

New York Managed Care Consumer Bill of Rights Compliance Survey:



The Failure of New York HMOs to Provide Important Coverage Information to Consumers

A REPORT FROM

**THE NEW YORK STATE DEPARTMENT
OF LAW
HEALTH CARE BUREAU**



**ELIOT SPITZER
ATTORNEY GENERAL
March, 2004**

Health Care Bureau

The Health Care Bureau (HCB) is part of the Division of Public Advocacy in the Office of the New York State Attorney General. The HCB's principal mandate is to protect and advocate for the rights of health care consumers statewide, through:

- **Operation of the Health Care Helpline.** This toll-free telephone hotline provides assistance to New York health care consumers by employing staff who provide helpful information and referrals, investigate individual complaints, and attempt to reach 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, 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 Managed Care Consumer Bill of Rights 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, affordable health care in New York State.

Health Care Helpline

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Mailing address: 120 Broadway, 25th Floor, New York, NY 10271-0334

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EXECUTIVE SUMMARY

This report analyzes the results of the Attorney General's survey of health plan compliance with the New York Managed Care Consumer Bill of Rights' requirement to provide clinical review criteria to consumers upon their written request. Unfortunately, the Attorney General finds that the vast majority of health plans violated the law by failing to disclose the requested clinical review criteria to the surveyors.

The Survey

New York's Managed Care Consumer Bill of Rights ("MCCBOR") provides consumers with rights to information about health plans, including clinical review criteria, to assist them in choosing an appropriate plan and accessing care as plan members. Clinical review criteria are indispensable to informed decision-making because they contain the actual medical standards health plans use to determine whether a covered service is medically necessary for the particular individual requesting the treatment. If a medical service is not deemed medically necessary, then the health plan will not pay for it, and the consumer is left with the choice of either paying for services out-of-pocket or foregoing treatment. Prospective members with imminent or existing medical needs must have access to clinical review criteria that apply to their condition in order to effectively shop for the best health plan for their particular medical needs. The MCCBOR requires clinical review criteria to be disclosed to both members and prospective members upon written request.

In order to accurately gauge compliance with the MCCBOR, Office of Attorney General ("OAG") surveyors, posing as prospective enrollees with specific medical needs, sent letters to twenty-two (22) health plans in New York (these plans sell policies to individual consumers) requesting the clinical review criteria for a specified medical need.

Each plan received five written requests, one for each of five designated needs – insulin pump for diabetes, surgery for Crohn’s disease, arthroscopic knee surgery, enteral formulas (nutritional supplements) and breast reduction surgery. The particular services or supplies were chosen because plans typically subject them to medical necessity determinations. Every individual response was reviewed to determine if it contained clinical review criteria that satisfied the statutory mandate. Each plan then received a grade from “A” to “F” based on the number of satisfactory responses received (e.g., a “B” was given for 3 satisfactory responses and an “F” for no satisfactory responses). The findings and chart below detail the performance of the plans surveyed.

Our Findings

The Attorney General’s survey found that:

- Out of a total of 110 individual written requests for disclosure (5 to each of the 22 plans), only 16 satisfactory responses were received – an overall compliance rate of just 15%.
- Half (11) of the plans received an “F” because they did not provide a single satisfactory response to any of the requests for disclosure.
- Seven plans received a “D” by providing satisfactory clinical review criteria in response to only one of the five medical needs surveyed.
- Three plans received a “C” for providing satisfactory clinical review criteria in response to 2 out of the 5 letters sent.
- One plan received a “B” for providing satisfactory clinical review criteria in response to 3 out of the 5 letters sent.

- Because none of the plans provided more than 3 satisfactory responses, no plan received an “A.”

The Compliance Report Card below shows the names of the plans surveyed and how they fared.

COMPLIANCE REPORT CARD				
GRADE	NUMBER OF SATISFACTORY RESPONSES	HEALTH PLAN	NUMBER OF PLANS	PERCENTAGE
A	4-5	–	None	0%
B	3	Empire HealthChoice	1	5%
C	2	Excellus Group Health Inc. (GHI) - HMO Independent Health	3	14%
D	1	Atlantis Health Plan Capital District Physicians Health Plan HealthNow New York MVP Health Plan Oxford United Healthcare of New York Vytra Health Plans	7	31%
F	0	Aetna US Healthcare AmeriHealth Health Plan CIGNA Health Care of New York Health Insurance Plan (HIP) Health Net Horizon Healthcare of New York Magna Health Managed Health MDNY Healthcare, Inc. Preferred Care (Rochester) WellCare of New York	11	50%

The health plans’ violation of the information disclosure requirements of the MCCBOR is not an abstract or statistical problem – the direct consequences of such violations can be genuine confusion, anxiety and fear among consumers with real medical needs who require such information to make informed health care decisions. Without clinical review information, some of New York’s most vulnerable consumers – those with imminent

and chronic medical needs – are forced to make important health care coverage decisions without the detailed information that is guaranteed to them by law. Additionally, the plans that are not sending clinical review criteria in violation of the MCCBOR are, in effect, making it harder for people with pre-existing medical needs to evaluate and purchase their plans. Consequently, the health plans that violate the law are benefitting by deterring the sickest New Yorkers with high-cost health needs from enrolling in their plans, while those that diligently follow the law are being penalized by helping higher-cost enrollees to acquire their plans – a penalty for following the law that is forced upon them by their competitors.

Enforcement Action and Legislative Proposal

The Executive Law and General Business Law authorize the Attorney General to prosecute any business entity that repeatedly engages in fraudulent, deceptive or illegal business activity. With release of this report, letters have gone out to each health plan detailing its particular violations and requesting that the plan comply with the law and set a meeting date to discuss permanent compliance measures. The Attorney General may commence litigation seeking a court injunction ordering compliance with the law against any plan that does not voluntarily agree to do so.

The Attorney General believes that the lack of specific penalties for violations of particular provisions of the MCCBOR leaves a hole in the law's enforcement capabilities and has therefore developed legislation that would establish a three-tiered system of penalties for violations of the MCCBOR. Passage of this legislation will give the MCCBOR the teeth that it is so conspicuously missing.

I. INTRODUCTION

A. The Managed Care Consumer Bill of Rights

New York's Managed Care Consumer Bill of Rights ("MCCBOR")¹ provides consumers with important rights and protections in three general categories:

- Rights to information about health plans to assist consumers in choosing an appropriate plan and in accessing care as plan members;
- Rights to access specialty, out-of-network and emergency care; and
- Rights to contest certain health plan decisions through mandatory grievance and appeal procedures.

The right to information about health plan benefits and the rules and procedures for accessing those benefits are especially important to consumers. The MCCBOR provides that each member and prospective member, upon request, must be supplied with a member handbook or contract that includes, among other things, a description of benefits, prior authorization requirements, premiums, copayments, and grievance and appeal procedures.

The requirement imposed on all health plans to disclose information in the member handbook or contract allows consumers to shop effectively for insurance by providing them with the means to make informed choices about the coverage options available to them.²

¹ L. 1996, ch. 705, effective date of April 1, 1997.

² The broad consensus for enhanced disclosure requirements contained in the MCCBOR's legislative record extended well beyond the traditional consumer advocacy groups. For example, the New York State HMO Conference, the trade organization for many health plans, declared that: "HMOs have always been and remain committed to disclosure of consumer information ensuring that enrollees understand the various aspects of the [sic] health care coverage. HMOs also support efforts to enhance the ability of consumers to make informed decisions about available health care options." Legislative Bill Jacket, L. 1996, ch.

While a review of general plan materials may suffice for many consumers, it does not always provide consumers who have a serious or chronic illness with adequate information. For example, a consumer with rheumatoid arthritis reading the typical plan member handbook will likely learn if her plan covers physical therapy, but will probably not discover whether such therapy would be approved and covered as “medically necessary” for her particular diagnosis.

To address this concern, the MCCBOR requires health plans to provide consumers, upon written request, with the plan’s clinical review criteria to ensure that consumers with specific medical conditions (as well as other consumers) possess the means to decide which plans are best suited to their particular needs.³ Clinical review criteria are indispensable to informed decision-making because they contain the actual medical standards health plans use to determine whether a covered service is medically necessary for the particular individual requesting the treatment. If a medical service is not deemed medically

705 - Support Memo of New York State HMO Conference.

³ Section 4408. Disclosure of Information.

1. Each subscriber, and upon request each prospective subscriber prior to enrollment, shall be supplied with written disclosure information which may be incorporated into the member handbook . . .
2. Each health maintenance organization shall, upon request of an enrollee or prospective enrollee . . . (j) upon written request, provide specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information which the organization might consider in its utilization review and the organization may include with the information a description of how it will be used in the utilization review process; provided, however, that to the extent such information is proprietary to the organization, the enrollee or prospective enrollee shall only use the information for the purposes of assisting the enrollee or prospective enrollee in evaluating the covered services provided by the organization.
(Section 4408 of the Public Health Law)

necessary, then the health plan will not cover the service, in which case the consumer is left with the difficult choice of either paying for services out-of-pocket or foregoing treatment.

In effect, the clinical review criteria define and qualify the covered benefits found in member handbooks and subscriber contracts. Thus, the prospective enrollee with an imminent or existing medical condition must ask two questions in evaluating a health plan: (1) Is the service I need a covered benefit under this plan?; and (2) If yes, what criteria will the plan use to determine if the service is medically necessary, and thus covered or reimbursable, in my particular case? As a result, prospective members with imminent or existing medical needs must have access to the clinical review criteria that apply to their condition in order to shop effectively for the best health plan.

B. This Report

The Attorney General has focused considerable resources on enforcing the MCCBOR and securing the rights it affords consumers.⁴ This report analyzes the results of a survey that the Attorney General conducted regarding health plan compliance with the MCCBOR's requirement to provide clinical review criteria to consumers upon their written request.

Unfortunately, the Attorney General finds, as detailed in this report, that the majority of surveyed health plans violated the MCCBOR by frequently failing to disclose the requested clinical review criteria. Many plans provided only a subscriber contract or a member handbook with no more than general coverage information, even though specific

⁴ See, 2002 Health Care Helpline Report at www.ag.ny.gov

clinical review criteria were explicitly requested. And some plans did not respond at all to some of the written requests for information.

The survey demonstrates that a central goal of the MCCBOR – supplying critical information to consumers so that they may make informed health care decisions – is being thwarted by health plans’ non-compliance with the MCCBOR. Consequently, those with imminent or chronic medical needs, some of New York’s most vulnerable citizens, are forced to make important health care coverage decisions without the detailed information that is guaranteed to them by law.⁵

Additionally, the plans that are not sending clinical review criteria in violation of the MCCBOR are, in effect, making it harder for people with pre-existing medical needs to evaluate and purchase their plans. Consequently, the health plans that violate the law are benefitting by deterring the sickest New Yorkers with high-cost health needs from enrolling in their plans, while those that diligently follow the law are being penalized by helping higher-cost enrollees to acquire their plans – a penalty for following the law that is forced upon them by their competitors.

II. METHODOLOGY

OAG surveyors in five regions of the state (Long Island, New York City, Western New York, Central New York and the Capital Region), posing as prospective health

⁵ Considering that 90 million Americans are currently living with a chronic illness, and treatment for such illnesses accounts for over 70% of annual U.S. health care costs, (Centers for Disease Control Website [www.cdc.gov], “The Burden of Chronic Disease and the Future of Public Health,” James Marks, MD, MPH [1/13/03]), the deleterious effects of non-compliance with the MCCBOR’s disclosure requirements become even more significant.

plan enrollees,⁶ sent letters to twenty-two (22) New York State-licensed health plans requesting the clinical review criteria for a specified medical need.⁷ Each plan received five written requests, one for each of the following five specific medical needs:

- insulin pump for diabetes;
- surgery for Crohn's disease;
- arthroscopic knee surgery;
- enteral formulas; and
- breast reduction surgery.⁸

Each surveyor stated in the letter that he or she was (i) moving into or living in that particular plan's geographic service area, (ii) shopping for individual health insurance and (iii) requesting general enrollment materials and the clinical review criteria used to determine if coverage would be provided for one of the specific medical needs listed above if he or she chose to purchase that particular plan (see, Appendix A for the text of the letters).

Every letter, with the exception of those sent regarding surgery for Crohn's disease, used the specific phrase "clinical review criteria." The Crohn's disease letters stated,

⁶ As noted above, the MCCBOR requires clinical review criteria to be disclosed to both members and prospective members upon written request.

⁷ Mailing addresses were secured from the New York State Departments of Health and Insurance and Health Plan Association lists. Letters were sent between December 23, 2002 and March 11, 2003. Although there is no specific statutory time frame in which the plans are required to respond, they have thus far had approximately one year to respond, if they have not already. However, any response after three months would have been of little use to our surveyors/prospective enrollees who stated that they would be moving into the plan's service area and needed to make a relatively quick decision about which plan suited their needs best. Any returned letters were re-sent after checking the address.

⁸ The particular services or supplies were chosen because plans typically subject them to medical necessity determinations.

in part: “Please send me general information about the policies offered and also any criteria the plan would review when deciding if surgery for Crohn’s disease is covered.” (Attached as part of Appendix A). As a result, the language of the letters clearly and unambiguously conveyed the intent to obtain specific clinical review criteria – in addition to general enrollment materials – to assist the consumer in deciding whether or not the specified medical need would be covered if he or she chose to purchase the plan.

Each plan received an overall grade ranging from “A” to “F” based on the number of satisfactory responses, as follows:

Grade	Criteria
A	Plan provided 4 or 5 Satisfactory Responses
B	Plan provided 3 Satisfactory Responses
C	Plan provided 2 Satisfactory Responses
D	Plan provided 1 Satisfactory Response
F	Plan provided No Satisfactory Responses

The adequacy of each individual response was measured as follows:

- “Satisfactory” – the plan satisfied the statute by sending sufficiently specific information to constitute clinical review criteria, whether the language was included in the subscriber handbook or provided as a separate document.
- “Unsatisfactory” – either the plan sent only general plan materials that did not contain information sufficient to constitute clinical review criteria or the plan did not respond at all.

III. FINDINGS

A. Overall Results

COMPLIANCE REPORT CARD				
GRADE	NUMBER OF SATISFACTORY RESPONSES	HEALTH PLAN	NUMBER OF PLANS	PERCENTAGE
A	4-5	–	None	0%
B	3	Empire HealthChoice	1	5%
C	2	Excellus Group Health Inc. (GHI) - HMO Independent Health	3	14%
D	1	Atlantis Health Plan Capital District Physicians Health Plan HealthNow New York MVP Health Plan Oxford United Healthcare of New York Vytra Health Plans	7	31%
F	0	Aetna US Healthcare AmeriHealth Health Plan CIGNA Health Care of New York Health Insurance Plan (HIP) Health Net Horizon Healthcare of New York Magna Health Managed Health MDNY Healthcare, Inc. Preferred Care (Rochester) WellCare of New York	11	50%

Out of a total of 110 letters (5 to each of the 22 health plans), the Attorney General received only 16 satisfactory responses – an overall compliance rate of only 15%. No health plan sent 4-5 satisfactory responses; thus, no health plan received an “A.” One health plan – Empire HealthChoice⁹ – received a “B” by providing satisfactory clinical review criteria for three medical needs. Only three health plans – Excellus, Group Health Inc. (GHI)

⁹ See, sections on Arthroscopic Knee Surgery (p. 12) and Breast Reduction Surgery (p. 15) in this report. Of Empire’s three satisfactory responses, two responses did not contain the actual clinical review criteria but instead requested additional diagnostic information from the consumer before such criteria could be released. We will explore further with Empire the appropriateness of this reply.

- HMO and Independent Health – received a “C” by providing satisfactory clinical review criteria for two medical needs. Seven health plans (31%) received a “D” by providing clinical review criteria for just one out of the five medical conditions surveyed.¹⁰

The remaining 11 health plans (50%) failed with an “F” because they did not provide a single satisfactory response to any of the requests.¹¹

Among the health plans that did respond, some sent only subscriber contracts or other general handbook materials, despite the explicit request for specific clinical review criteria. Such general coverage information is of little use to prospective health plan enrollees with specific medical needs because these consumers will probably base their decisions on whether or not to purchase a health plan on one thing alone – the likelihood of coverage for their particular needs. Without the requested clinical review criteria, this decision must be made with little or no helpful information about the prospects for coverage.

Health plan cover letters accompanying general plan materials were usually not responsive to the particular requests made by our surveyors. Many seemed to be generic

¹⁰ Given the dismal performance of most of the plans and the poor performance of the rest of the plans, it is difficult to point to any plan as a model of compliance and customer service. However, Excellus and MVP did provide all of the information necessary to constitute clinical review criteria for breast reduction surgery. Both plans provided the requested information in a detailed, step-by-step, understandable manner that allows a consumer to make a fully informed decision about her coverage questions. For example, the two plans provided specific height and weight criteria for the surgery and also informed the consumer that photographs may be needed to further document the medical condition. These responses present the clinical review criteria in a useful, understandable format.

¹¹ Some plans did provide general handbook or contract materials that referenced the medical condition or service queried, but the information referenced did not constitute clinical review criteria. When a plan sent a member handbook that did contain clinical review criteria, this was noted as a satisfactory response.

cover letters used for all requests. For example, a Horizon Healthcare cover letter sent in response to a surveyor's specific request for the clinical review criteria for breast reduction surgery states in part: "In response to your request, enclosed please find several pieces of information that gives [sic] you an overview of the products we have to offer..." (Emphasis Added). However, the surveyor had requested specific clinical review criteria about a medical service, much more than a mere "overview" of the plan's products.¹²

Several written requests received no response from certain plans. No response at all is irresponsible and illegal. At the very least, plans should send a letter stating that either (i) no clinical review criteria are available or applicable or (ii) they do not understand the request.

B. Impact on Consumers

The impact of these findings must be measured in human terms. Violation of the information disclosure requirements of the MCCBOR is not an abstract problem. The direct consequences of such violations are likely to be confusion, anxiety and fear among consumers with real medical needs.

Navigating the health care market is no easy task, and when the chore is compounded by an imminent or existing medical need, full disclosure by health plans takes on added significance. Each time a plan neglects to provide clinical review criteria, the consumer is cast into a state of limbo in which a critical life decision is reduced to uncertain guesswork and high-risk speculation. Any miscalculation caused by a lack of information

¹² However, some plans did provide cover letters that were responsive to the surveyor's request. (See, section on Arthroscopic Knee Surgery in this report, p. 12).

could leave the prospective enrollee with the choice of either paying for expensive treatment out-of-pocket or foregoing necessary medical care. The MCCBOR was passed so that consumers would not face that choice. Our survey demonstrates the urgent need to ensure that New York health plans comply with the law.

C. Results for Each Medical Service or Supply Surveyed

1. Insulin Pump

The insulin pump is used in the treatment of diabetes. As an alternative to periodic injections, the insulin pump continuously provides a supply of insulin from a reservoir worn on the body through a small needle that is left in the skin to more closely resemble the rate at which the body produces insulin.¹³ The pump is most appropriate for patients demonstrating difficulty controlling treatment and those who need greater dietary, exercise and sleep flexibility.¹⁴ A health plan member in need of an insulin pump must know the criteria that the plan will use to determine if he or she is an appropriate candidate for the pump.

Two plans – GHI and Independent Health – provided the required clinical review criteria for the insulin pump. Twelve plans provided general plan materials that did not include specific clinical review criteria. Eight plans did not respond at all.

AmeriHealth HMO's response presents an example of an inadequate response. AmeriHealth's Member Handbook and Subscriber Contract lists the insulin pump as a

¹³ Merck Manual of Medical Information (Second Home Edition), Mark H. Beers, MD, Editor-in-Chief (2003)

¹⁴ Ibid.

covered treatment and contains two broad statements qualifying the coverage for such treatment. First, “The items must be Medically Necessary as determined by the Member’s Network Physician and will only be provided in amounts that are in accordance with the treatment plan developed by the Network Physician for the Member,” and second, “All requests for insulin pumps must be reviewed by one of Our Medical Case Managers and be approved by Our Medical Director.” The plan’s response is inadequate because it simply raises the question that would be answered by providing the requested clinical review criteria; namely, in what circumstances will AmeriHealth’s medical director approve insulin pumps as medically necessary?

2. Surgery for Crohn’s Disease

Crohn’s disease is an inflammation of the intestinal wall. While there is no known cure or cause, the disease can be treated with drug therapy and surgery.¹⁵ Surgery to remove the affected area of the intestines is usually necessary when drug therapy has failed, serious side effects from medication exist or other specific complications are present.¹⁶ The conditions under which a plan will deem surgery to be medically necessary should be contained, and provided upon written request, in the plan’s clinical review criteria for Crohn’s disease.

¹⁵ Merck Manual of Medical Information (Second Home Edition), Mark H. Beers, MD, Editor-in-Chief (2003).

¹⁶ Ibid.

No plan provided the required clinical review criteria for Crohn’s disease surgery. Eighteen plans provided general plan materials that did not contain specific clinical review criteria. Four plans did not respond at all.

3. Arthroscopic Knee Surgery

Arthroscopic knee surgery is performed to repair damaged joint surfaces and surrounding soft tissue, such as ligaments and cartilage. An arthroscope with a light and camera is inserted into the joint so that the damaged area and the surgical procedure can be viewed on a monitor.¹⁷ A surgical instrument is inserted into the affected area to shave bone tissue, remove calcium deposits, bone spurs and inflamed tissue and repair or cut ligaments and cartilage.¹⁸

An arthroscopic review is often necessary when physical examination, x-rays, CT scans or magnetic resonance imaging are inconclusive.¹⁹ After viewing the affected area through the arthroscope, the physician must determine whether the joint is abnormal and thus in need of surgical repair.²⁰ An HMO member or prospective member in need of arthroscopic knee surgery must know the criteria the plan uses to decide if the arthroscopy and the subsequent surgery are medically necessary.

One plan – United Healthcare of New York – responded that clinical review is not required for this service, and one plan – Empire HealthChoice – provided a specific

¹⁷ “Healthwise” a publication of Kaiser Permanente at www.kaiserpermanente.org.

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ Ibid.

response to the arthroscopic knee surgery letter. Twelve plans provided general plan materials that did not include specific clinical review criteria. Eight plans did not respond at all.

Empire HealthChoice provided its subscriber contract, which had a general reference to arthroscopic surgery, and in its cover letter stated that it would provide “specific clinical review criteria” if the consumer sent in another written request containing the particular diagnosis and procedure code. While we will explore the appropriateness of this response with this plan, we have counted this as an adequate response for purposes of this survey.

United Healthcare of New York sent a response stating: “When using a United Healthcare-contracted provider, there is no clinical review required for the services outlined in your inquiry letter.” This response was deemed “satisfactory” as it indicates that the plan waives medical necessity review entirely for this surgery, requiring only the recommendation of the treating physician. If this representation is accurate, United Healthcare’s response enables the consumer to make an informed decision.

4. Enteral Formulas

Enteral formulas are a general category of nutritional supplements (e.g., Ensure, Neocate) used to prevent malnourishment or disabling conditions. Coverage for enteral formulas in certain circumstances is a mandated benefit under New York law.²¹

²¹ Insurance Law Section 3216(i)(21) states: “Such written order [i.e., a doctor’s prescription] shall state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases for which enteral formulas have been

The requests for clinical review criteria for enteral formulas resulted in the greatest rate of compliance, albeit still unacceptably low, among the five medical services and supplies surveyed. Compliance was probably facilitated by the fact that the New York law mandating coverage for enteral formulas contains language that can be considered to constitute clinical review criteria.²² Many of the complying plans simply mirrored the statutory language in their plan materials.

Nine plans provided adequate clinical review criteria – CDPHP, Empire HealthChoice, GHI-HMO, Excellus, Atlantis Healthplan, Independent Health, HealthNow New York, Oxford Health Plans and Vytra Health Plan. Two of those plans – CDPHP and GHI-HMO – provided a separate clinical review document in addition to general plan materials. The other seven provided satisfactory clinical review language in their plan subscriber handbook materials.

Seven plans provided general plan materials that did not include specific clinical review criteria. Six plans did not respond at all.

For example, WellCare provided its Subscriber Contract with only general coverage information about enteral formulas: “We will also pay for medically necessary enteral formulas for the treatment of specific diseases.” Such language provides little

proven effective shall include, but are not limited to, inherited diseases of amino acid or organic acid metabolism; Crohn’s Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; multiple, severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death.” See also, Insurance Law Sections 3221(k)(11) and 4303(y).

²² Ibid.

guidance to the prospective enrollee seeking specific clinical review criteria and, like AmeriHealth's response to the insulin pump inquiry, raises the question that would be answered by providing the requested clinical review criteria; namely, in what circumstances will WellCare's medical personnel approve enteral formulas as medically necessary?

5. Breast Reduction Surgery (Reduction Mammoplasty)

Breast reduction surgery is often excluded from coverage as a "cosmetic" procedure. However, plans should cover breast reduction surgery when it is medically necessary, primarily in cases where breast size has caused a related medical condition – e.g., back, shoulder or neck pain, shoulder sores or abrasions due to bra use and postural changes.

Two plans – Excellus and MVP Health Plan – provided actual clinical review criteria for breast reduction surgery. Excellus and MVP present the criteria in an accessible and understandable manner that allows the consumer to reach a reasonable conclusion about whether or not coverage will be provided under her particular medical circumstances. The criteria provide specific height and weight criteria for the surgery and inform the consumer that photographs may be needed to further document the medical condition. Excellus and MVP's disclosure of clinical review criteria for breast reduction surgery demonstrates that exemplary and effective compliance with the MCCBOR is feasible.

One plan – Empire HealthChoice – provided a cover letter stating that it would provide specific clinical review criteria "if the consumer sent another written request containing the particular diagnosis and procedure code." While we will explore the appropriateness of this response with the plan, we have counted this as a satisfactory response for purposes of this survey.

Fifteen plans provided general plan materials that did not include specific clinical review criteria. Four plans did not respond at all. For instance, Preferred Care's HMO Health Care Contract states that "Plastic and Reconstructive Surgery" – the category in which breast reduction surgery is generally classified – is a covered benefit only "when there is a congenital disease or anomaly which has caused a functional defect, but only when the surgery is reasonably expected to correct the condition." The information provided simply does not constitute complete clinical review criteria. Further, Preferred Care's generic cover letter did not point the consumer to this section of the plan booklet. Thus, the consumer has no way of knowing that this statement may apply to breast reduction surgery.

MDNY Healthcare's Certificate of Coverage lists breast reduction surgery under "Exclusions" that contains the following language: "Reduction mammoplasty, surgical procedures and liposuction for the treatment of obesity, unless medically necessary" (Emphasis Added). There are no clinical review criteria provided to set forth the circumstances under which breast reduction surgery would be approved and covered as medically necessary.

IV. ACTION BY THE ATTORNEY GENERAL

A. Enforcement Action

The MCCBOR contains strong, comprehensive information disclosure requirements to empower consumers with a meaningful opportunity to compare and contrast health care plans in the market so that they may choose the plan that best meets their needs. The right to obtain clinical review criteria for specific medical conditions is a critical

protection for New Yorkers with imminent or existing health care needs, enabling them to evaluate effectively the coverage offered by different plans.

The Attorney General's survey suggests that these 22 HMOs are not adequately complying with the disclosure requirement for clinical review criteria. The Executive Law and General Business Law authorize the Attorney General to prosecute any business entity that repeatedly engages in fraudulent, deceptive or illegal business activity. With release of this report, letters have gone out to each health plan detailing its particular violations and requesting that the plan comply with the law and set a meeting date to discuss permanent compliance measures. The Attorney General may commence litigation seeking a court injunction ordering compliance with the law against any plan that does not voluntarily agree to do so.

B. Legislative Proposal

The Attorney General has previously demonstrated that the lack of specific penalties for violations of particular provisions of the MCCBOR leaves a hole in the law's enforcement capabilities.²³ The results of this survey confirm the need for stronger penalties as an added enforcement tool.

Last year, the Attorney General submitted Program Bill #68 (A.8604/Gottfried; S.5063/Hannon) that would have established a three-tiered system of penalties for violations of the MCCBOR: (1) violations involving no actual physical harm, no immediate jeopardy to health and safety and minimal potential for physical or financial harm

²³ See, Health Care Helpline Report and the 1997 Managed Care Consumer Bill of Rights Compliance Survey Report accessible at www.ag.ny.gov

and can result in a fine of up to \$500 per occurrence; (2) violations involving no actual physical or financial harm, no immediate jeopardy to health and safety and a potential for physical or financial harm that is more than minimal can result in a fine of up to \$2000 per occurrence; and (3) violations involving actual physical or financial harm or immediate jeopardy to health and safety can result in a fine of up to \$5000 per occurrence.²⁴ The tiered system allows state enforcement officials – the Commissioner of Health, the Superintendent of Insurance and the Attorney General – to fashion penalties that are appropriate to the circumstances and severity of each violation. Passage of this legislation will fill the enforcement void created by the absence of specific penalties and give the MCCBOR the teeth that it is so conspicuously missing.

²⁴ Similar legislation was submitted by the Attorney General in the 2001-2002 legislative session as A.8556/S.5179.

Appendix A

Date

Name
Address

Health Plan
Address

To Whom It May Concern:

I recently found out I will be moving to [] and am writing to obtain some basic enrollment information about [PLAN's] individual, direct pay health care policy. I am interested in finding out more about a specific procedure that I may have to undergo in the future. I sustained an injury to my knee while running several years ago which may require arthroscopic surgery to repair a torn ligament.

Based on my doctor's suggestion, I am requesting that you send me the guidelines you use to determine the amount of coverage, and medical necessity for arthroscopic knee surgery. I'm told this is called the clinical review criteria. I hope this information will help me to choose a new health plan.

If you have any questions or need additional information from me, please contact me at my home address which is listed above. Thank you for your assistance.

Sincerely,

Ms. _____
_____ Drive
_____, NY

Date

Health Care Plan

Address

Dear _____ :

I am writing to request information about an individual health care policy that {PLAN} offers. I am recently divorced and am now required to purchase a policy on my own. I am looking for a plan that will provide me with the most coverage at a reasonable cost. I expect to be moving to { } in the very near future and I was told {PLAN} covers this area.

In addition to the usual enrollment information, please send me any relevant information you have about breast reduction surgery. I am contemplating breast reduction surgery because of back pain I have endured for a number of years and my doctor instructed me to request a copy of the written clinical review criteria for breast reduction surgery. Please send me your enrollment materials and the criteria at the address listed above. Thank you for your assistance with this matter.

Very truly yours,

cc: Dr. K.

Name
Address

Date

Health Plan
Address

Dear Sir or Madam:

I am writing to request information about a health insurance policy for my son and myself. My employer currently provides our health insurance but, because I will be leaving my job and moving next month, I will need to purchase a direct pay policy. I understand that [PLAN] provides coverage in [] County.

In addition to general enrollment information, I need to obtain information about [PLAN's] coverage of pediatric enteral formula. My infant son's pediatrician has placed him on enteral formula for at least the next six months. I would like to know if pediatric enteral formula is covered and if so what clinical review criteria [PLAN] uses to make coverage determinations. I would like to review this information before I make a decision about purchasing a new policy, so please send me the information at your earliest convenience.

Thank you,

Name
Address

Date

Health Care Plan
Address

Dear _____ :

I am a graphic artist in a small company that I own and am interested in purchasing an individual health care policy for myself. I am a diabetic and my doctor recently advised me that I may soon require an insulin pump to effectively treat my condition. It is my primary concern that the cost of the insulin pump and all other treatments recommended by my doctor be covered by the insurance policy that I purchase. Please send me any information that will help me determine what services are covered under your plan for the treatment of diabetes, including an insulin pump, along with the standard enrollment materials. Also, if you have any information on how [PLAN] decides if an insulin pump will be covered, such as the clinical review criteria, I would like that information also. Thank you for your assistance.

Very truly yours,

Name
Address

Health Care Plan
Address

Dear _____ :

I am an interior designer and am currently working in [_____], New York but will soon be moving to [_____] to work with a design firm. Since I am an independent contractor, I believe I will need to purchase an individual health care policy.

I would appreciate it if you could send me information about any health care policies offered by [PLAN] which may be appropriate for me. I suffer from Crohn's disease and need a policy which covers treatment for this condition. My doctor recently informed me that I may need surgery to treat the Crohn's disease. I am therefore interested in learning about [PLAN's] coverage for this surgery. Please send me general information about the policies offered and also any criteria [PLAN] would review when deciding if surgery to treat Crohn's disease is covered.

Thank you for your anticipated cooperation.

Very truly yours,