



**State of New York
Office of the Attorney General
Division of Social Justice**

HEALTH CARE BUREAU

Real Solutions for New Yorkers: 2014

**Prepared by
The Health Care Bureau**

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Health Care Bureau
Real Solutions for New Yorkers
2014

This report briefly describes the work of the Attorney General's Health Care Bureau ("HCB") for the period of January 1, 2014 through December 31, 2014. For further information about the HCB, including press releases on our most recent work, consumer information materials, and reports, please visit <http://www.ag.ny.gov/bureau/health-care-bureau>.

HEALTH CARE BUREAU

The Health Care Bureau is part of the Social Justice Division¹ in the New York State Office of the Attorney General. The Health Care Bureau's principal mandate is to protect and advocate for the rights of health care consumers statewide through:

- **Operation of the Health Care Bureau Helpline.** This toll-free telephone hotline (800-428-9071) serves as a direct line between consumers and the Office of the Attorney General. The Helpline is staffed by intake specialists and advocates trained to provide assistance to New York health care consumers. Assistance ranges from providing helpful information and referrals, investigation of individual complaints, and mediation of disputes to help protect consumers' rights within the health care system.
- **Investigations and enforcement actions.** The HCB conducts investigations and litigation against health plans, health care providers, and other individuals and entities that engage in fraudulent, misleading, deceptive or illegal practices in the health care market.
- **Consumer education.** Through outreach and dissemination of information and materials, the HCB seeks to inform New Yorkers about their rights under state and federal health and consumer protection laws.
- **Legislation and policy initiatives.** The HCB promotes legislative and policy initiatives to enhance the rights and well-being of consumers and their ability to access high-quality and affordable health care in New York State.

HEALTH CARE BUREAU HELPLINE

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

In 2014, the HCB Helpline staff handled 5,982 cases. Of these cases, HCB Helpline staff investigated and resolved 3,991 consumer complaints and provided another 1,991 consumers with information or referrals to an appropriate agency to handle the inquiry. The complaints handled by the Helpline highlight the challenges faced by New York health care consumers and are an important means of identifying systemic problems in New York's health care

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

system, which may then form the basis of further investigation and enforcement actions against health plans, providers, and other entities operating in the health care market, with the objective of protecting consumers' health care rights by providing affirmative, systemic relief and by helping affected consumers obtain appropriate monetary refunds (known as "restitution").

HEALTH CARE BUREAU DATA

2014 YEAR AT A GLANCE

Benefits to Consumers Across New York State. During 2014, the work of HCB Helpline staff yielded significant results benefitting individual consumers across New York State. A review of the HCB complaint data for the year shows that the HCB Helpline secured more than **\$3,357,000** for consumers in restitution and savings resulting from uncovering incorrect medical billing, wrongful rejection of insurance claims and the failure to process insurance claims. Individual restitution/savings range from over \$170,000 to \$100 or less. In addition, efforts of the HCB Helpline staff yielded additional invaluable results that are not quantifiable, by helping New York consumers obtain medically necessary care or prescriptions that were previously denied; and helping New York consumers whose health coverage was incorrectly terminated.

Issues Raised by Consumers and Resolved by HCB Advocates. A review of the HCB complaint data shows the following:

- **"Provider Billing" is the number one issue that prompted New Yorkers to contact the HCB Helpline in 2014** (26% of all handled, non-referred complaints). The majority of these complaints (58.92%) relate to improper provider billing practices, such as the improper balance billing of patients and the failure to submit claims to insurance companies.

Note: Since 2011 provider billing has consistently ranked as the number one issue raised by consumers for resolution by the HCB Helpline.

- The other most common issues prompting New Yorkers to contact the HCB Helpline in 2014 are claim processing/payment complaints, which include health plan mistakes in preparing, processing, or paying claims (18%); health plan denials of care or coverage, such as denials based on the treatment not being "medically necessary" or that the care provided was not a covered benefit (14.42%); wrongful practices (7.76%); problems obtaining and keeping health insurance coverage (14%); and problems accessing prescription medications (11.96%).

Note: The number of calls related to problems obtaining and keeping health insurance coverage increased from 9% in 2013 to 14% in 2014. This trend may be explained by initial confusion in the rollout and implementation of the Patient Protection and Affordable Care Act. Another change observed includes an increase in the number of complaints related to accessing prescription medication, from 7.6% in 2013 to almost 12% in 2014. A decrease in the number of

complaints related to wrongful practices is also noted, from 12% in 2013 to 7.76% in 2014.

- Many consumers who call the Helpline are confused about their benefits, the rules to follow to secure coverage for care, doctor or hospital charges, appeal rights, or where to get help with some other aspect of health care. While not all consumer complaints and inquiries can be resolved in the consumer's favor (*e.g.*, where the consumer is frustrated with a valid denial of care, a legitimate bill, or the inherent imperfections of the health care system), the HCB Helpline plays a crucial role as a source of reliable and objective information for health care consumers.

HIGHLIGHTS: HELPLINE RESOLUTIONS AND HEALTH CARE BUREAU ENFORCEMENT ACTIONS

The following provides further information on the most common issues prompting health care consumers to call the Helpline, specific and notable examples of resolutions achieved by Helpline advocates, as well as HCB enforcement actions.

(1) Provider Billing Practices

A significant number of consumer complaints (26%) were prompted by concerns regarding provider billing practices. Although state regulations and many provider health insurance contracts forbid participating in-network providers from “balance-billing” consumers, some in-network providers who have agreed to accept the contracted payment from the insurance company nonetheless improperly bill consumers and subject them to collection actions. Other typical complaints related to provider billing include:

- Billing of consumers by an out-of-network provider who participated in the consumer's care — often to the surprise of the consumer who either received services in the emergency room by an out-of-network provider, or in the context of a planned hospital procedure, did not know that the provider was part of the medical team providing services (*e.g.*, out-of-network anesthesiologists or radiologists providing care at an in-network hospital).
- Provider's failure to submit the claim to the insurance company.

Notable Helpline Resolutions for Provider Billing Practice Cases

- **Emergency Out-of-Network Hospitalization Bill.** A consumer was hospitalized after an emergency room visit, and underwent surgery for a brain aneurism. The hospital was out-of-network at the time of surgery and the consumer subsequently received bills and a collection notice for over \$157,000. Payment had been issued by the insurer for a small percentage of the total charged. After the advocate's intervention, the insurer negotiated to reimburse the hospital 75% of the total charges and hold the consumer harmless. Accordingly, the insurer reprocessed the claim to reimburse additional payment to the hospital, the provider agreed that the

consumer was not responsible for the balance of the bill and the patient had zero responsibility for the charges.

- **Surprise Bill for Out-of-Network Anesthesiologist.** A consumer received anesthesia services for a medical procedure in 2007. In 2011, the consumer began receiving bills for additional monies over and above what her insurance company paid and she was served with a judgment demanding \$4,234 with interest and attorney fees. After intervention by the advocate, the physician agreed to accept the insurance payment as payment in full and discontinued the lawsuit.
- **Improper Billing for Emergency Care.** A consumer went to an emergency room at an in-network hospital for severe back pain. While consumer was in the emergency room, she was put on a high dose of morphine and received multiple tests which revealed previously undiagnosed breast cancer. The radiologist was out-of-network and the consumer received a bill for radiology services from the hospital. After intervention by the advocate, an adjustment was made and the consumer received a zero balance letter.

(2) Claim Processing and Payment Problems

Eighteen percent of all HCB consumer complaints arise from claim processing/payment errors. Nearly 35% of these complaints involved errors by the health plans, including the plan's failure to process or pay the claims, the health plan paying the incorrect amount, or errors by the health plans regarding deductibles and/or copayments. Some of the most common complaints relating to health plans' claims and payment processes include:

- Health plan failure to process claims at all or failure to process them in a timely manner.
- Health plan lack of clarity about out-of-network coverage/reimbursement, and consumers' lack of understanding about out-of-network provider reimbursement rates and their out-of-pocket liability for seeing an out-of-network provider.

Notable Helpline Resolutions for Claim Processing/Payment Error Cases

- **Health Plan Payment Error.** A consumer's child was diagnosed with a rare illness. Initially, physicians participating with the consumer's health plan had a difficult time diagnosing the condition. Eventually, participating doctors referred the family for treatment at an out-of-network children's hospital. Although prior authorization was obtained, when the hospital and physicians submitted claims, the insurance carrier denied payment. The consumer appealed multiple times, and each appeal included prior authorization information. In response to the appeals, the health plan issued multiple form letter denials that did not address the prior authorization. After intervention by an advocate, who asked why their denials did not address the prior authorization given for treatment, the denial was overturned and payments totaling \$18,000 were issued.

- **Undue Delay in Reimbursement by Health Plan.** A consumer mistakenly authorized his health plan to pay his out-of-network provider, and the plan issued two checks to the provider in February and March 2012, totaling \$4,056. Since the provider was out-of-network and the member had already paid the provider, payment should have been issued to the member. After realizing his mistake, consumer and his provider contacted the health plan no less than thirteen times since February 2012 regarding this issue, and were almost always told that the checks were stopped and re-issued. As of March 2014, however, the consumer still had not received reimbursement, and he contacted HCB for assistance. An advocate sent an inquiry to the health plan and fourteen days later, the plan agreed to issue a check to consumer in the amount of \$4,056 within ten business days.
- **Provider Billing Error.** A consumer went to an Urgent Care Center. A \$150 emergency room copayment was applied by the insurer, rather than the urgent care copayment of \$45. The advocate inquired as to why the \$150 copayment was applied, and it turned out that the claim had been submitted with an incorrect service location of a hospital, so it was processed as an emergency room visit. As a result of intervention by the advocate, the claim was reprocessed and the copayment was corrected to reflect the \$45 urgent care amount.

(3) Health Plan Denials of Care or Coverage

Approximately 15% of all HCB consumer complaints involve health plan denials of care or coverage for care. Such denials most often occur based on claims that the care was not medically necessary (47.84%) or that the care provided was not a covered benefit (28.37%), and in 16.83% of the complaints the denial was due to health plan error.

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

- **Coverage Denial Due to Health Plan Error.** A consumer suffers with neuropathy that affects her motor skills and needs to receive monthly home infusion therapy sessions. She expressed to HCB that the treatment costs approximately \$14,000 a month. She contacted the Health Care Bureau because she did not receive her May session due to insurer's denial, which was based upon the failure to provide proper paperwork. However, the paperwork had been sent by both the consumer and her physician. After an advocate intervened and made an inquiry with the insurer, the consumer received notification that the service had been approved.
- **Medical Necessity Denial.** A consumer contacted the HCB after her son was involved in an automobile accident, airlifted to a nearby hospital, and the air transport was denied as medically unnecessary. The consumer filed an external appeal with the Department of Financial Services and the reviewing agent upheld the denial. After reviewing the external appeal, the advocate noted certain discrepancies and recommended that the consumer contact DFS to request a new external appeal on the basis that the first decision contained multiple errors. The first external appeal decision was overturned and the health plan was directed to pay the \$16,000 air ambulance bill.

- **Coverage Denial Due to “Experimental” Status.** A consumer contacted the HCB after insurer denied coverage for out-of-network breast reconstruction surgery. The insurer had denied the type of reconstruction as investigational/experimental. The advocate asserted that the insurer was required by law to pay for surgery “as deemed appropriate between patient and surgeon” and therefore the denial basis was incorrect. The insurer overturned its decision and paid for the out-of-network services.

Enforcement Actions²

- **Enforcement of Mental Health Parity Laws against Cigna Corporation.³** An investigation conducted by the HCB uncovered the wrongful denial of hundreds of claims by Cigna Corporation for nutritional counseling for mental health conditions. The HCB launched an investigation into Cigna Corporation’s administration of mental health benefits following the receipt of a complaint from a family regarding their daughter who suffered from anorexia nervosa. The consumer complained that Cigna had improperly denied coverage for nutritional counseling necessary for her mental health treatment. The company denied the benefit citing a limit of three visits per calendar year. While limiting nutritional counseling to three visits for behavioral health, Cigna did not limit nutritional counseling visits for members with diseases outside the behavioral health realm. As part of an Assurance of Discontinuance⁴ (“AOD”) executed with Cigna Corporation in January 2014, the insurer was required to reprocess and pay hundreds of claims for nutritional counseling for mental health conditions, in particular eating disorders, to members who were wrongfully denied those benefits. Additionally, Cigna was required to eliminate the three-visit cap for mental health conditions, and pay \$23,000 to the OAG as a civil penalty.
- **Enforcement of Mental Health Parity Laws against MVP Health.** An investigation conducted by the HCB uncovered widespread violation of mental health parity laws by Schenectady-based MVP Health Care, and revealed that since 2009, when MVP outsourced administration of behavioral health benefits to Value Options, a managed behavioral health organization, MVP Health Care had scrutinized behavioral health care claims more rigorously than medical and surgical claims, resulting in denial of coverage to thousands of consumers for care requested by their doctors and therapists. Findings of the investigation included that, since at least 2011, MVP Health Care, through Value Options, issued 40% more denials of coverage in behavioral health cases than in medical cases; that before 2014, MVP Health Care did not cover residential treatment for behavioral health conditions; and

² “Enforcement Action” refers to action, including investigation, litigation, and resolution, taken by Health Care Bureau assistant attorneys general to address a violation of law.

³ New York’s mental health parity law, known as Timothy’s Law, was enacted in 2006, and requires that insurers provide mental health coverage at least equal to coverage provided for other health conditions. The federal Mental Health Parity and Addiction Equity Act, enacted in 2008, prohibits health plans from imposing greater financial requirements or treatment limitations on mental health or substance use disorder benefits than on medical or surgical benefits.

⁴ An “Assurance of Discontinuance” is a settlement document that the Attorney General may accept in exchange for “discontinuing” an ongoing investigation instead of filing a civil lawsuit in any case for which a person or entity has engaged in acts or practices that are in violation of the law.

that MVP Health Care also charged the higher, specialist co-payment for psychotherapy. As part of an AOD executed with MVP Health Care in March 2014, the health insurer was required to reform its behavioral health claims review process, cover residential treatment, and charge the lower primary care co-payment for outpatient visits to most mental health and substance abuse treatment providers. The settlement also requires the health insurance plan to submit claims or requests that were denied as not medically necessary during a specified time frame for independent review. Under the settlement, MVP Health Care will also submit to monitoring and will pay \$300,000 to the OAG as a civil penalty.

- **Enforcement of Mental Health Parity Laws against EmblemHealth, Inc.** An investigation conducted by the HCB uncovered widespread violation of mental health parity laws by New York City-based EmblemHealth, Inc., and revealed that EmblemHealth had scrutinized behavioral health care claims more rigorously than medical and surgical claims, resulting in denial of coverage to thousands of consumers for care requested by their doctors and therapists. Findings of the investigation included that since at least 2011, EmblemHealth, through its behavioral health subcontractor, Value Options, issued 64% more denials of coverage in behavioral health cases than in medical cases; that before 2014, EmblemHealth did not cover residential treatment for behavioral health conditions; that EmblemHealth improperly denied requests for coverage of substance abuse rehabilitation; and that EmblemHealth also charged some consumers the higher, specialist co-payment for psychotherapy. As part of an AOD executed with EmblemHealth in July 2014, the health insurer was required to reform its behavioral health claims review process, cover residential treatment and charge the lower, primary care co-payment for outpatient visits to mental health and substance abuse treatment providers. The settlement also requires the health insurance plan to submit previously denied mental health and substance abuse treatment claims for independent review, submit to monitoring by an external entity, and pay \$1.2 million to the OAG as a civil penalty.
- **Best Practices Agreement for Consumers Undergoing Breast Reconstruction.** In response to coverage issues for out-of-network plastic surgeons, where no in-network plastic surgeon was available at the hospital where a mastectomy surgeon had scheduled surgery, a best-practices agreement with Empire BCBS was entered in May 2014. This agreement requires Empire to fully cover an out-of-network plastic surgeon if no in-network plastic surgeon is available at the hospital where the mastectomy surgeon has scheduled the surgery. In addition, Empire will provide earlier and better notice about network providers and procedures for requesting an out-of-network exception.

(4) Wrongful practices

Nearly 8% of consumer complaints were due to wrongful practices. Most of the consumer complaints (70.98%) related to wrongful business practices, such as false advertising, outdated provider directories, and predatory lending/health care financing. Another 28.13% of the consumer complaints related to the quality of care received from their providers.

Enforcement Actions

- **Violation of New York’s Prohibition of the Unauthorized Corporate Practice of Medicine.** An investigation by the HCB began as the result of a referral from the New York State Commission of Correction and the New York State Education Department. The Commission of Correction found significant lapses in medical care provided to six prisoners who died in custody between 2009 and 2012 at five county jails contracted with Pennsylvania-Based Correctional Medical Care, Inc. (CMC), a for-profit prison health care contractor that provides medical services in jails in 13 upstate counties. The findings of the investigation by the HCB included that CMC was understaffing facilities and shifting work hours from physicians and dentists to less qualified and lower-wage staff. Findings also included that CMC violated New York’s prohibition of the unauthorized corporate practice of medicine, which bars general business corporations from practicing medicine or employing physicians to provide medical services. As part of an AOD executed with CMC in September 2014, CMC was required to provide only administrative services to bring operations into compliance with the New York law prohibiting the corporate practice of medicine, and create a separate professional medical corporation to provide medical care. Other requirements included oversight by an independent monitor, restitution and \$100,000 in civil penalties to New York State.
- **Misleading Advertising.** An investigation conducted by the HCB uncovered misleading advertising in the indoor tanning salon industry. Findings included that Hollywood Tans NYC, through its website, blog and social media outlets, made numerous misleading and false representations about the safety and health benefits associated with UV tanning, and that the UV tanning industry’s false claims targeted teenagers. As part of an AOD executed in March 2014, an agreement was entered into with HT Franchising Management LLC, doing business as Hollywood Tans, and Hollywood Tans NYC, a Manhattan-based franchise of the national chain, requiring them to stop making health-related representations to promote tanning services. The parent corporation has six other franchises in New York State and more than 100 franchises across the country. The agreements prohibit all Hollywood Tans franchises in New York from making health claims, from offering “unlimited” tanning packages, and from targeting high school students. In addition, Hollywood Tans will be required to submit and obtain approval from the parent corporation for all self-generated advertising materials.
- **Inadequate Disclosure of Out-of-Network Benefits.** An investigation conducted by the HCB, after receiving numerous consumer complaints, uncovered that disclosures regarding the out-of-network benefits by GHI’s Comprehensive Benefits Plan were inadequate to inform members and prospective members about low reimbursement rates and the potential of facing large balance bills from out-of-network providers. In many instances, GHI’s materials did not accurately set forth the potentially wide gap between the out-of-network reimbursement and out-of-network charges, and potentially substantial out-of-pocket amounts for which GHI Plan members would be responsible. As part of an AOD executed with GHI in September 2014, improved plan disclosures for out-of-network provider benefits to consumers were required. GHI was also required to establish a \$3.5 million

consumer assistance fund to provide financial relief to members, most of them New York City employees, and pay \$300,000 in penalties to the Attorney General's office.

- **Predatory Medical Loans.** An investigation conducted by the HCB began after the HCB received a complaint from a consumer about Surgeryloan.com. The investigation resulted in AODs in April 2014 with four out-of-state companies accused of financing retail installment obligations ("RIOs") at usurious rates of interest, ranging up to 55%, for New York consumers who sought financing for elective medical and surgical procedures. The companies are MyMedicalloan.com, doing business as Surgeryloan.com; Duvera Billing Services, LLC; Highlands Premier Acceptance Corporation; and Paramount Capital Group, Inc. Under the terms of the AODs, the companies, which were not licensed to finance RIOs in New York, were required to recast the RIOs to the legal interest rate (no more than 16%) and issue about \$230,000 in repayments or credits to more than 300 New York consumers. The AODs also required the companies to cease all conduct as unlicensed sales finance companies in New York and to notify any consumer reporting agencies to which they gave consumer information to delete all references to the transactions from customers' credit reports. The companies will collectively pay \$35,000 in penalties.
- **Inaccurate Representations of Financial Responsibility.** An investigation conducted by the HCB after receiving repeated complaints from patients faced with unexpected out-of-pocket costs uncovered that PATH Medical misrepresented to patients how much of the cost of tests and services a health insurer was likely to cover, including extensive testing routinely done during a patient's initial visit. While the business did not participate in any health insurance plans, it led some consumers to believe that a significant percentage of the charges (sometimes up to 80%) would be covered by their health plans' out-of-network benefit. However, patients' health plans were not typically covering a significant percentage of the total charges for PATH Medical's services or were routinely denying the claims submitted by the practice, resulting in some patients facing thousands of dollars in unexpected costs for a single visit. As part of an AOD executed in December 2014, PATH Medical was required to reform its practices to ensure that patients are provided with accurate information about their financial responsibility, including revision of consent forms and invoices.

(5) Obtaining and Keeping Coverage

Fourteen percent of consumer complaints involved obtaining and keeping coverage. Of these complaints, 12.62% implicate employers as a primary culprit. Consumers complain that some employers terminate coverage without informing employees, neglect to pay premiums (even when employees have paid their share), and refuse to allow employees to continue coverage as required by state and federal law (commonly referred to as "COBRA").

Notable Helpline Resolutions for Obtaining and Keeping Coverage Cases

- **Plan's Failure to Ensure Coverage of Newborn Baby.** A consumer contacted our office for assistance with insurance coverage for her newborn son. When the baby was born the consumer contacted the insurer to put the baby on the policy effective on the date of birth. Instead, the effective date was incorrectly listed as about two months later and none of the bills related to the birth event were being covered. The consumer contacted the insurer and was told nothing could be done. After intervention of an advocate, the insurer corrected the effective date and the claims, which totaled over \$13,000, were paid.
- **Employer's Failure to Submit Required Paperwork.** A consumer was a brain cancer patient who had chemotherapy and stem cell treatment scheduled two days after contacting the Helpline. He was on COBRA and paid his premium check to his employer, which had been cashed. He recently discovered, however, that he was not covered. An advocate called the insurance broker and was informed that the entire group lost coverage because the employer did not submit the required paperwork to the insurer on time. The employer had recently submitted the paperwork to insurer's Risk Department. The advocate faxed urgent inquiry to the insurer explaining the consumer's dire situation and requested that they expedite the process. As a result of the request, within 24 hours the group was reinstated retroactively with no lapse in coverage.
- **Paperwork not Submitted to Insurer.** A consumer with an extremely rare form of bone cancer who requires specialty medication to survive contacted the Helpline after learning that neither her husband's employer nor their broker was able to explain why the insurer had no record of them having insurance. An advocate contacted the broker and learned that the paperwork submitted to the insurer somehow was never received. However the plan did receive the payment for the group. The advocate contacted the insurer and was advised that the group was enrolled and member identification numbers were issued.

(6) Access to Prescription Drugs

Nearly 12% of HCB consumer complaints concerned accessing prescription medications. These complaints ranged from problems with the formularies, problems with mail-order drugs (including delays and non-deliveries), and denials of preauthorization for high-cost specialty drugs. Such complaints include:

- Denial of coverage or higher copayments for prescribed drugs that are not on the insurance plan's formulary or which are on a higher tier (and therefore have a higher copayment); assistance is often provided in obtaining pre-authorizations for the medications or with filing appeals of adverse determinations.
- Confusion regarding insurance plan requirements to obtain certain medications through mail-order pharmacies instead of retail pharmacies, as well as confusion regarding a change in the law that narrowly expands patients' ability to obtain drugs at retail pharmacies.

Notable Helpline Resolutions for Prescription Drug Access Cases

- **Mail Order Pharmacy Requirements.** A consumer living with HIV sought an exception to his plan's mail order requirement for the purchase of specialty drugs. This case was assigned as a priority as the consumer was nearly out of his medication. An advocate immediately telephoned the health plan's Director of Compliance and explained that member wanted to continue using his local retail pharmacy because he travels often and cannot wait in his apartment building for his life-sustaining medication to arrive. The plan issued an override to its mail-order requirement for the purchase of specialty drugs the very next day and member was able to obtain his medication at his local retail pharmacy.
- **Brand-Name Medication Denial.** A consumer called the Helpline because her insurer was denying brand-name medications Topamax and Keppra, prescribed for her seizures. The plan wanted her to take generic forms of the drugs instead. She and her neurologist believed that switching medications could be harmful to her health. Upon the advocate's advice, the consumer sent an appeal to the insurer and requested that her neurologist submit a letter of medical necessity. The advocate faxed a letter in support of the appeal and requested that the appeal be expedited, as consumer was almost out of medication. The insurer responded that the appeal did not qualify for expedited review, but approved a 30 day supply of both medications while appeal is processed. The insurer subsequently overturned its prior denial.

Conclusion

The Health Care Bureau's Helpline is an invaluable resource for health care consumers in New York State. As these examples demonstrate, our advocates ensure that consumers understand their rights within the health care system and work to protect those rights across the broad range of issues highlighted in this report. Additionally, the Health Care Bureau analyzes these complaints to identify systemic health care problems, and can then take appropriate affirmative steps to address these systemic problems, including initiating investigations of fraudulent practices and bringing enforcement actions, or advocating for legislation that can further protect consumers' rights.