thought it would cover the claim. The secondary plan initially paid, but then denied the claim after discovering another plan was primary.

The primary plan denied the MRI because Mr. V had not received prior authorization. With the help of the HCB, Mr. V appealed his primary plan's denial and the plan paid the \$1,900 MRI claim.

4. GETTING AND KEEPING HEALTH COVERAGE

A total of 17% of complaints concern access to and the affordability of health insurance coverage. In addition, a majority of information and referral calls handled by the Helpline (and not detailed in this report) concern these issues. Consequently, getting and keeping health insurance coverage is the single greatest issue that prompts New Yorkers to call the Helpline. This is not surprising given that there are 2.9 million uninsured New Yorkers and that many New Yorkers with employer-provided insurance feel insecure about the stability of such coverage.

Consumer complaints about getting and keeping health coverage break down into the eight categories listed in Table 4 below. Consumers called the HCB to file coverage-related complaints prompted by health plan errors (72 cases) and by policy terminations by employers and failures by employers to make premium payments (69 cases). Other consumers expressed confusion and affordability concerns about their coverage (65 cases) or complained about a complete lack of coverage (19 cases).

Enforcement Action

Protecting the Uninsured

In resolving consumer complaints, the HCB found that Health Insurance Plan of Greater New York (HIP) improperly terminated and Health Net of the Northeast (Health Net) threatened to improperly terminate the individual health insurance policies of members when they reached age 65 and allegedly became eligible for Medicare when federal and state law allowed them to renew these policies at their option. Settlement agreements signed with both plans provide for reinstatement and other restitution to affected members.

| Table 4 Consumer complaints Problems getting and keeping coverage | No. of Helpline Cases | % of all Consumer Complaints |
|--|------------------------------|-------------------------------------|
| Policy terminated | 69 | 2.7 |
| By employer | 48 | 1.9 |
| By health plan due to employer premium default | 21 | 0.8 |
| COBRA - problems getting enrolled / employer mistakes | 59 | 2.3 |
| Enrollment prevented or policy terminated - health plan error | 72 | 2.8 |
| Enrollment prevented or policy terminated - consumer error | 53 | 2.1 |
| Health plan computer glitches causing eligibility problems | 38 | 1.5 |
| Confusion or affordability | 65 | 2.5 |
| No insurance | 19 | 0.7 |

| | | |
|----------------------------|-----|------|
| Other eligibility problems | 62 | 2.4 |
| TOTAL | 437 | 17.0 |

Many New Yorkers do have health insurance through their employment and face the prospect of losing coverage or having to change health plans whenever they take a new job or lose a job, and whenever their employer terminates coverage. It is especially hard for consumers to understand that they might lose health coverage while still working at the same job. Judging from complaint patterns, it is a crisis many New Yorkers confront.

Policy termination by employer/union or health plan

The 69 consumer complaints classified in this sub-section each arose from either an employer's deliberate termination of its group health insurance policy or its failure to make premium payments to the health plan. In many of these cases, the employer was collecting premium payments from the employees' paychecks – and allowing the employees to continue to believe that they had health coverage – but was failing to forward the premiums to the health plan. Many of these premium non-payment cases involved businesses that were in serious financial difficulty or in bankruptcy. Employees frequently discovered after they had already received care that their plan had been terminated.

COBRA - Problems getting enrolled, employer mistakes

Fortunately, both federal and state law require employers to offer most terminated employees and their dependents continued health coverage for either 18, 29 or 36 months, if employees pay the premiums (such continuation coverage is commonly referred to as "COBRA").³¹ However, few people take advantage of their COBRA rights. The reason: it is simply too expensive.

Consumer Tips

Protecting your COBRA rights

- When you lose or leave your job, ask your employer for information and forms to enroll in COBRA continuation coverage. If possible, do so in advance.
- Always comply with all COBRA enrollment and premium payment deadlines.
- For more information, go to [www.ins.state.ny.us/faqs1.htm #cobra](http://www.ins.state.ny.us/faqs1.htm#cobra).
- If your employer refuses to comply, contact the Attorney General's Health Care Helpline at (800) 771-7755 (option 3).

Many of the Helpline's COBRA-related calls and letters during the relevant period were from employees facing the possibility of layoff who wanted to make sure they understood in advance how to enroll in COBRA. Many

others, however, were from consumers whose employers had failed in one way or another to fulfill their clear legal obligations, with the result that consumers and often families had lost their coverage. The most common failures by employers were not telling employees in advance about COBRA; not providing them with enrollment forms and other materials; and not telling them about filing deadlines.

Mr. F left his place of employment and wanted to continue his health insurance coverage. The employer believed he was not obligated to offer continuation coverage because he had less than 20 employees and because federal law only requires employers to offer continuation of coverage for groups of 20 or more people. HCB contacted the employer and informed him that New York law requires continued coverage for groups of less than 20.

Employers' failures often leave consumers without health insurance coverage at a time when they are financially most vulnerable. And, again, consumers are often the last to learn that their coverage has been terminated, receiving denial notices and even collection notices when they thought they would be fully covered.

Confusion, Affordability, and No Insurance

A growing number of consumers called the Helpline in 2003 to request information about advertised insurance plans and medical or prescription drug discount cards. Unfortunately, in some cases, the

advertised plans were operating in New York without a license or sufficient reserves to pay claims and the discount cards were engaging in deceptive business practices and false advertising. The HCB has brought enforcement actions against unlicensed plans (see box) and unscrupulous discount cards (see 2002 Helpline Report at www.ag.ny.gov). Additionally, the HCB has developed a consumer education brochure about discount cards to help consumers purchase such cards wisely, which is available at www.ag.ny.gov.

Enforcement Action

Protecting the Uninsured

Attorney General Eliot Spitzer and State Superintendent of Insurance Gregory V. Serio sued an Albany health plan, Universal Value Care sold by Millennium Business Association of America, Inc., for operating an unlicensed insurance business, engaging in deceptive business practices, and failing to demonstrate adequate reserves from which to pay promised benefits. The court granted an immediate temporary restraining order to stop operation of the plan and later approved a settlement that provided for a \$100,000 fund to pay claims and other restitution to consumers.

Mr. Z, an 85-year-old-man, received a call from someone offering to sell him a medical discount card. Mr. Z gave the telemarketer his checking account number over the phone and \$349 was deducted from his account. When Mr. Z did not receive his card, his son-in-law made several unsuccessful attempts to find out what he had purchased and then contacted the HCB. After a phone call to the discount card company, the HCB was able to obtain a full refund for Mr. Z. However, the HCB had many cases against this discount card company, which were referred to the Federal Trade Commission for investigation. See Enforcement Action box below.

Consumer TipUnlicensed Health Plans

Always check with the New York State Department of Insurance at 1-800-342-3736 before purchasing a health insurance policy to confirm that the health plan is licensed to do business in New York.

Enforcement ActionProtecting the Uninsured

The HCB Helpline and Consumer Frauds and Protection Bureau (CFB) received more than 80 complaints against MedPlan, a Canadian enterprise that purportedly sold a discount card but really duped consumers into providing their checking account numbers and then debited \$349 from their checking accounts without their permission. We were able to obtain refunds for most consumers. The HCB and CFB also teamed with the Federal Trade Commission (FTC) in conjunction with the Toronto Strategic Partnership, a cross-border fraud law enforcement partnership, to shut down this fraudulent scheme. A federal lawsuit has been filed in the U.S. District Court for the Northern District of Illinois.

5. IMPROPER BILLING BY PROVIDERS

As noted in Chapter 1, errors by providers in claims processing account for nearly 9% of Helpline complaints. Table 5 shows that 13.2% of Helpline complaints are prompted by providers' improper billing of consumers.³² Almost two-thirds of these complaints concern the balance billing of health plan members by participating providers, while the rest are about processing errors of one kind or another by doctors' offices, hospital billing departments, diagnostic facilities, and other health care providers.

| Table 5 Consumer complaints Improper billing by providers | No. of Helpline Cases | % of all Consumer Complaints |
|--|--------------------------------------|---|
| Balance billing by participating provider | 209 | 8.1 |
| Wrong amount or wrong code | 24 | 0.9 |
| Wrong person | 59 | 2.3 |
| Other billing problem | 48 | 1.9 |
| TOTAL | 340 | 13.2 |

Balance billing by participating providers

State regulations prohibit a provider from billing a consumer who is properly enrolled as a member of an HMO licensed to do business in New York State if (1) the provider participates with the consumer's HMO, and (2) the services rendered by the provider are covered benefits. If these two conditions are met, the provider must seek payment for covered services (other than applicable deductibles, co-insurance or amounts designated by the HMO as the consumer's responsibility in the certificate of coverage) solely from the HMO, not the consumer. The provider can bill a consumer only if the consumer is not an eligible member of the HMO or the services provided are not covered benefits under the consumer's certificate of coverage. To bill a consumer for any other reason constitutes prohibited "balance billing."³³ Similar protection is usually afforded PPO members through a "hold-harmless"³⁴ clause in the contracts between the PPO and its preferred providers.

Ms. G contacted the HCB after receiving a hospital bill in the amount of \$1,323.58. The HCB contacted Ms. G's health plan and confirmed that the hospital is a participating provider and that the hospital should have accepted the health plan's payment as payment in full pursuant to its contract with the health plan. After the intervention of the HCB, the hospital ceased billing Ms. G.

Participating providers who balance bill their patients often argue that they are forced to do so by the failure of the health plan in question to process and pay their claims in a timely manner.³⁵ Some providers even infer from a plan's lack of response to a claim that the patient was never a member of the plan or has lost coverage.

Enforcement Action

The HCB began an investigation of Quest Diagnostics, Inc., the nation's largest diagnostic laboratory, after receiving complaints from consumers that it had balance billed them. The HCB found that Quest was improperly balance billing consumers by billing them for the entire balance of the bill when it had submitted a claim to the consumer's health plan but received no response from the plan. Quest agreed to cease billing consumers in this situation and to provide restitution to consumers who were improperly billed in the past.

While health plans' mistakes and omissions may be a cause of genuine aggravation to providers, there is no justification for balance billing consumers in violation of state regulations and participating provider contracts. To make matters worse, some of the members who receive these providers' bills pay them because they do not know that laws or contract provisions specifically forbid the practice.

Mr. C, who has been diagnosed with prostate cancer, went to a participating hospital for outpatient services. However, Mr. C was balance billed by the participating hospital in the amount of \$2,625. After HCB intervention with the hospital and Mr. C's health plan, the hospital ceased billing Mr. C because it did so in violation of its provider contract with the plan.

The remaining complaints in this category result from a provider using the wrong diagnostic or procedure code on an otherwise appropriate bill for a consumer; and billing the wrong consumer entirely.

Enforcement Action

Protecting Nursing Home Residents

The HCB continued to survey nursing home admission contracts and found that many contained inaccurate, misleading and, in some cases, illegal language requiring third-party guarantees. The contracts also stipulated arbitrary grounds for discharging residents. Six nursing homes across the state, joining nine others that settled with the HCB in June 2001, agreed to change their admission contracts by eliminating (1) third-party guarantees that impose financial obligations on families as a condition of admission and (2) vague language that allowed wide latitude to discharge residents involuntarily (although none of the homes had billed third parties or involuntarily discharged residents illegally).

Enforcement ActionProtecting Assisted Living Facility Residents

After investigating complaints from consumers, the HCB found that Atria Communities, Inc, one of the nation's major operators of senior living facilities and adult homes, charged New York residents a mandatory, non-refundable "Community Fee" of \$5,000 for supplemental services beyond those required to be provided by state law. The Attorney General's settlement with Atria requires it to revoke the community fee, not impose any other mandatory fee for services unless the fee complies with applicable law, and refund all or part of the fee to certain former residents of Atria's facilities.

6. CONSUMER ACCESS TO PRESCRIPTION DRUGS

Many of the 2,444 complaints already discussed in this report – whether they related to denials of coverage, access to specialty care, problems obtaining or losing coverage, or some other issue – involved prescriptions in one way or another. In a number of cases, however,

the real issue is the prescription itself – whether, for example, it is medically necessary or covered under the member's plan. These cases have been collected here for separate presentation and discussion (see Table 6 below).

Enforcement Action

The Attorney General sued GlaxoSmithKline, Pharmacia and Aventis for conducting elaborate illegal schemes to inflate the price of prescription drugs for consumers and government health plans. The ongoing lawsuits focus on the companies' reporting of the "average wholesale price" that Medicare, Medicaid and EPIC use as the base for reimbursement for drugs. The companies are alleged to have reported an inflated average wholesale price in relation to the lower price charged to doctors, pharmacists and other health care providers. The companies exploit this "spread" to market their drugs, improperly inducing doctors to prescribe drugs and thereby increasing the companies' market share.

| Table 6 Consumer complaints Consumer access to prescription drugs | No. of Helpline Cases | % of all Consumer Complaints |
|--|--------------------------------------|---|
| Formularies - preferred drugs, generics, substitution | 48 | 1.9 |
| Plan denies pre-authorization for medication | 12 | 0.5 |
| Plan / Pharmacist cuts the number of pills dispensed per visit | 24 | 0.9 |
| Mail orders - return/reimbursement | 31 | 1.2 |
| Other prescription issues | 19 | 0.7 |
| TOTAL | 134 | 5.2 |

Formulary issues: preferred drugs, generics, substitution

With drug costs rising faster than the rate of overall health spending, thus accounting for an increased percentage of all health care spending,³⁶ health plans are devoting more energy to containing the cost of prescription benefits, primarily through the use of formularies. A formulary is a list of prescription medications and, sometimes, non-prescription medications covered by a health plan. If a medication is on the formulary, it is covered; any other medication is not covered, or is covered only partially. Formularies

are usually managed on behalf of health plans by companies known as pharmacy benefit managers (PBMs).

Formularies are increasingly structured in tiers, with lower co-payments for “preferred” drugs and higher co-payments for others. Preferred drugs are, as the name suggests, those a health plan would prefer its members use, in contrast to other, usually more expensive, drugs. Preferred drugs are usually generic³⁷ versions of brand-name or “pioneer” drugs, but they may also be brand-name drugs that, for one reason or another (e.g. bulk discounts or rebates from manufacturers), are cheaper for the health plan than other brand-name drugs. Health plans encourage the substitution of generics for brand-name drugs wherever possible. Pharmacists are allowed to substitute a generic for a brand-name drug at the time the prescription is filled unless the prescribing physician has written “DAW” (dispense as written) on the prescription.³⁸

More than one-third of all consumer calls and letters that dealt specifically with access to prescriptions were about the use of formularies (48 cases). Most commonly, a consumer was unable to fill a prescription for a drug because it was not on the health plan formulary. In some cases, the health plan told the consumer that it would only pay for the generic version of a drug – *i.e.* it was insisting on substituting a generic for the brand – when the consumer believed there was no generic equivalent to the brand-name drug.

Mail orders - return/reimbursement

The Helpline staff received 31 cases about prescriptions filled through mail orders. The most common complaint involved problems cancelling prescription orders before the pharmacy benefit manager sent all or part of the order and billed the consumer.

Ms. U had telephoned her health plan in early November to re-order a 30-day supply of medication. After Ms. U reordered her medication, her physician took her off the drug because of an adverse reaction. Accordingly, Ms. U contacted her health plan to cancel the order before it was shipped. In December, however, she received the drug and returned it unopened. Her health plan charged her anyway. The HCB contacted the health plan and learned that if the consumer or provider called to cancel after the drug had left the building to be shipped, the plan charged the consumer because the drug had to be destroyed upon return. Ms. U's plan, however, did credit her account in the amount of \$30.

Plan/Pharmacist cuts the number of pills dispensed per visit

Consumers experience another constraint on their access to health services when a plan refuses to fill an entire prescription and insists that the consumer return to the pharmacy another day for the remainder. While such actions are almost always dictated by some policy of the member's health plan or the PBM hired by the plan to administer the prescription benefit, the practice is often explained to the member as being the result of a limited supply on the shelf or required by the Food and Drug Administration. At other times no explanation is given. A practical effect of this kind of limitation, aside from causing the consumer the inconvenience of additional travel, is that the member often has to make an additional co-payment to receive the remainder of the prescription. This can create an unexpected financial burden for those who maintain their health with prescription medications.

Ms. B is enrolled in a PPO and suffers severe migraine headaches. Her internist prescribed 45 tablets of Imitrex for a 30-day period and her plan would only allow 11 tablets for a 7-day period. After the HCB contacted her plan and sent additional medical documentation supporting medical necessity, the plan reversed its decision.

CONCLUSION

The experiences of the consumers who contact the HCB Helpline are not necessarily representative of the experiences of all New York health care consumers. After all, we only hear from people who are dissatisfied with their health care or health care coverage. However, we believe that data presented in this report indicate impediments to consumers' ability to access care and suggest areas of improvement in the delivery of coverage and care. We feel that there may be many other consumers who are experiencing difficulties but are not aware of our Helpline and its ability to assist them. Toward that end, we will continue to educate New Yorkers about the HCB and its services. The Attorney General's Health Care Bureau is committed to working with all New Yorkers who have a stake in our vital health care system - consumers, providers and health plans - to help make affordable, high-quality health care available to all and to ensure that the system functions properly.

ENDNOTES

1. Kaiser Family Foundation, "State Health Facts Online," at <http://statehealthfacts.kff.org>. Statistics are for 2001-2002.
2. United Hospital Fund, "Trends in Health Insurance Coverage 2000 and 2001," at http://www.uhfny.org/usr_doc/trends_in_health_insurance_coverage.pdf
3. Ibid.
4. Ibid.
5. The Managed Care Reform Act of 1996 (L.1996, ch. 705) is commonly referred to as the "Managed Care Consumer Bill of Rights." The MCCBOR also includes various statutory provisions enacted subsequently, in particular the External Appeal Law (Article 49, Title II of both the Public Health Law and Insurance Law), which established a right for consumers and providers to appeal certain health plan coverage denials to an independent third party, as well as the Prompt Pay Law (Insurance Law § 3224-a), which requires most health plans to pay or deny claims within certain time frames. For more information about the MCCBOR, see the Attorney General's website at www.ag.ny.gov/health/bill_rights.html; or the Insurance Department website at www.ins.state.ny.us/hrights.htm.
6. MCCAP, established to respond to rising managed care enrollment and a corresponding increase in consumer confusion and complaints, is funded by the New York State Legislature and administered by the New York State Attorney General's Health Care Bureau to empower consumers to make informed choices among managed care plans; educate consumers about their rights and responsibilities as health plan enrollees; and resolve consumer and provider complaints about health plans. To view a copy of MCCAP's 2002-2003 annual report, go to www.ag.ny.gov/health/mccap_report03.pdf
7. In some instances, we have combined facts from different cases to create a complete case scenario.
8. For an explanation of the acronyms, see the panel titled, "Types of Health Plans," on page 1.
9. Wherever investigation revealed some other reason for the delay, the complaint was assigned to the appropriate category. For example, if the health plan was not processing a claim because it lacked sufficient clinical information on which to base a decision (because the provider had not submitted the information), the complaint was assigned to "Claims processing and payment problems: Denials due to provider error: Insufficient clinical information" (see page 9). If a health plan was not paying a claim because it believed that it was not the primary payer when in fact it was, the complaint was assigned to "Denials of care or coverage: Denials due to health plan errors: Coordination of benefits - primary/secondary" (see page 16).

10. Insurance Law § 3224-a.
11. Insurance Law § 3224-a(c). For example, see Department of Insurance Press Release, "MVP Health Plan agrees to pay \$33,800 for Prompt Pay Violations," March 28, 2001; available at www.ins.state.ny.us/p0103281.htm.
12. MCCAP, established to respond to rising managed care enrollment and a corresponding increase in consumer confusion and complaints, is funded by the New York State Legislature and administered by the New York State Attorney General's Health Care Bureau to empower consumers to make informed choices among managed care plans; educate consumers about their rights and responsibilities as health plan enrollees; and resolve consumer and provider complaints about health plans.
13. These cases were classified under "Other provider error."
14. In New York State, a coverage denial can be contested according to procedures set out in § 4408-a of the Public Health Law; such a challenge is known as a Grievance. A medical necessity denial (adverse determination), on the other hand, can be contested according to UR procedures set forth in Article 49 of the Insurance Law and/or Article 49 of the Public Health Law (the UR Law); such a challenge is known as an Appeal. Final decisions on Grievances are made by the health plan; decisions on Appeals made by the health plan can be challenged through an External Appeal process administered by the Insurance Department.
15. A clinical peer reviewer (CPR) for purposes of making initial adverse determinations under the UR Law must be (a) a licensed physician or (b) a health care professional other than a licensed physician who is licensed, certified, registered or accredited, as appropriate, and who is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review. Insurance Law § 4900(b)(1); Public Health Law § 4900(2)(a).

Note that the same-specialty requirement applies only to non-physician CPRs at the initial adverse determination stage. The qualifications for CPRs hearing internal appeals of adverse determinations were relaxed, effective July 1, 1999. Prior to that date, the UR Law imposed a same-specialty requirement on all CPRs – both physician and non-physician. Now, the UR Law provides that, in the context of an external appeal, a clinical peer reviewer must have at least 5 years of experience in the same or similar specialty and be knowledgeable about the health care service or treatment under appeal. See Insurance Law § 4900(b)(2); Public Health Law § 4900(2)(b); and 11 NYCRR §§ 410.1 through 410.13.
16. Title II of Article 49 of the Insurance Law; Title II of Article 49 of the Public Health Law.
17. Insurance Law § 4902(a)(8); Public Health Law § 4905(13).
18. Insurance Law § 4900(c); Public Health Law § 4900(3).
19. Insurance Law §§ 4902(a)(8) and 4905(m); Public Health Law §§ 4902(1)(h) and 4905(13).

20. Insurance Law § 4905(m); Public Health Law § 4902(1)(h).
21. See 11 NYCRR § 62 ("Regulation 62"). The definition of cosmetic surgery is set forth at 11 NYCRR § 52.16(c). The definition of custodial care is set forth at 11 NYCRR § 52.25(a)(1).
22. NYS Insurance Department and NYS Department of Health, *New York State External Appeal Program Annual Report, July 1, 2000 - June 29, 2001*, p. 17.
23. The complaints discussed here involve health plan denials of services that are clearly included in the contract as a covered benefit.
24. Insurance Law §§ 4318(a), 4318(b), 3232(a) and 3232(b); *Health Insurance Portability and Accountability Act of 1996*, 42 USC §§ 300gg(a)(1) and 300gg(c)(2)(A).
25. The Attorney General has examined mental health coverage limits in the context of complaints about such limits from consumers with eating disorders. See, Focus On: Eating Disorders.
26. Health plans may use other names for this concept, such as "reasonable and customary charge," "reasonable and customary rate," or "allowed amount."
27. Reimbursements for out-of-network benefits received by direct-pay individual enrollees in non-profit HMOs can be set according to a different method. Under New York Insurance Law § 4322(d), non-profit HMOs can set levels of reimbursement for out-of-network benefits for their individual direct-pay enrollees according to their own fee schedule, as long as they provide a level of reimbursement comparable to 80% of UCR. These fee schedules must be filed with the Department of Insurance.
28. One such service is the Prevailing Healthcare Charges System® (PHCS), a commercial data service offered by Ingenix, Inc. It is used by hundreds of health insurers across the country.
29. Public Health Law § 4408(1)(k).
30. See 10 NYCRR §§ 98-1.13(d) and 98-1.5(b)(6)(iii).
31. COBRA is an acronym for the federal *Consolidated Omnibus Budget Reconciliation Act of 1985*, 29 U.S.C.A. § 1161 *et seq.* It applies to employees and their dependents who would otherwise lose their insurance coverage as a result of a "qualifying event." The length of additional coverage they receive (18, 29 or 36 months) depends on the qualifying event. New York State law provides similar "continuation coverage" to employees not covered by federal COBRA – specifically, those working for employers with under 20 employees. For New York State law, see Insurance Law §§ 3221(m) & 4305(e); Labor Law §§ 195 & 217; and www.ins.state.ny.us/faqs1.htm#cobra.
32. This section discusses only *improper* billing of consumers by providers. When consumers complained about a provider's bill but further investigation revealed that the provider's bill was appropriate, those complaints were assigned to other categories. For example, if a consumer received a bill from a non-participating provider for the full cost of health services because the consumer had received services out-of-network without health

- plan pre-authorization, the complaint was classified under "Access to specialty care: Consumer received out-of-network services without pre-authorization" (see page 31).
33. See 10 NYCRR 98-1.5(b)(6)(ii). See Department of Health, "HMO and IPA Provider Contract Guidelines," July 31, 1998 (available at www.health.state.ny.us/nysdoh/manicare/hmoipa/guidelines.htm), p. 3.
 34. For an explanation of "hold harmless," see page 24.
 35. The problem of health plans' late reimbursement of providers is discussed on pages 7-8.
 36. The Centers for Medicare and Medicaid Services (CMS) predicted that prescription drug spending growth between 2001 and 2011 will exceed total health spending growth by almost 5 percentage points per year on average, so that by 2011 prescription drug spending will account for 14.7% of total health expenditures, compared with its 2000 level of 9.4%. Stephen Heffler *et al.*, "Health Spending Projections For 2001-2011: The Latest Outlook," *Health Affairs*, March/April 2002, p. 215.
 37. A generic drug is defined by the Food and Drug Administration as "a copy [of a brand-name drug] that is the same as a brand-name drug in dosage, safety, strength, how it is taken, quality, performance and intended use." See www.fda.gov/cder/consumerinfo/generics_q&a.htm.
 38. Education Law §§ 6810(6) & 6816-a.