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

2004 and 2005 Health Care Helpline Report

– Complaint Patterns –
– Consumer Tips –
– Reform Recommendations –

Eliot Spitzer
Attorney General

Acknowledgments

Helpline information in this report was compiled primarily by Jacquelyn Heffner with the assistance of Marie Briscoe, Phyllis Burger, Elizabeth Canam, Bela Changrani, Chris D'Ippolito, and Eileen Saddlemire.

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

OFFICE OF THE NEW YORK STATE ATTORNEY GENERAL
DIVISION OF PUBLIC ADVOCACY
HEALTH CARE BUREAU STAFF

Joe Baker, Bureau Chief
Paul Beyer, Assistant Attorney General
Marie Briscoe, Helpline Legal Assistant II
Phyllis Burger, Helpline Intake Specialist
Dorothea Caldwell-Brown, Assistant Attorney General
Brant Campbell, Assistant Attorney General
Elizabeth Canam, Helpline Senior Consumer Frauds Representative
Bela Changrani, Secretary and Helpline Intake Specialist
Donna Charbonneau, Helpline Legal Assistant II
Rob Courrier, Helpline Intake Specialist
Chris D'Ippolito, Helpline Legal Assistant II
Vincent P. Esposito, Jr., Assistant Attorney General
Linda Friedman, Helpline Legal Assistant II
Sandra Jefferson Grannum, Deputy Bureau Chief
Jacquelyn Heffner, Helpline Legal Assistant I
Carol Hunt, Assistant Attorney General
Heather Hussar, Assistant Attorney General
Susan Kirchheimer, Assistant Attorney General
Troy Oechsner, Deputy Bureau Chief
John Powell, Assistant Attorney General
Soonmatee Ramsahai, Administrative Manager
John Rice, Helpline Consumer Frauds Representative
Eileen Saddlemire, Helpline Intake Specialist
Brooke Turallo, Legal Assistant
Rashmi Vasisht, Director of Policy and Research
Henry Weintraub, Assistant Attorney General

Health Care Helpline
Tel: 1-800-771-7755, option 3
Fax: 518-402-2163

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

Albany Office
Mailing address: The Capitol, Albany, NY 12224-0341

Table of Contents

Liist of Tables

EXECUTIVE SUMMARY

HEALTH CARE HELPLINE

The Attorney General's 2004/2005 Health Care Helpline Report covers the time periods from July 1, 2003, through June 30, 2004 (referred to herein as "the 2004 reporting period" or "2004"), and July 1, 2004, through June 30, 2005 (referred to herein as the "2005 reporting period" or "2005").

During the 2004 reporting period, staff of the Health Care Helpline of the Attorney General's Health Care Bureau (HCB) handled 7,100 cases. Of these 7,100 cases, 2,243 were consumer complaints resolved by Helpline staff and 4,421 were consumer inquiries in response to which Helpline intake staff provided information or referrals to other agencies. Complaints from providers accounted for the remaining 436 cases.

During the 2005 reporting period, Helpline staff handled 6,502 cases: 2,031 were consumer complaints resolved by staff, 3,988 were referrals or requests for information and 483 were provider complaints.

In 2004 and 2005, Helpline staff assisted consumers in obtaining approximately $4.2 million in additional care or coverage for care from health plans, providers and other entities. Also, the HCB's enforcement actions generated approximately $2.4 million in restitution to consumers in New York and over $3.1 million in penalties and costs to the state.

The experiences of the consumers who contact the HCB Helpline are not necessarily representative of the experiences of all New York health care consumers. This is because the HCB only hears from people who are dissatisfied with their health care or health care coverage. However, the HCB believes 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.

This report:

- analyzes the 4,274 individual consumer complaints that were investigated by HCB staff during the 2004 and 2005 reporting periods;

- the complaints were divided into six general categories (each with more specific sub-categories): (1) claims processing and payment problems; (2) health plan denials of care or coverage for care; (3) access to specialty care; (4) 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;

- explains certain health care laws and regulations;

- reports consumer complaint trends from the Helpline;

- provides tips to consumers about how to protect their rights and maximize their health care coverage; and

- proposes reform recommendations to address systemic problems.

Our Findings

An analysis of the 2004 and 2005 Helpline complaints reveals that:

- access to health care remains the primary issue for New York consumers with almost 2 out of 3 of all complaints received during the 24-month period covered by the report concerning either denials of care or coverage by health plans, problems getting and keeping health insurance coverage, access to specialty care, or access to prescription drugs;

- there is a continuing decline in complaints concerning access to specialty care (down 4.6% from 21.9% to 17.3% of all complaints in 2004, and down another 3.5% to 13.8% of all complaints in 2005);

- complaints about health plan denials of pre-authorizations and refusals of referrals to out-of-network providers have remained at essentially the same level; and

When comparing the 2005 Helpline complaints with those complaints analyzed in our 2003 report, we have identified the following trends:

- claims processing and payment problems decreased from 25.3% to 22.3% of all complaints;

- denials of care or coverage by health plans increased from 17.4% to 20.1% of all complaints;

- problems with access to specialty care and out-of-network care decreased from 21.9% to 13.8% of all complaints;

- complaints concerning problems getting and keeping coverage increased from 17% to 19.6% of all complaints;

- complaints regarding improper billing by providers increased from 13.2% to 16.6% of all complaints; and

- complaints regarding consumer access to prescription benefits increased from 5.2% to 7.6% of all complaints.

The top ten (10) consumer complaints in 2005 were:

1. Claims processing and payment problems due to health plan errors (334 cases/16.4% of all complaints; p. 8 of the Report);

2. Problems getting and keeping coverage through consumer confusion or lack of affordability of the coverage (188 cases/9.3%; p. 29);

3. Improper balance billing by participating providers (186 cases/9.2%; p. 34);

4. Health plan denials of care or coverage for care because of lack of medical-necessity (165 cases/8.1%; p. 12);

5. Health plan denials of care or coverage for care for covered benefits denials (131 cases/6.5%; p. 12);

6. Claims processing and payment problems due to provider error (119 cases/5.9%; p. 8);

7. Health plan denials of care or coverage for care because of health plan errors (112 cases/5.5%; p. 12);
8. Access to specialty care: surprise bills from a non-participating provider unknown to the consumer (91cases/4.5%; p. 24);

9. Providers improperly billing the wrong person(74 cases/3.6%; p. 34); and

10. Consumer disputed a plan's usual and customary rate used to reimburse for out-of-network care (64 cases/3.2%; p. 24).

CONSUMER COMPLAINTS, HCB ENFORCEMENT ACTIONS AND CONSUMER EDUCATION: HIGHLIGHTS

Claims Processing and Payment Problems

In 2004, nearly 20% of all HCB consumer complaints arose from provider or health plan mistakes in preparing, processing or paying claims. Two-thirds of these complaints (approximately 14% of all consumer complaints) were due to health plans errors and made it the number one consumer complaint. The most common sub-category of complaints relating to health plans' claims and payment processing errors was that health plans do not process claims at all or do not process them in a timely manner (8.7% of all consumer complaints).

In 2005, over 22% of all Helpline complaints were claims processing and payment problems due to either health plan or provider errors. Once again, claims processing and payment problems due to health plan errors is most frequently heard consumer complaint.

Health Plan Denials of Care or Coverage for Care

In 2004, almost 22% of all HCB consumer complaints involved health plan denials of care or coverage for care. This category had the greatest number of complaints (492) among the six main consumer complaint categories. In 2005, the number of complaints due to health plan denials of care or coverage for care (408) declined slightly to 20%.

Enforcement Actions

- After conducting a survey of all health plans in New York State offering coverage to individuals, the HCB found that some plans failed to comply with state law that requires them to disclose "clinical review criteria" to consumers. The clinical review criteria are the standards that the health plans use to determine whether a specific treatment is medically necessary; if not, coverage is denied and the consumer is left with the choice of either foregoing medical care or paying out-of-pocket for it. The Attorney General's settlement with 21 health plans requires them to ensure that all consumer requests for clinical review criteria are honored and to submit annual compliance reports to the Attorney General.

- The Attorney General reached an agreement with Empire BlueCross BlueShield (Empire) to resolve consumer complaints about the automatic denial of mandated coverage for over-the-counter nutritional supplements. Empire agreed to make its claims adjudication procedure compliant with state law and make refunds to aggrieved consumers.

HCB Investigative Report

- The Attorney General released a report in July 2004, Getting the Lead Out: Are New York's Managed Care Plans Complying with the State's Childhood Lead Screening Law, that found that certain Medicaid and Child Health Plus managed care health plans have lead screening rates for infants and young children below the statewide average. The report marked the beginning of an inquiry to determine whether plans are complying with state law that mandates universal lead screening and identify steps plans may take to increase their childhood lead screening rates.

Access to Specialty and Out-of-Network Care

Seventeen percent of all HCB consumer complaints received in 2004 and 14% in 2005 involved problems accessing or paying for specialty medical care, down from 21.9% in 2003. However, complaints regarding plan error in administering these processes continue at essentially the same level over both time periods. Each year a significant percentage of these complaints concerns health plans' inadequate "usual and customary" reimbursement of non-participating providers, which leaves consumers with a hefty portion of the bill.

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 Utilization Review

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.

Getting and Keeping Coverage

Approximately 20% of the 2004 and 2005 consumer complaints involve getting and keeping coverage. Employers are frequently responsible for the 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). If health benefits are terminated or not offered by the employer, employees are forced to look elsewhere for affordable health insurance which can make them more vulnerable to unscrupulous businesses that engage in illegal and deceptive business practices. It can be very confusing to consumers to sort out which health plans are legitimate.

Enforcement Actions

- After investigating complaints from consumers that a New York City-based health plan was not paying claims and denying access to care, the Attorney General, State Superintendent of Insurance and State Commissioner of Health sued to halt the operation of the plan, known as Metro Health, that was not licensed or authorized to conduct an insurance business in New York. The court immediately issued a temporary restraining order and later approved a settlement permanently closing the plan and requiring its operator, Blanca Jaravata, to provide funds for restitution to affected consumers. Additionally, the Attorney General's Criminal Prosecutions Bureau obtained an indictment against Jaravata that resulted in felony convictions for scheme to defraud and grand larceny (5 counts) in connection with the Metro Health scam.

- The HCB and the Consumer Frauds and Protection Bureau (CFB) investigated two companies that offer medical discount cards – MedAdvantage, LLC and National Association of Preferred Providers/Family Care – and found that they failed to disclose the costs and benefits of their discount card programs. The companies agreed to reform their advertising and marketing practices and to refund enrollment fees and unauthorized charges to qualified

complainants.

- As a result of the medical discount card investigations, the Attorney General developed guidelines to assist the industry in advertising and marketing discount cards in a lawful, non-deceptive manner.

Improper Billing by Providers

In 2004 and 2005, approximately 16% and 17%, respectively, 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 improperly or illegally bill consumers and subject them to collection actions.

Enforcement Actions

- After receiving complaints from consumers, a HCB investigation revealed that Vineall Ambulance Company had a policy of billing consumers for the balance due between Vineall's charges and the health plan's reimbursement rate. Such "balance billing" is prohibited under New York's "Ambulance Mandate." Vineall agreed to issue refunds to consumers who were improperly billed.

- WellCare of New York, a Medicare HMO, agreed to contact some 5,000 of its members who used non-participating ambulance services between 1998 and 2002 and to provide refunds to those who paid bills that should have been fully covered by the health plan. WellCare's failure to pay such bills violated federal regulations and state law.

- As a result of an HCB investigation and as part of the Attorney General's statewide "Project Clean Bills of Health" initiative, a settlement was reached with MDS, Inc., a provider of medical laboratory services, that provides refunds to New York consumers who were improperly "balance billed" for services covered or already paid for by their health plans.

Access to Prescription Drugs

In 2004, nearly 5% of HCB consumer complaints were about access to

prescription drugs. In 2005, almost 8% of all complaints fell into this category. With drug costs rising precipitously, health plans try 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.

Another issue regarding access to prescription drugs concerns the adequate disclosure of clinical studies, negative as well as positive findings, so that prescribing physicians will be fully informed of potential risks and side effects of the medication.

Enforcement Actions

- Medco Health Solutions (Medco), the world's largest pharmaceutical benefits management company (PBM), settled claims brought under state deceptive business practices laws by the Attorney General and 19 other state Attorneys General for Medco's drug switching practices. Medco encouraged physicians to switch patients to different prescription drugs without disclosing that the switches benefited Medco by increasing rebate payments from drug manufacturers. Medco agreed to provide disclosure to consumers about the reasons for drug switching and to pay more than $29 million to the states and identifiable consumers in restitution, damages and costs.

- The HCB and the CFB sued GlaxoSmithKline (GSK) for concealing from doctors and their patients important safety and efficacy information about children and adolescents' use of Paxil, an anti-depressant. In settling the lawsuit, GSK agreed to post all the Paxil studies it had concealed and to establish a website where it would post summaries of results of other clinical trials.

- The HCB and the CFB similarly investigated Forest Laboratories, Inc., for concealing from doctors and their patients important safety and efficacy information about the off-label uses of certain drugs, including the anti-depressants Lexapro and Celexa. Like GSK, Forest agreed to establish a website where it would post summaries of results of its clinical trials.

- The Attorney General and NYS Department of Civil Service sued Express Scripts, Inc., then the nation's third largest PBM and the PBM for New York State's largest employee health plan, the Empire Plan, for fraud and breach of contract. The complaint alleges that Express Scripts improperly (1) inflated the cost of generic drugs, (2) retained millions of dollars in manufacturer rebates that belonged to the Empire Plan, (3) improperly induced physicians to switch a patient's prescription to another drug for which Express Scripts would receive a rebate from the drug manufacturer, and (4) sold and licensed data belonging to the Empire Plan to drug manufacturers, data collection services and others without the permission of the Empire Plan and in violation of the State's contract.

CONSUMER EDUCATION

An important aspect of the work of the Health Care Bureau is consumer education. During the 2004 and 2005 Helpline Report years, new consumer education reports were issued and a major consumer project was initiated.

- In February 2004, the HCB instituted a new consumer education series entitled "Focus On." The first release, Focus On: Eating Disorders, documented the unique problems that patients diagnosed with eating disorders and their families encounter when accessing the health care system, such as inadequate coverage for mental health care. The report also provides tips that consumers may use to maximize their health care coverage for treatment of the disorders.

- The second report in this series, Focus on: Overcoming Obesity, released in November 2004, provided information about the difficulties many consumers encounter in accessing bariatric surgery and other treatments. The report also guided consumers about how to obtain benefits available to them for these medical services.

- In January 2005, the HCB published, "Planning Your Health Care in Advance: How To Make Your Wishes Known and Honored" which describes steps that may be taken under state law to accept or refuse medical treatments and ensure that, when a patient is unable to express his or her wishes, medical decisions remain in the hands of loved ones or other trusted persons.

- In August 2004, the Attorney General launched a pilot drug price

comparison website to help consumers across the state access the best price for commonly prescribed medications: www.NYAGRx.org. Initially, 440 pharmacies across the state were surveyed to determine the prices of the 25 most frequently prescribed drugs. Subsequently, the survey was dramatically expanded to include selected pharmacies in all 62 counties across the state and to report on the 150 most frequently prescribed drugs.

REFORM RECOMMENDATIONS

The information and trends identified in this report reaffirm the continued need to review the statutory provisions that impact on access to health care and consumer education issues. Gaps in the law can be seen with respect to the enforcement of rights afforded by the Managed Care Consumer Bill of Rights, the review of denials for out-of-network providers, the adequacy of denial notices, and the funding of consumer education and advocacy programs.

Accordingly, the Attorney General urges that these reform recommendations be acted upon:

- Fully fund New York's Managed Care Consumer Assistance Program (MCCAP) to ameliorate widespread confusion or lack of information on the part of consumers and their frequent inability to protect their rights and access benefits. MCCAP was established in New York to fund and support local organizations that provide consumers with assistance and education regarding managed care issues.

- Establish statutory penalties for violations 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.

- Require health plans to use a standardized 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.

- 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 Utilization Review Law, allowing consumers access to the external appeals process.

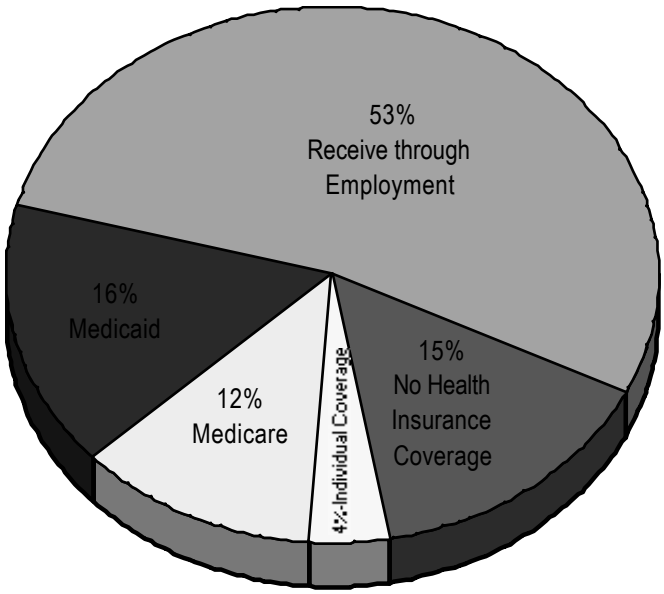
INTRODUCTION

HEALTH CARE COVERAGE IN NEW YORK STATE

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

New Yorkers receive health insurance coverage from a variety of sources – 53% through employment, 16% through Medicaid, 12% have Medicare, 4% have individual policies with other public or private insurers, and 15% have no health insurance coverage at all.[1]

HEALTH INSURANCE COVERAGE SOURCES FOR NEW YORKERS



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.

- 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-authorization 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 contract 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 or dependents of workers. More than 78% of uninsured workers do not have access to employer-sponsored coverage.[3] Many of these workers are not eligible for government-subsidized coverage 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. Furthermore, 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 plan 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.

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

Consumer Tip
You should carefully read your entire health plan handbook or insurance policy because it contains valuable information on the coverage and benefits to which you are entitled. If you have not received a handbook or policy, you should contact your plan or insurer and request one. If you have questions about your benefits, you should call your plan's customer service department – the phone number is usually located on the back of your health insurance card.

THE HEALTH CARE BUREAU AND THE HEALTH CARE HELPLINE

Helping ensure consumers are aware of their rights and understand how to exercise them is a core function of the Attorney General's Health Care Bureau (HCB).

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** (1-800-771-7755, option 3). 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, such as presentations for consumer advocacy groups, senior centers, and consumer publications, 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.

In the 2004 reporting period (July 1, 2003, and June 30, 2004), the HCB handled 7,100 cases of which 2,243 were consumer complaints resolved by Helpline staff and 4,421 were consumer inquiries to which Helpline intake staff responded by providing information or referrals to other agencies. Complaints from providers accounted for the remaining 436 cases.

In the 2005 reporting period (July 1, 2004, and June 30, 2005), Helpline staff handled 6,502 cases: 2,031 were consumer complaints resolved by staff, 3,988 were referrals or requests for information and 483 were provider complaints.

In 2004 and 2005, Helpline staff assisted consumers in obtaining approximately $4.2 million in additional care or coverage for care from health plans, providers and other entities. Also, the HCB's enforcement actions generated approximately $2.4 million in restitution to consumers in New York and over $3.1 million in penalties and costs to the state.

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

- helping consumers challenge denials of care or coverage for care by health plans;

- helping consumers 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 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, and helping consumers and their health

plans identify the exact nature of a particular dispute.

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 investigate the matter further. These investigations may result in the bringing of 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. 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. Therefore, the Attorney General recommends continued funding for the New York State Managed Care Consumer Assistance Program (MCCAP).[6]

THIS REPORT

The 4,274 cases handled by the HCB Helpline staff in 2004 and 2005 (2,243 and 2,031, respectively), reflect the experiences of the state's health care consumers and identify some of the stress points in the state's health care system. HCB staff intervened on behalf of consumers to resolve their complaints. These complaints have been grouped into six categories: (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. Table A provides a breakdown for all of the categories of complaints and referrals handled by the Helpline. Each of these categories is discussed in a separate chapter in the report.

Each chapter in this report includes descriptions of the various Helpline complaints that illuminate both the nature of the issue under discussion and the kind of assistance the Helpline staff provided to individual consumers. In addition, side panels describe enforcement actions pursued by the HCB regarding that particular issue, offer consumer tips on how to deal with problems or questions more effectively and provide background information on relevant

laws. Finally, we have highlighted certain trends and differences in complaints reviewed in this report and the 2003 Health Care Helpline Report.

Table A Helpline Cases by Type and Issue		2004/2005 No. of Helpline Cases	2004/2005 % of Consumer Complaints	2003 % of Consumer Complaints	% Difference between 2003 and 2004/% difference between 2004 and 2005
Table	Consumer Complaints – Issue				
1	Claims processing and payment problems	445/453	19.8/22.3	25.3	-5.5/+2.5
2	Denials of care or coverage by health plans	492/408	21.9/20.1	17.4	4.5/-1.8
3	Access to specialty care and out-of-network care	388/280	17.3/13.8	21.9	- 4.6/-3.5
4	Getting and keeping coverage	452/398	20.2/19.6	17.0	3.2/-0.6
5	Billing errors by providers	357/337	15.9/16.6	13.2	2.7/+0.7
6	Access to prescription drugs	109/155	4.9/7.6	5.2	- 0.3/+2.7
	Sub-total - Consumer Complaints:	2,243/2,031	100.0/100.0	100.0	
	Provider complaints	436/483			
	Referrals and information	4,421/3,988			
TOTAL		7,100/6,502			

The report does not analyze the 8,409 consumer referral and information inquiries and provider complaints identified in Table A, above (cases in which HCB staff provided only information or a referral).

THE HELPLINE DATASET

All calls from the public to the Helpline are entered into a 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.

This report generally describes consumer complaints in two ways. 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 (page 12) 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 attributing fault on any party – such as in Table 2.1 (page 14), "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.

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 needing 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.

CONSUMER COMPLAINTS

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 payments process. Table 1, below, shows that approximately one-fifth of all Helpline consumer complaints (19.8% in 2004 and 22.3% in 2005) originate from provider or health plan mistakes in claims preparation, processing and payment, and that the majority of these mistakes are attributable to health plans.

2005 Trends
From 2003 to 2005, complaints regarding claims processing and payment problems due to health plan and provider errors declined from 25.3% to 22.3%of all complaints.

Consumers' problems with the health care system tend to begin with the paperwork and electronic transmissions that inevitably follow a provider-patient encounter. This paperwork consists of providers and consumers preparing and submitting claims, health plans processing those claims, and finally the health plans issuing payments. In HMO, HMO-POS plans or PPO plans,[7] most of this paperwork passes between providers and health plans, and increasingly by electronic means. The consumers' role in the submission and processing of claims is generally very limited. However, it is often the consumer who suffers when problems occur during those processes.

Table 1 Consumer complaints Claims processing and payment problems	2004/2005 No. of Helpline Cases	2004/2005 % w/in Consumer Complaint Category	2004/2005 % of all Consumer Complaints	2003 % of all Consumer Complaints	% Difference between 2003 and 2004/% difference between 2004 and 2005
Due to health plan errors	306/334	68.8/73.7	13.6/16.4	16.3	- 2.7/+2.8
Due to provider errors	139/119	31.2/26.3	6.2/5.9	9.0	- 2.8/-0.3
TOTAL	445/453	100/100	19.8/22.3	25.3	- 5.5/+2.5

Claims Processing and Payment Problems Due to Health Plan Errors

The consumer complaints regarding claims processing and payment problems due to health plan errors were distributed into six sub-categories. The most common complaint in 2004 was that health plans failed to process claims or pay the claim at all. These failures accounted for nearly 9% of all Helpline

consumer complaints and 64% of complaints regarding claims processing and payment problems due to health plan errors. In 2005, this subcategory accounted for 10% of all consumer complaints (see Table 1.1, below).

Health plan errors with respect to paying the wrong amount and errors regarding deductibles or co-payments were also a source of significant complaints within this category, accounting for 12.1% and 8.2% of such complaints, respectively, in 2004 and 15.9% and 8.4%, respectively, in 2005 (see Table 1.1, below).

At A Glance: Insurance Law §3224-1, New York's Prompt Pay Law

The state's "prompt payment" law requires health plans to pay "clean claims" within 45 days of receipt. 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. The NYS Department of Insurance has established a dedicated hotline for consumers and providers to file prompt pay complaints at 1-800-358-9260.[8]

Table 1.1 Consumer complaints Claims processing and payment problems due to health plan errors	2004/2005 No. of Helpline Cases	2004/2005 % w/in Consumer Complaint Category	2004/2005 % of all Consumer Complaints	2003 % of all Consumer Complaints	% Difference between 2003 and 2004/% difference between 2004 and 2005
Health plan not processing or paying claims	196/206	64.1/61.7	8.7/10.1	9.6	- 0.9/+1.4
Health plan paid wrong amount	37/53	12.1/15.9	1.6/2.6	1.1	0.5/+1.0
Health plan overpaid provider	10/7	3.3/2.1	0.4/0.3	0.6	- 0.2/-0.1
Health plan paid wrong person	16/16	5.2/4.8	0.7/0.8	0.6	0.1/+0.1
Health plan error regarding deductible or co-payment	25/28	8.2/8.4	1.1/1.4	1.1	same/+0.3
Other claims processing or payment problem	22/24	7.2/7.2	1.0/1.2	3.4	- 2.4/+0.2
TOTAL	306/334	†100*/100*	13.6*/16.4	16.3	- 2.7*/+2.8*

† An asterisk (*) will be used whenever totaling the column of figures does not equal 100% or when the column total does not equal the corresponding value calculated in another table. Any discrepancy is due to the rounding off of the figures.

Health Plan Not Processing or Paying Claims

When a health plan fails to process or pay a claim, it can be a great source of frustration and anxiety for consumers.

For two years, Ms. R. experienced great difficulty with her health plan for non-payment of claims. Ms. R's provider stated that he had submitted the claims numerous times but the plan gave various reasons why it was not paying. After spending considerable time and money mailing and faxing information to the health plan, with no results, Ms. R contacted the HCB. An inquiry was filed on Ms. R's behalf and after several follow up calls, the HCB was able to get the claims reprocessed quickly and Ms. R received payment of $2,900.

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.

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. In 2004 and 2005, this error accounted for 2.3% of all consumer complaints. Entering the wrong diagnostic or procedure code on a claim form declined drastically from 2004 to 2005, from 20.1% to 9.2% of complaints in this category.

In most situations where the mistake is typographical, only one or at most two numbers will be wrong, but this will almost always cause a mismatch between the diagnosis and the treatment. Accordingly, health plan computer systems 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 claims to the wrong health plan.

Table 1.2 Consumer complaints Claims processing and payment problems due to provider error	2004/2005 No. of Helpline Cases	2004/2005 % w/in Consumer Complaint Category	2004/2005 % of all Consumer Complaints	2003 % of all Consumer Complaints	% Difference between 2003 and 2004/% difference between 2004 and 2005
Late filing of claim	52/46	37.4/38.7	2.3/2.3	1.8	0.5/same
Insufficient clinical information	20/19	14.4/16.0	0.9/0.9	1.6	- 0.7/same
Wrong diagnostic or procedure code	28/11	20.1/9.2	1.2/0.5	1.0	0.2/-0.8
Participating provider failed to issue referral or obtain authorization	14/18	10.1/15.1	0.6/0.9	0.7	- 0.1/+0.3
Coordination of benefits: primary/secondary	11/12	7.9/10.1	0.5/0.6	NA	NA/+0.1
Other provider error	14/13	10.1/10.9	0.6/0.6	3.8	- 3.2/0.0
TOTAL	139/119	100/100	6.2*/5.9*	9.0*	-2.8*/-0.3*

Nearly all of these cases were resolved promptly by Helpline staff contacting the provider and asking that corrected information, or additional information, be submitted to the health plan. In many of these cases, prior to intervention by the Helpline staff, the consumer was making the same request for weeks, if not months, to no avail.

Consumer Tips

Avoiding 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 the services you received and your medical diagnosis are accurately reported on all bills and claims forms.
- 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 approval and 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.

Table 2 Consumer complaints Health plan denials of care or coverage for care	2004/2005 No. of Helpline Cases	2004/2005 % w/in Consumer Complaint Category	2004/2005 % of all Consumer Complaints	2003 % of all Consumer Complaints	% Difference between 2003 and 2004/% difference between 2004 and 2005
Medical necessity denials	170/165	34.6/40.4	7.6/8.1	7.2	0.4/+0.5
Denials due to health plan errors	146/112	29.7/27.5	6.5/5.5	5.2	1.3/-1.0
Covered benefit denials	176/131	35.8/32.1	7.8/6.5	5.0	2.8/-1.3
TOTAL	492/408	100*/100	21.9/20.1	17.4	4.5/-1.8

Health plan denials of care are the most common complaint on the Helpline, representing more than a fifth of all complaints (21.9% in 2004 and 20.1% in 2005) (see Table A, page 6). These consumer complaints fall into three subcategories: 1) medical necessity denials, 2) denials due to health plan errors and 3) covered benefit denials. The distribution of cases within this category of consumer complaints is shown in Table 2, above.

2005 Trends

From 2003 to 2005, complaints involving health plan denials of care or coverage increased from 17.4% to 20.1% 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.[9] UR can take place at three different stages: in advance of a requested service (known as pre-authorization or pre-certification), after the service has been delivered (known as retrospective review), and during the delivery of an ongoing service (known as concurrent review).

At A Glance: New York's Utilization Review Law

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, 30 days for retrospective reviews, and 1 day for concurrent reviews; and
- decisions to authorize or deny care are made in writing and must include the following:
  1. an informative notice of adverse determinations, including a clear statement of the reasons and clinical rationale, if any, for the denial; and
  2. information regarding appeal rights, specifically:
     (a) a standard internal appeal or an expedited appeal, conducted by a clinical peer reviewer[10] within the health plan who was not involved in the initial adverse determination; and
     (b) an external appeal to an independent clinical peer reviewer.

Table 2.1, below, shows the frequency with which New York consumers contacted the HCB Helpline with complaints concerning their health plans' medical necessity or UR practices. We have categorized the medical necessity complaints into eight categories to demonstrate the diversity of cases that fall within this complaint area.

Table 2.1 Consumer complaints Health plan denials of care or coverage for care Medical necessity denials	2004/2005 No. of Helpline Cases	2004/2005 % w/in Consumer Complaint Category	2004/2005 % of all Consumer Complaints	2003 % of all Consumer Complaints	% Difference between 2003 and 2004/% difference between 2004 and 2005
Pre-authorization denials	44/32	25.9/19.4	2.0/1.6	2.1	- 0.1/-0.4
Retrospective denials Denials of emergency care	17/16 4/10	10.0/9.7 2.4/6.1	0.8/0.8 0.2/0.5	0.7 0.6	+0.1/same - 0.4/+0.3
Concurrent denials	20/20	11.8/12.1	0.9/1.0	1.9	-1.0/+0.1
Denials of care as experimental or investigational	42/37	24.7/22.4	1.9/1.8	1.0	0.9/-0.1
Plan considered service to be "cosmetic"	20/17	11.8/10.3	0.9/0.8	0.5	0.4/-0.1
Plan considered service to be "custodial"	6/11	3.5/6.7	0.3/0.5	0.2	0.1/+0.2
Defective or late notices, late appeal decisions, other UR violations	3/4	1.8/2.4	0.1/0.2	N/A	N/A/+0.1
Medical necessity - other	14/18	8.2/10.9	0.6/0.9	0.2	0.4/+0.3
TOTAL	170/165	100*/100	7.6*/8.1	7.2	0.4*/+0.5*

HCB Enforcement Action

Health Plans Fail to Disclose Required Coverage Information

After conducting a survey of all health plans in New York State offering coverage to individuals, the HCB found that almost all of the plans failed to comply with state law that requires them to disclose "clinical review criteria" to consumers. The clinical review criteria are the standards that the health plans use to determine whether a specific treatment is medically necessary; if not, coverage is denied and the consumer is left with the choice of either foregoing medical care or paying out-of-pocket for it. The Attorney General's settlement with 21 health plans requires them to ensure that all consumer requests for clinical review criteria are honored and to submit annual compliance reports to the Attorney General.

HCB Enforcement Action

Health Plan Corrects Policy on Nutritional Supplement

The Attorney General reached an agreement with Empire BlueCross BlueShield (Empire) to resolve consumer complaints about the improper automatic denial of mandated coverage for over-the-counter nutritional supplements. Empire agreed to make its claims adjudication procedure compliant with state law and make refunds to aggrieved consumers.

HCB Investigative Report

The Attorney General released a report in July 2004, Getting the Lead Out: Are New York's Managed Care Plans Complying with the State's Childhood Lead Screening Law, that found that certain Medicaid and Child Health Plus managed care health plans have lead screening rates for infants and young children below the statewide average. The report marked the beginning of an inquiry to determine whether plans are complying with state law that mandates universal childhood lead screening and identify steps plans may take to increase their screening rates.

Pre-authorization Denials

As noted in Table 2.1, pre-authorization denials accounted for 2.0% of all consumer complaints in 2004 and 1.6% in 2005. 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. 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; notification to the health plan within 24 or 48 hours 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.

At A Glance: New York's "Prudent Layperson" Standard for Coverage of Emergency Care

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.[11] Health plans must cover emergency claims when the individual has symptoms that an ordinary, prudent layperson would consider to pose a serious health risk. 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.

A related protection prohibits health plans from insisting that members receive pre-

authorization before seeking emergency care. 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.[12]

When Ms. B became ill while attending college away from home, she called the local hospital and described her symptoms. She was told by the hospital that she should go to the emergency room. However, her HMO denied the claim for these out-of-network services, contending that this was not an emergency situation. After the HCB contacted the health plan and medical records were reviewed, the plan overturned its denial and paid the claim in full.

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 one business day of a request for continuing coverage of a health care service whether or not to approve the request.[13] If the health plan needs additional information and requests it, the 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.

Mrs. F suffered from two herniated disks. Physical therapy treatments were recommended by her physician. Mrs. F's health plan approved only eight visits, and refused to cover her for the full number of visits that her doctor believed to be medically necessary to effectively treat her. With help from the HCB, Mrs. F. requested reconsideration of the number of visits and the health plan reversed its decision and additional physical therapy sessions were approved.

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. However, consumers should be aware that denial of an experimental or investigational treatment or service triggers the same timing, notice and appeal processes as that for medical necessity determinations, including the ability to file an external appeal.

J. and J., 11 and 7 years old, were diagnosed with primary immune deficiency. Their pediatrician requested coverage of IVIG therapy (intravenous immunoglobulin - a type of protein found in human blood that helps fight off harmful bacteria, viruses and other germs) for the children. The children's health plan denied the request for coverage on the ground that it was experimental. With the HCB's assistance, the children's parents appealed the denial, with additional medical documentation from the pediatrician. The plan overturned its denial and authorized IVIG therapy for six months.

"Cosmetic" or "Custodial" Denials

New York law permits health plans to exclude coverage for cosmetic and custodial services. Generally, the determination of whether a health service is cosmetic or custodial is a medical necessity determination. However, because a procedure or service has a cosmetic purpose does not preclude it from also being medically necessary and, therefore, covered by the health plan.

Ms. R's physicians wrote letters to her health plan detailing the medical necessity for her breast reduction surgery. The health plan denied coverage on the ground that it was cosmetic surgery. An appeal was filed along with supporting medical documentation but the decision was upheld. Ms. R filed a second level appeal, and after getting no response, she contacted the HCB. The HCB contacted the health plan which stated it never received Ms. R's second appeal. After the HCB advised her to obtain the clinical review criteria that the health plan used in her case, Ms. R resubmitted her second appeal, the plan reviewed it and approved Ms. R's surgery.

Defective or Late Notices, Late Appeal Decision, Other UR Violations

When a health plan denies care or coverage for care based on medical necessity, it must provide the consumer with notice of that determination. Article 49 of the New York Public Health Law and Article 49 of the Insurance Law dictate the information that must be included in these notices. Unfortunately,

sometimes the health plan's claim denial notice is confusing or lacks required information. To address this problem, the Attorney General recommends that health plans be required to use a standardized 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.

Sometimes health plans do not provide timely notices or adhere to the timetable for processing appeals. If the health plan does not adhere to the timetable for processing appeals, the consumer may be entitled to a favorable determination.[14]

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, below, 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	2004/2005 No. of Helpline Cases	2004/2005 % w/in Consumer Complaint Category	2004/2005 % of all Consumer Complaints	2003 % of all Consumer Complaints	% Difference between 2003 and 2004/% difference between 2004 and 2005
Coordination of benefits - primary/secondary	64/26	43.8/23.2	2.9/1.3	2.2	0.7/-1.6
Improper "Late filing of claim" denials	9/33	6.2/29.5	0.4/1.6	0.6	- 0.2/+1.2
Improper "Lack of information" denials	20/13	13.7/11.6	0.9/0.6	0.7	0.2/-0.3
Improper "Not a covered benefit" denials	35/14	24.0/12.5	1.6/0.7	1.5	0.1/-0.9
Processing / paying codes incorrectly	13/15	8.9/13.4	0.6/0.7	NA	NA/+0.1
Other - including computer problems	5/11	3.4/9.8	0.2/0.5	0.3	- 0.1/+0.3
TOTAL	146/112	100/100	6.5*/5.5*	5.2*	1.3*/-1.0*

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;[15]

- 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 are rejected as coming from a non-participating provider; and

- the health plan enters an incorrect diagnosis or procedure code, causing the claim to be denied.

In Table 2.2, we have organized consumer complaint calls relating to denials due to health plan errors into six subcategories. In 2004, the largest percentage (43.8%) of consumer complaints in this area was the result of failed coordination of benefits by health plans, followed by improper "not a covered benefit" denials (24%). In 2005, improper "late filing of claim" denials (29.5%) was the top complaint.

Coordination of Benefits – Primary/Secondary

In these cases, individuals are often covered by more than one health plan (e.g., their own plan and their spouse's plan) and the 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 or provider then submits this EOB to the secondary plan, which may then (and only then) issue a payment to discharge its own obligation.

Mr. M had health coverage through his place of employment and secondary coverage through his wife's employer. When Mr. M retired, his wife's health plan became the primary carrier. However, despite written correspondence and numerous telephone calls, Mrs. M's plan continued to deny coverage for Mr.

M's medical bills on the basis that it was the secondary carrier. Mr. & Mrs. M contacted the HCB and inquiries by Helpline staffers resulted in the health plan acknowledging its error.

Covered Benefit Denials

Health plans deny coverage for a service if they determine that such a service is not a covered benefit. A service may not be a covered benefit for the reason that it is simply not covered under the contract or for a more specific reason, as detailed in the complaints reported in Table 2.3. 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, below).

Table 2.3 Consumer complaints Health plan denials of care or coverage for care Covered benefit denials	2004/2005 No. of Helpline Cases	2004/2005 % w/in Consumer Complaint Category	2004/2005 % of all Consumer Complaints	2003 % of all Consumer Complaints	% Difference between 2003 and 2004/% difference between 2004 and 2005
Consumer has reached benefit maximum	31/28	17.6/21.4	1.4/1.4	2.1	- 0.7/same
Pre-existing condition	26/20	14.8/15.3	1.2/1.0	1.6	- 0.4/-0.2
Denial of durable medical equipment / service considered convenience	30/16	17.0/12.2	1.3/0.8	1.0	0.3/-0.5
Not a covered benefit	77/47	43.8/35.9	3.4/2.3	NA	NA/-1.1
Other covered benefit denials	12/20	6.8/15.3	0.5/1.0	0.3	0.2/+0.5
TOTAL	176/131	100/100*	7.8/6.5	5.0	2.8*/-1.3

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 contact.
- Be sure to obtain 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 1-800-771-7755, option 3.

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 care[16], and limits on total medical services.

Consumer Tip
You should request an accounting of services with benefit maximums from your health insurance plan if you are concerned about reaching a benefit maximum. Also, you should keep good records so you know how close you are to reaching your benefit maximum.

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 6 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 12 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 63 or more consecutive days between the end of membership in the prior plan and the start of membership in the current plan.[17]

Consumer Tip
When changing health plans, you should make sure to get a "certificate of creditable coverage" from your former health insurer. This certificate will be proof of how long you had continuous coverage under the previous plan which will then be used to determine how much time should be credited towards any pre-existing condition waiting period that may apply under a new health plan. For example, if you had eight months of credible coverage (without a break of 63 or more days between the time the old coverage lapsed and the new coverage began) from your old plan, only a four-month waiting period would occur for a pre-existing condition.

Denial of Durable Medical Equipment/Service Considered Convenience

Durable medical equipment includes items such as wheelchairs, oxygen tanks, scooters, lifts, hospital beds, canes and medical monitors. Durable medical equipment is usually doctor ordered, reusable and for use in the home. Health

plans may deny claims for an item of durable medical equipment or a service because they consider it an item of convenience, that is not medically necessary, or it is explicitly excluded from coverage.

Not a Covered Benefit

In this report we also identified complaints where the requested service was either a type of service that is never covered under the plan (i.e., some plans do not provide any mental health services or vision coverage) or a service for which specific conditions have to be met before coverage will be provided.

Ms. C's primary care physician contacted her HMO and acquired authorization for orthotics. After services were rendered, the coverage was denied. After the HCB requested a review, the plan advised that under her contract, benefits are provided for orthotics only when received within 30 days of a related surgery. However, since Ms. C's health plan did not advise her provider of such a limitation when she contacted the plan prior to the services being rendered, the claim was reprocessed and payment of $208 was issued.

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 1-800-771-7755, 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.

Some health plans do not always appropriately reimburse consumers for out-of-network care. In 2004, this was the most frequent consumer complaint in the access to specialty care category (see Table 3, below). However, in 2005, half as many complaints were received regarding this issue and the top complaint was 'receiving a surprise bill from an unknown non-participating provider' see discussion below).

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, below).

Table 3 Consumer complaints Access to specialty and out-of-network care	2004/2005 No. of Helpline Cases	2004/2005 % w/in Consumer Complaint Category	2004/2005 % of all Consumer Complaints	2003 % of all Consumer Complaints	% Difference between 2003 and 2004/% difference between 2004 and 2005
Consumer disputed plan's usual & customary rate payment for out-of-network care	120/64	30.9/22.9	5.3/3.2	7.6	- 2.3/-2.1
Consumer received out-of-network services w/out pre-authorization	19/17	4.9/6.1	0.8/0.8	3.3	- 2.5/same
Plan issued improper "No pre-authorization" or "No referral" denial	29/18	7.5/6.4	1.3/0.9	1.1	0.2/-0.4
Plan refused a referral to an out-of-network provider	48/38	12.4/13.6	2.1/1.9	2.1	same/-0.2
Consumer received surprise bill from unknown non-participating provider	101/91	26.0/32.5	4.5/4.5	2.7	1.8/same
Plan gave wrong information on the "participating" status of a provider	33/25	8.5/8.9	1.5/1.2	1.5	same/-0.3
Consumer received an in-network service without pre-authorization	8/12	2.1/4.3	0.4/0.6	2.1	- 1.7/+0.2
Access to patient records	5/3	1.3/1.1	0.2/0.1	0.7	- 0.5/-0.1
Other	25/12	6.4/4.3	1.1/0.6	0.8	0.3/-0.5
TOTAL	388/280	100/100*	17.3*/13.8	21.9	- 4.6 */-3.5*

2005 Trends

From 2003 to 2004, complaints about access to specialty and out-of-network care declined from 21.9% to 17.3% of all complaints. In 2005, these complaints declined to 13.8% of all complaints.

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 the plan determines to be the "usual and customary rate" or the "reasonable and customary rate" (both are referred to as UCR) charged for a particular service,[18] and the member is liable for the remainder of the UCR plus whatever balance the provider charges, as well as any applicable co-payments or deductibles.

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 use schedules of rates for health services, procedures, treatments, and items of equipment,[19] 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.[20] 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.

The HCB received a written complaint from Mrs. G against her health plan disputing the usual and customary rate payment for out-of-network care. Mrs. G's physician billed her health plan $10,000 for a myomectomy and uterus reconstruction surgery. The charge was $9,000 for the myomectomy and $1,000 for reconstruction. The health plan's explanation of benefit statement reimbursed $800 of the $1,000 reconstruction charge and stated that the $9,000 charge was included in the global procedure. Mrs. G's secondary insurer reimbursed $200 for the reconstruction. The total amount paid to the provider was $1,000. Mrs. G paid $2,000 prior to the surgery and had recently received a bill for $7,200. The HCB contacted Mrs. G's primary insurer requesting a review of the reimbursement. Mrs. G's health plan telephoned the HCB stating that an error was made on the primary procedure code and an additional payment was made.

Consumer Received Out-of-Network Services Without Pre-authorization

Some health plans require pre-authorization in order to have out-of-network services covered. If pre-authorization is not obtained, the consumer may be liable for the provider's entire charge for services. From 2003 to 2004, there was a significant drop in the number of helpline cases in this subcategory: 86 complaints (3.3% of all complaints) in 2003 versus 19 complaints in 2004 (0.8% of all complaints - same in 2005). This suggests that consumers knowledge about their plan's requirements for obtaining out-of-network services may be improving.

Plan Wrongly Issued a "No Pre-authorization" or "No Referral" Denial

Pre-authorizations and referrals issued by one department in the health plan are sometimes 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.[21] 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 specialized 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.

Mr. A suffers from an irregular heart beat and his primary care physician recommended that he be treated by an out-of-network surgeon who would "map" his heart. Mr. A's health plan denied coverage on the basis that there were in-network providers capable of performing this type of surgery. When Mr. A's health plan denied authorization for the surgery with the non-participating surgeon, the HCB intervened. The health plan's medical director reviewed the matter, the decision was reversed and Mr. A obtained approval for the procedure performed by the out-of-network provider.

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 to receive a bill from a non-participating provider who was "brought in" during the procedure or service. Consumer

complaints of this nature accounted for 26% of all complaints in this category in 2004 and 32.5% in 2005.

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).[22] 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, HMOs sometimes erroneously insist that members are responsible for the full cost of services provided by non-participating providers in these situations.

Ms. T, an HMO enrollee, went to her ob/gyn and had lab work performed. Ms. T received a $262.00 bill for pathology services and the bill was eventually placed into collection. After the HCB contacted Ms. T's health plan, it was learned that the pathologist was out-of-network. However, because the lab work was sent out-of-network by a participating provider, the plan paid in full and Ms. T was held harmless.

Plan Gave Wrong Information on the "Participating" Status of a Provider

Provider networks routinely change as providers are added and others leave. Sometimes health plans do not provide accurate information to members regarding the "participating" status of a provider.

Consumer Tip
Consumers should make an effort to confirm that their health care provider is a "participating" provider in their health plan's network. This can be accomplished by contacting both the provider and health plan.

Consumer Received an In-Network Service without Pre-authorization

HMO members who want to receive certain specialized health services must usually first obtain a referral from their primary care physician 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 required referral or a pre-authorization. The mere eight complaints on this issue in 2004 and twelve in 2005, as compared to 54 in 2003, suggests that consumers may be becoming more aware of the need for pre-authorization for some in-network

services.

Access to Patient Records

A few complaints came from consumers who were having difficulty accessing their medical records. There are state and federal laws that govern access to patient records. Under New York State law, consumers are entitled to receive copies of their medical records with a few exceptions.[23]

At A Glance: New York's Patient Medical Records Law

New York State law gives consumers and other qualified individuals the right to view and obtain copies of their medical records. The law places restrictions on the fees and charges that can be made by providers for medical records. Consumers should be aware that certain medical information is not required by law to be released to them. Requests should be made in writing, be as detailed as possible (i.e., include the period of time for which the records are being requested, and to whom and where the records should be sent), and signed by the consumer. If the request for medical records is denied, consumers are able to appeal that determination with the New York State Department of Health.

Qualified Individuals - In addition to the individual consumer, other people ("qualified individuals") may be allowed access to the patient's medical records. Parents or guardians as well as attorneys representing patients may be allowed access to medical records.

Fees and Charges - No more than 75 cents per page may be charged. The actual cost for reproducing X-rays or other images may be charged to the consumer. It is important to note that the release of medical records cannot be denied solely because the consumer cannot afford the reproduction costs. However, the consumer may be required to prove that she cannot afford to pay.

Information Not Required to be Released - A physician's personal notes and observations, as well as information that a provider believes may cause substantial harm to the consumer or to others, does not have to be released. Additionally, substance abuse program records and clinical records of facilities licensed or operated by the Office of Mental Health can only be disclosed subject to the requirements under the Mental Hygiene Law or other applicable law.

Consumer Tip

If you have questions regarding access to your medical records, call the NYS Department of Health, Office of Professional Medical Conduct:

- For records held by physicians or health care facilities call 518-402-0836; or
- If you have questions regarding access to records held by facilities licensed or operated by the NYS Office of Mental Health contact the facility or call 800-597-8481; or
- If you have questions regarding substance abuse records, contact the facility or call the NYS Office of Alcoholism and Substance Abuse Service at 518-473-3460; or
- For more detailed information about your rights to access your medical records in NYS, see Your Medical Record Rights in New York, by Joy Pritts, J.D., Health Policy Institute -

Georgetown University http://hpi.georgetown.edu/privacy/stateguides/ny/nyguide.html

4. GETTING AND KEEPING HEALTH COVERAGE

Access to and the affordability of health insurance coverage continues to be a large source of concern, accounting for approximately 20% of all consumer complaints in both 2004 and 2005. 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 continues to be a significant 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.

2005 Trends

From 2003 to 2005, consumer complaints concerning problems getting and keeping coverage increased from 17% to 19.6% of all complaints.

Consumer complaints about getting and keeping health care coverage break down into the eight subcategories listed in Table 4, below.

Table 4 Consumer complaints Problems getting and keeping coverage	2004/2005 No. of Helpline Cases	2004/2005 % w/in Consumer Complaint Category	2004/2005 % of all Consumer Complaints	2003 % of all Consumer Complaints	% Difference between 2003 and 2004/% difference between 2004 and 2005
Policy terminated By employer By health plan due to employer premium default	 24/15 21/19	 4.6/3.8 4.6/4.8	 1.1/0.7 0.9/0.9	 1.9 0.8	 - 0.8/-0.4 0.1/same
COBRA - problems getting enrolled / employer mistakes	34/22	7.5/5.5	1.5/1.1	2.3	- 0.8/-0.4
Enrollment prevented or policy terminated - health plan error	58/33	12.8/8.3	2.6/1.6	2.8	- 0.2/-1.0
Enrollment prevented or policy terminated - consumer error	54/24	11.9/6.0	2.4/1.2	2.1	0.3/-1.2
Health plan computer glitches causing eligibility problems	9/15	2.0/3.8	0.4/0.7	1.5	- 1.1/+0.3
Confusion or Lack of affordability	142/188	31.4/47.2	6.3/9.3	2.5	3.8/+3.0
No insurance	91/36	20.1/9.0	4.1/1.8	0.7	3.4/-2.3
Other eligibility problems	19/46	4.2/11.6	0.8/2.3	2.4	- 1.6/+1.5

TOTAL	452/398	100*/100	20.2*/19.6	17.0	3.2*/-0.6*

Many New Yorkers 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 consumer complaints classified in this subcategory 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 some 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. Some 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").[24] However, few people take advantage of their COBRA rights. The reason: it is simply too expensive for the consumer to pick up the portion of premium previously paid by the employer.

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/faqcs1.htm #cobra.
- If your employer refuses to comply, contact the Attorney General's Health Care Helpline at 1-800-771-7755, option 3.

Some 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.

At A Glance: Continuation of Health Insurance Coverage Under Federal or State COBRA

COBRA is a federal law that allows "qualified beneficiaries" (the covered employee, spouse of the covered employee, or dependent child or children of the covered employee) to continue to receive employer sponsored group health insurance when they would otherwise lose their coverage as a result of a "qualifying event." A "qualifying event" is one of the following events that would lead to the loss of health insurance coverage: 1) death of the covered employee, 2) loss of employment, 3) reduction in hours, 4) divorce or legal separation from the covered employee, 5) covered employee becoming eligible for Medicare, and 6) a dependent child of the covered employee who is no longer a dependent child.

COBRA covers most private employers with 20 or more employees. New York State law requires employers with fewer than 20 employees to provide equivalent coverage to their employees.

- Each qualifying beneficiary is entitled to elect the same coverage that is being offered to current employees - no more, no less.
- The qualifying beneficiary who elects to continue the health insurance is responsible for paying up to 102% of the cost of the insurance coverage.
- The employee or family member must notify the plan administrator of a divorce, legal separation or change in the status of a dependent child within 60 days after the later of the date of the qualifying event or the date the qualified beneficiary would lose coverage.
- A qualified beneficiary has 60 days from the later of 1) the date he or she would lose coverage due to a qualifying event, or 2) the date that he or she is sent notice of the right to elect COBRA continuation of coverage.
- If the qualifying event was loss of employment or reduction of hours, COBRA coverage can last for 18 months; if the qualified beneficiary is determined to be totally disabled within 60 days of a qualifying event, COBRA coverage can last 29 months; and for all other qualifying events the COBRA coverage can last a maximum of 36 months.

Such employers' mistakes often leave consumers without health insurance coverage at a time when they are financially most vulnerable. 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. Fortunately, from 2003 to 2005, the Helpline complaints in this subcategory have declined slightly each year.

Health Plan Computer Glitches Causing Eligibility Problems

From time to time, health plan computer glitches result in eligibility problems for consumers.

Mr. F had recently enrolled in a health plan; however, he was having difficulty obtaining payment on claims because he was told his coverage was terminated. The enrollment coordinator of the health plan verified Mr. F's membership status was active in the health plans's computer. The coordinator researched the matter and learned that the health plan's direct billing office did not have Mr. F in their computer system and, as a result, claims were being denied. The HCB intervened. It was determined that the problem was a glitch that resulted from the health plan changing computer systems. Mr. F's coverage was reinstated and claims were paid accordingly.

Confusion, Lack of Affordability, and No Insurance

In an effort to sort through the myriad kinds of health plans being offered and identify legitimate, affordable plans, a growing number of consumers called the Helpline in 2004 to request information about advertised insurance plans and medical or prescription drug discount cards. Unfortunately, in some cases, the advertised plans are simply too good to be true, offering services or discounts at very low costs but not providing the advertised full benefits, if any, to consumers. Complaints were made against one plan that was operating illegally in New York without a license and two discount card companies that were engaging in deceptive business practices and false advertising. The HCB has brought enforcement actions against unlicensed plans and unscrupulous discount card companies (see box below and 2002 Helpline Report Chapter 4 at www.ag.ny.gov

As a result
of these and other medical discount card investigations, the Attorney General developed guidelines to assist the industry in advertising and marketing discount cards in a lawful, non-deceptive manner. 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.

HCB Enforcement Action

Unlicensed Plan Engaged in Fraud and Deception.

After receiving and investigating complaints from consumers that a New York City-based health plan was not paying claims and denying access to care, the Attorney General, State Superintendent of Insurance and State Commissioner of Health sued to halt the operation of the plan, known as Metro Health, that was not licensed or authorized to conduct an insurance business in New York. The court immediately issued a temporary restraining order and later approved a settlement permanently closing the plan and requiring its operator, Blanca Jaravata, to provide funds for restitution to affected consumers. Additionally, the Attorney General's Criminal Prosecutions Bureau pursued an indictment against Jaravata that resulted in felony convictions for scheme to defraud and grand larceny (5 counts) in connection with the Metro Health scam.

HCB Enforcement Action

Advertising and Marketing of Drug and Medical "Discount Cards" Failed to Truthfully Disclose Costs and Benefits of the Cards.

The HCB and the Consumer Frauds and Protection Bureau investigated two companies that offer medical discount cards – MedAdvantage, LLC and National Association of Preferred Providers/Family Care – and found that they failed to truthfully disclose the costs and benefits of their discount card programs. The companies agreed to reform their advertising and marketing practices, and to refund enrollment fees and unauthorized charges to qualified

Consumer Tip

Unlicensed Health Plan

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.

5. IMPROPER BILLING BY PROVIDERS

Table 5, below, shows that in 2004 15.9% of all Helpline complaints were prompted by providers' improper billing of consumers and those complaints increased to 16.6% of all complaints in 2005.[25] 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	2004/2005 No. of Helpline Cases	2004/2005 % w/in Consumer Complaint Category	2004/2005 % of all Consumer Complaints	2003 % of all Consumer Complaints	% Difference between 2003 and 2004/% difference between 2004 and 2005
Balance billing by participating provider	217/186	60.8/55.2	9.7/9.2	8.1	1.6/-0.5
Wrong amount or wrong code	36/47	10.1/13.9	1.6/2.3	0.9	0.7/+0.7
Wrong person	57/74	16.0/22.0	2.5/3.6	2.3	0.2/+1.1
Other billing problem	47/30	13.2/8.9	2.1/1.5	1.9	0.2/-0.6
TOTAL	357/337	100*/100	15.9/16.6	13.2	2.7/+0.7

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 is a Participating Provider with the HMO; (2) the member met all contractual obligations under his or her subscriber contract or certificate of coverage; (3) the services rendered by the provider were provided pursuant to the member's subscriber contract or certificate of coverage with the HMO; and (4) the provider did not inform the member prior to rendering the service that the service would not be covered and the member would be financially liable for the service. If these four conditions are met, the provider must seek payment for services (other than applicable deductibles, co-insurance and amounts designated by the HMO as the member's responsibility in his or her subscriber contract or certificate of coverage) solely from the HMO.[26] Similar protection is usually afforded PPO members through a "hold-harmless"[27] clause in the contracts between the PPO and its preferred providers.

The HCB received a complaint from Ms. N stating that she had been notified that her health insurance plan had denied coverage for previously authorized physical therapy services. Ms. N paid for one of these services out of pocket just to avoid collections. The HCB forwarded an inquiry to both the provider and the health plan. The health plan responded by stating that some dates of service had been properly reimbursed. The remaining claims were denied due to late filing by the provider and, consequently, the provider was precluded from balance billing Ms. N. The provider issued a refund to Ms. N.

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.[28] 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.

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 the law or contract provisions specifically forbid the practice.

2005 Trends
From 2003 to 2005, complaints about improper billing by providers increased from 13.2% to 16.6% of all complaints.

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.

HCB Enforcement Actions

Ambulance Service and Lab Bill Improperly

- After receiving complaints from consumers, an HCB investigation revealed that Vineall Ambulance Company had a policy of billing consumers for the balance due between Vineall's charges and the health plan's reimbursement rate. Such "balance billing" is prohibited under New York's "Ambulance Mandate." Vineall agreed to issue refunds to consumers who were improperly billed.

- As a result of an HCB investigation and as part of the Attorney General's statewide "Project Clean Bills of Health" initiative, a settlement was reached with MDS, Inc., a provider of medical laboratory services, that provided refunds to New York consumers (potentially up to 2 million) who were improperly "balance billed" for services covered or

HCB Enforcement Action

Plan Fails to Cover Ambulance Service

WellCare of New York, a Medicare HMO, agreed to contact some 5,000 of its members who used non-participating ambulance services between 1998 and 2002 and to provide refunds to those who paid bills that should have been fully covered by the health plan. WellCare's failure to pay such bills violated federal regulations and state law.

6. CONSUMER ACCESS TO PRESCRIPTION DRUGS

Many of the 4,274 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 prescription drugs in some capacity. However, for the cases below (see Table 6, below), the real issue is whether, for example, the prescribed medication is medically necessary or a covered benefit under the member's plan.

Table 6 Consumer complaints Consumer access to prescription benefits	2004/2005 No. of Helpline Cases	2004/2005 % w/in Consumer Complaint Category	2004/2005 % of all Consumer Complaints	2003 % of all Consumer Complaints	% Difference between 2003 and 2004/% difference between 2004 and 2005
Formularies - preferred drugs, generics, substitution	28/59	25.7/38.1	1.2/2.9	1.9	- 0.7/+1.7
Plan denies pre-authorization for medication	24/24	22.0/15.5	1.1/1.2	0.5	0.6/+0.1
Plan /Pharmacist cuts the number of pills dispensed per visit	10/19	9.2/12.3	0.4/0.9	0.9	- 0.5/+0.5
Mail orders - return/reimbursement	33/30	30.3/19.4	1.5/1.5	1.2	0.3/0.0
Other prescription issues	14/23	12.8/14.8	0.6/1.1	0.7	- 0.1/+0.5
TOTAL	109/155	100/100*	4.9*/7.6	5.2	- 0.3 */+2.7 *

2005 Trends

From 2003 to 2005, complaints regarding consumer access to prescription benefits increased from 5.2% to 7.6% of all complaints.

Formulary Issues: Preferred Drugs, Generics, Substitution

With drug costs rising faster than the rate of overall health spending,[29] health plans are devoting more energy to containing the cost of prescription benefits, primarily through the use of formularies and higher copayments. A formulary is a list of 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 benefits 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 generic versions of brand-name or "pioneer" drugs, but they may also be brand-name drugs that are cheaper for the health plan than other brand-name drugs (possibly because of bulk discounts or rebates from manufacturers).

New York State encourages the substitution of generics for brand-name drugs whenever possible (see At A Glance: New York's Generic Drug Substitution Law, below).[30] Pharmacists must 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.

The HCB has received calls and letters from consumers that deal specifically with access to prescriptions. In 2004, 25.7% of the complaints in this category were about the use of formularies; that grew to 38.1% in 2005. Most commonly, a consumer was unable to get coverage for a prescription 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 for the brand-name drug.

Mr. K telephoned the HCB after learning that his health plan's PBM was insistent upon substituting his mail order prescription with generic drugs instead of brand names as prescribed by his physician. The PBM requested supporting medical documentation from the physician to justify the need for the brand names. The physician's office faxed the requested information twice and the PBM denied receipt. The HCB requested that the PBM telephone the physician immediately for justification and, after that consultation, Mr. K's prescriptions were mailed out

At A Glance: New York's Generic Drug Substitution Law

Pharmacists in New York State are required to substitute a less expensive generic equivalent for a brand name drug provided the following conditions are met:

1) the prescription is written on a legal prescription form, and the prescriber does not prohibit substitution (in the case of oral prescriptions, the prescriber must expressly state whether the prescription is to be filled as written or not);
2) the submitted drug must be approved or authorized by the Food and Drug Administration (FDA) as being safe and effective for its labeled indication for use, and the FDA has deemed the drug as not having an actual or potential bioequivalence problem; and
3) the pharmacist must include the name, strength, and drug manufacturer on the label,

HCB Enforcement Action

New York and 19 Other States Settle Deceptive Trade Practices Claims with Medco

Medco Health Solutions (Medco), the world's largest PBM, settled claims brought under state deceptive business practices laws by the Attorney General and 19 other states' Attorneys General, for Medco's drug switching practices. Under such practices, Medco encouraged physicians to switch patients to different prescription drugs without disclosing that the switches benefited Medco by increasing rebate payments from drug manufacturers. Medco agreed to provide disclosure to consumers about the reasons for drug switching and to pay more than $29 million in restitution, damages and costs.

HCB Enforcement Action

New York Sues PBM for Fraud and Breach of Contract

The Attorney General and NYS Civil Service Commissioner sued Express Scripts, Inc., then the nation's third largest PBM and the PBM for New York State's largest employee health plan, the Empire Plan, for fraud and breach of contract. The complaint alleges that Express Scripts improperly (1) inflated the cost of generic drugs, (2) retained millions of dollars in manufacturer rebates that belonged to the Empire Plan, (3) improperly induced physicians to switch a patient's prescription to another drug for which Express Scripts would receive a rebate from the drug manufacturer, and (4) sold and licensed data belonging to the Empire Plan to drug manufacturers, data collection services and others without the permission of the Empire Plan and in violation of the State's contract.

Plan Denies Pre-authorization for Medication

Some medications require pre-authorization before the medication can be dispensed. For medications requiring pre-authorization, the consumer will be liable for the cost of the medication if it is obtained without the pre-authorization.

Plan/Pharmacist Cuts the Number of Pills Dispensed per Visit

Consumers experience another constraint on 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.

Mail Orders - Return/Reimbursement

A typical complaint involved problems cancelling prescription orders before the PBM sent all or part of the order and billed the consumer.

Ms. G wrote the HCB advising that she notified her health plan's PBM that her prescriptions are to be kept on file only (without automatic mailing) and that she would manually order her prescriptions when necessary. However, all of Ms. G's prescriptions on file arrived as an automatic monthly order anyway. The HCB contacted the health plan and Ms. G's account was credited accordingly.

Other Prescription Drug Issues

Some pharmaceutical companies have concealed scientific studies that contain important information about their products. Concealing these findings may jeopardize the health and safety of consumers.

HCB Enforcement Actions

New York State Sues Pharmaceutical Firms for Concealing Drug Information

- The HCB and the Consumer Frauds and Protection Bureau (CFB) sued GlaxoSmithKline (GSK) for concealing from doctors and their patients important safety and efficacy information about the use of Paxil, an anti-depressant, for children and adolescents. In settling the lawsuit, GSK agreed to post all the Paxil studies it had concealed and to establish a website where it would post summaries of results of its clinical trials.

- The HCB and the CFB similarly investigated Forest Laboratories, Inc., for concealing from doctors and their patients important safety and efficacy information about the off-label uses of certain drugs, including the anti-depressants Lexapro and Celexa. Like GSK, Forest agreed to establish a website where it would post summaries of results of its clinical trials.

CONSUMER EDUCATION

- In February 2004, the HCB released a special report entitled: Focus On: Eating Disorders[31], which documented the unique problems that patients diagnosed with eating disorders and their families encounter when accessing the health care system. The report also provides tips that consumers may use to maximize their health care coverage for treatment of the disorders.

  Since this special report was issued, the Helpline has handled 18 complaints regarding the denial of coverage of claims for the treatment of eating disorders and secured over $50,000 in coverage for these consumers.[32]

- The second report in this series, Focus on: Overcoming Obesity[33], released in November 2004, provided information about the difficulties many consumers encounter in accessing bariatric surgery and other treatments. The report also guided consumers about how to obtain benefits available to them for these medical services.

- In January 2005, the HCB published, "Planning Your Health Care in Advance: How To Make Your Wishes Known and Honored"[34] which describes steps that may be taken under state law to accept or refuse medical treatments and ensure that, if a patient is unable to express his or her wishes, medical decisions remain in the hands of loved ones or other trusted persons.

- In August 2004, the Attorney General launched a pilot drug price comparison website to help consumers across the state access the best price for commonly prescribed medications: www.NYAGRx.org. Initially, 440 pharmacies across the state were surveyed to determine the prices of the 25 most frequently prescribed drugs. Subsequently, the survey was expanded to include selected pharmacies in all 62 counties across the state and to report

on the prices of 150 frequently prescribed drugs.

REFORM RECOMMENDATIONS

The information and trends identified in this report reaffirm the continued need to review and perhaps revise the statutory provisions that impact on access to health care and consumer education issues. Gaps in the law can be seen with respect to enforcement of rights afforded by the Managed Care Consumer Bill of Rights, the review of denials for out-of-network providers, to the adequacy of denial notices and the funding of consumer education and advocacy programs.

Accordingly, the Attorney General urges that these reform recommendations be acted upon:

- Fully fund New York's Managed Care Consumer Assistance Program (MCCAP) to ameliorate widespread confusion or lack of information on the part of consumers and their frequent inability to protect their rights and access benefits. MCCAP was established in New York to fund and support local organizations that provide consumers with assistance and education regarding managed care issues.

- Establish statutory penalties for violations 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.

- Require health plans to use a standardized 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.

- 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 Utilization Review Law, allowing consumers access to the external appeals process.

ENDNOTES

1. Kaiser Family Foundation, "statehealthfacts.org, Your source for state health data, "at www.statehealthfacts.org. Statistics are for 2003-04. Also, the category 'Individual and Other Public' includes individual direct-pay policies through private insurers (3%) and "individuals (only 1% of the total population) covered under certain state and public health insurance programs and military-related coverage programs...(Other Public). "

2. Ibid.

3. United Hospital Fund, "Health Insurance Coverage in New York, 2002-2003," at www.uhfnyc.org/usr_doc/Charts_Health_Insurance_CoverageinNY02-03.pdf

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.oag.state.ny.us/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.

7. For an explanation of the acronyms, see pages 1 - 2.

8. 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.

9. Title II of Article 49 of the Insurance Law and Title II of Article 49 of the Public Health Law. 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.

10. 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 five 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.

11. Insurance Law § 4900(c); Public Health Law § 4900(3).

12. Insurance Law §§ 4902(a)(8) and 4905(m); Public Health Law §§ 4902(1)(h) and 4905(13).

13. Insurance Law § 4903(a)(3)(c); Public Health Law § 4900(3).

14. Insurance Law § 4904(e); Public Health Law § 4904(5).

15. The complaints discussed here involve health plan denials of services that are clearly included in the contract as a covered benefit.

16. 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, page 41.

17. 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).

18. Health plans may use other names for this concept, such as "reasonable and customary charge," "reasonable and customary rate," or "allowed amount."

19. 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.

20. 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.

21. Public Health Law § 4408(1)(k).

22. See 10 NYCRR §§ 98-1.13(I) & 98-1.5(b)(6)(ii).

23. See Public Health Law §17 & §18 ; see also Health Insurance Portability and Accountability Act of 1996 and corresponding federal regulations 45 CFR Parts 160 and 164.

24. 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/faqcs1.htm#cobra.

25. 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 25.

26. 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/mancare/hmoipa/guidelines.htm), at page 3.

27. For an explanation of "hold harmless" see page 27.

28. The problem of health plans' late reimbursement of providers is discussed on page 9.

29. "While increases in drug spending tracked closely to increases in spending on other health services in the early 1990s, this pattern changed in the latter half of the 1990s and the early 2000s. From 1995 to 2000, increases in drug spending were two to five times larger than increases in spending on hospital care and physician services. This trend has moderated since 2000, with the prescription drug spending increase falling to 10.7% compared to the 8.5% increase in physician and clinical services spending and the 6.5% increase in hospital services spending." Kaiser Family Foundation, "Trends and Indicators in the Changing Health Care Marketplace Section 1: Trends in Health Spending and Costs, Including Prescription Drugs, Exhibit 1.6: Annual Percentage Change in National Spending for Selected Health Services, 1993-2003" at www.kff.org/insurance/7031/print-sec1.cfm.

30. Education Law §§ 6816-a & 6810(6)(a) and Public Health Law § 206.

31. The full text of Focus On: Eating Disorders is available at www.oag.state.ny.us/press/2004/feb/feb26a_04_attach.pdf.

32. This represents complaints received through August 31, 2005.

33. Full text of Focus on: Overcoming Obesity is available at www.oag.state.ny.us/press/2004/nov/nov28a_04_attach1.pdf

34. The full text of Planning Your Health Care in Advance: How To Make Your Wishes Known and Honored is available at www.oag.state.ny.us/health/EOLGUIDE.pdf.