Office of the New York State
Attorney General Letitia James

HEALTH CARE BUREAU 2022

Real Solutions for New Yorkers

Each year, the Office of the New York State Attorney General Letitia James (OAG) helps thousands of New Yorkers navigate the health care system. Through its Health Care Bureau's (HCB) health care helpline staffed by a dedicated team of advocates, OAG works with New Yorkers to resolve disputes with their insurance companies, correct overbilling, and obtain medically necessary health care and medication. The complaints received by the helpline often lead to larger investigations, enforcement actions, and policy initiatives by OAG[1].

In 2022, OAG secured over $1.5 million for health care costs in restitution and savings on behalf of New Yorkers. This report covers health care concerns facing New Yorkers in 2022, including existing and new health care issues related to COVID-19

1 For further information about the HCB, please visit https://ag.ny.gov/about/about-office/social-justice-division#healthcare.

2022 at a Glance

The Health Care Bureau's helpline offers an easy way for New Yorkers to notify the office about their health care concerns. Acting as OAG's front line for addressing consumer health care problems, the helpline's advocates review and resolve New Yorkers' complaints.

In 2022, New Yorkers filed 4,031 complaints with the helpline, chiefly requesting assistance or information about health care. Of these, 2,309 complaints were evaluated and handled directly by advocates. After assessing the remaining 1,722 complaints, helpline staff provided consumers with information or referred them to the appropriate agencies.

These complaints highlight the challenges that New Yorkers face and help identify systemic problems in New York's health care system. In addition, these complaints often provide the basis for further investigation and enforcement actions by OAG against health plans, providers, and other entities in the health care market.

During 2022, OAG secured $1,546,769 million for New Yorkers in restitution and savings. The OAG secured these funds by correcting erroneous medical billing, reversing wrongful rejection and processing of health insurance claims, and rectifying companies' wrongful business practices.

In addition, through the helpline, OAG helped New Yorkers obtain medically necessary care and prescriptions where the health plan had denied coverage, and helped reinstate health insurance where health plans had incorrectly terminated coverage.

The main issues for which New Yorkers call the helpline are:

- incorrect billing
- health plan errors
- uncertainty about benefits
- rules for obtaining coverage
- appeal rights
- referrals to other agencies, as appropriate

While not all complaints and inquiries can be resolved to consumers' satisfaction, the helpline plays a crucial role as a source of reliable and objective information for New Yorkers.

INCORRECT BILLING has been the number one issue raised by New Yorkers since 2011.

Most-common health care complaints made by helpline consumers

Complaints to the helpline fall into six general categories:

- provider billing
- health plan denials
- wrongful practices,
- claims processing
- prescription drugs
- insurance coverage

During 2022, COVID-19 continued to present novel health care issues across New York state, and OAG worked to identify, track, and resolve those complaints. Most of these complaints concern provider billing and claims processing.

COVID-19

About 17% of the complaints in 2022 concerned COVID-19 issues, a significant 8% increase over these complaints in 2021. Most COVID-19 complaints included improper billing for COVID-19 tests and health plans' claim-processing errors. During this period, helpline staff worked hard to prevent New Yorkers from being improperly charged by medical providers and improperly assessed cost sharing by insurers. Helpline staff uncovered provider coding errors, health plan claim-processing errors, deceptive business practices, and provider deficiencies in staffing and training.

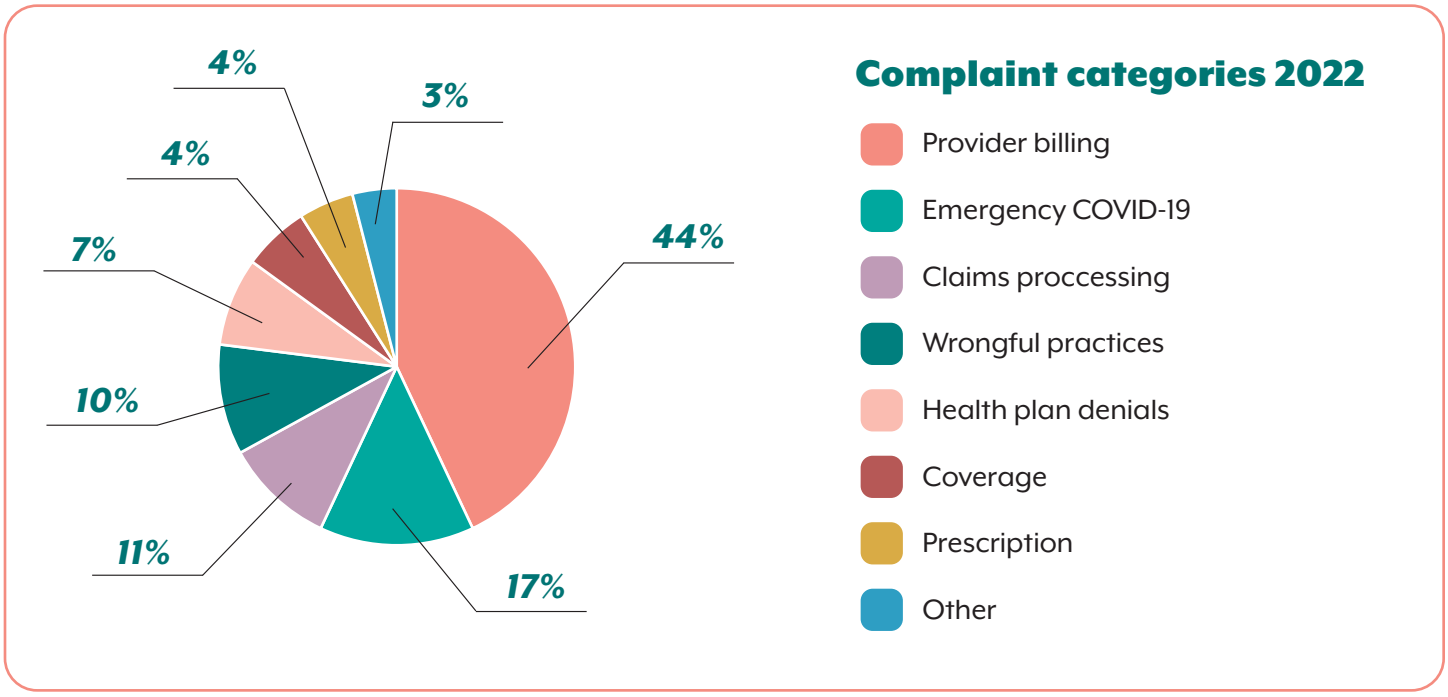
Some complaints were resolved by helpline staff or OAG attorneys. Others formed the basis for ongoing enforcement actions. As a result of OAG efforts, numerous provider billing and insurer claim-processing errors were corrected.

OAG continues to work to identify and resolve deceptive and unfair business practices concerning COVID-19.

Complaint Category Data

In 2022, most complaints to the helpline were about incorrect medical billing, including by private physician practices and hospitals. These issues typically include incorrectly "balance billing"[2] a patient; a provider failing to, or incorrectly, submitting claims to an insurance company; or duplicate billing.

Incorrect billing has been the number-one issue raised by New Yorkers to the helpline since 2011.



[2] "Balance billing" occurs when a provider bills a patient for the difference between the amount charged and the amount paid by the patient's health plan. When a provider is in network, the insurance payment should be accepted as payment in full, and the provider is not permitted to balance bill the patient (except for coinsurance, copayment, and deductible). Balance billing may be allowed, however, if the provider is not in the health plan's network.

How OAG Has Helped New Yorkers

Highlights: helpline resolutions and OAG enforcement resolutions and actions

Here are further details on the most common issues prompting helpline calls, and how OAG helped resolve them.

Provider billing practices

Erroneous provider bills unfortunately are not common, can be costly, and can lead to collection-agency referrals or legal judgments. In 2022, a significant number of complaints (44%) concerned provider billing practices.

COVID-19 testing bills recalled for uninsured consumers. Six uninsured consumers contacted OAG after receiving unexpected provider bills of $300 to $400 for COVID-19-related office visit between May 2020 and November 2021. The consumers had understood that they would not be charged for testing. After OAG became involved, patient balances were adjusted to zero.

Provider recalls cancellation fee for consumer with COVID-19 symptoms. A consumer filed a complaint about a $50 fee she was charged for canceling an appointment with a medical provider because of her COVID-19 symptoms. She tried unsuccessfully tried to work with the provider's office. OAG obtained a zero-balance statement from the provider.

Hospital recalls bill based on inconsistency with written estimate. A consumer filed a complaint with OAG regarding a bill for in-network services with a hospital because the bill was nearly twice as much as the initial written estimate. After OAG became involved, the hospital issued a zero-balance statement. The consumer saved about $1,000.

Provider recalls bill for laboratory services. A consumer was billed $429 for laboratory services. He had received an explanation of benefits from his insurance carrier indicating his responsibility would be $0. He verified that the provider was in his health plan's network. The consumer tried several times to contact the lab and discuss the bill. At one point, a supervisor told him that there was nothing that could be done. OAG sent an inquiry to the lab. They responded that the consumer had no financial v associated for the services, as the explanation of benefits had indicated.

Mobile Life Support Services, Inc., required to pay restitution and $100,000 penalty. Consumers complained that Mobile Life Support Services, Inc. (Mobile Life), an Orange County ambulance company, illegally billed patients for emergency medical services. Mobile Life billed patients for the difference between what their insurance plans paid and what the company charged. This is an unlawful practice that violates New York State Insurance Law's "Ambulance Mandate." Under the mandate, an insurer must pay the usual and customary charge to the ambulance service provider, unless there is a contract with a different negotiated rate. As a result of OAG's investigation, Mobile Life will pay full restitution plus interest to affected patients, request closure of all relevant accounts with debt collectors, update its billing practices, and pay a $100,000 penalty.

Health plan denials of coverage for care

Denials for coverage usually occur when an insurance company determines that care is not medically necessary, even though a physician determined the care was needed. In 2022, approximately 7% of all helpline complaints involved health plan denials of coverage – a 3% decrease from 2021, when about 10% of complaints involved denials of coverage. Complaints in this category have been declining steadily over the past four years. In 2020, 13% of consumer complaints were about denials of coverage for care, and in 2019, 16%. Although the number of complaints has decreased, these often represent many of the most important and challenging issues the helpline handles.

> ***Plan reverses denial of coverage for children's hospital.*** A consumer's son was born prematurely at 25 weeks. The infant had many surgeries and other interventions at his birth hospital, but needed a higher level of care, so his treatment team requested transfer to a children's hospital. His health plan denied their requests. After OAG became involved and asked the health plan to review the support for medical necessity, the health plan approved the transfer.
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> ***Plan reverses denial of coverage for MRI.*** A consumer had injured her foot and was in considerable pain for months. She scheduled an appointment with an orthopedic surgeon, who required an MRI to determine the best course of treatment. Her health plan denied both the initial request for coverage and an appeal. After OAG intervened, the health plan approved coverage for the MRI.
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> ***Plan reverses denial of coverage for infusion therapy.*** A consumer had been receiving infusion therapy for lupus at an outpatient hospital every four weeks for over a year. Her previous authorization expired. Her health plan denied a continuation of the authorization because the procedure was designated to occur at an outpatient hospital, and the health plan stated she could receive it at home. However, her doctor recommended that she be closely monitored during her infusions at an outpatient hospital facility because of other conditions and medications. After OAG involvement, the denial was overturned.

COVERAGE DENIALS FOR CARE

New Yorkers obtain medically necessary care recommended by their physicians.

Access to Prescription Drugs

These complaints included problems with formularies,[3] problems with mail-order drugs (including delays and non-deliveries), and denials of preauthorization for high-cost specialty drugs. In 2022, complaints concerning access to prescription medication constituted about 4% of all cases handled by helpline advocates

> ***Health plan approves bronchitis medication.*** A consumer tried to renew preauthorization for Flovent, her bronchitis medication. Her health plan denied the renewal because they wanted her to try two different alternatives. The consumer stated she had tried one of the two, and it caused scarring and burning in her throat. Since the preauthorization had been denied, she had been relying on a supply of expired Flovent. After OAG involvement, the plan contacted the doctor, and the health plan agreed to a new prescription for a product that all parties found acceptable.
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> ***Plan provides exception to delivery requirement for medication.*** A consumer contacted OAG because her plan required delivery of her medication, but she wanted to have it filled at her local pharmacy. The medication was temperature-sensitive and could be degraded by varying temperatures during delivery. After OAG involvement, the plan approved an exception, allowing the consumer to obtain the medication at her local pharmacy.

Wrongful Practices

These complaints included improper refund processes, general inefficiencies, and improper collection activity. Cases in this category may also fit into one of the previous categories. In 2022, about 10% of complaints pertained to a wrongful or fraudulent business practice.

> ***Refund provided for return of hearing aid.*** A consumer had received a hearing aid from her provider. Finding the hearing aid unsuitable, she attempted to return it within the 45-day return period outlined in her purchase agreement. She provided documents to support her statement. The OAG sent an inquiry to the provider, who agreed to accept the return in exchange for a refund of the purchase price (less 10% as the agreement stipulated).
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> ***Dispute resolved over ownership of CPAP machine.*** A consumer entered an agreement with a provider for a payment plan for a CPAP machine. He stated that the agreement indicated that after six months of payments, the terms would be satisfied and he would own the machine. After making more than six months' worth of payments, he was still receiving billing notices. The consumer provided an accounting of all his payments under the arrangement with the provider. The OAG sent the provider an inquiry including this documentation. As a result of OAG involvement, the provider applied all payments to the account and resolved the matter.

[3] A formulary is a list of prescription drugs covered by a prescription drug plan or an insurance plan offering prescription drug benefits.

Problems with claim processing and payment

These issues included health plan errors, such as a plan's failure to pay claims, processing errors, payment of incorrect amounts, or deductible or copayment errors. In 2022, 11% of all helpline complaints related to errors in claim processing or payment. Some of the most common complaints relating to health plan claim and payment processes include:

» issues with timely claim processing

» lack of clarity and understanding about out-of-network coverage and reimbursement, and liability for seeing an out-of-network provider

> ***Health plan reprocesses claim for COVID-19 test.*** A consumer was billed $110 by a provider for a COVID-19-related office visit, based on the cost sharing assessed by the health plan. Upon OAG inquiry, the health plan reprocessed the claim to remove the member's cost-share responsibility and paid the provider the amount due.
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> ***Claim processing error corrected for neuro-physical therapy.*** A consumer did not receive reimbursement for neuro-physical therapy claims. She was unsure whether the issue was due to her deductible or the provider's network status. After OAG contacted the health plan, it acknowledged that cost sharing was incorrectly applied. It reprocessed the claims, resulting in reimbursement to the consumer.

Obtaining and keeping coverage

In 2022, 4% of consumer complaints involved obtaining and keeping health insurance coverage. Of these complaints, 30% were due to health-plan error and 13% were due to employer error.

> ***Health insurance reinstated retroactively despite insufficient payment.*** A consumer contacted OAG because she had run out of a medication and had several unpaid medical bills. She was told her policy had been canceled despite making payment. After OAG inquired about the cancellation, the health plan advised that her initial premium payment was rejected for insufficient funds. The health plan agreed to accept later payments to reinstate her health insurance with no lapse in coverage. The consumer was able to obtain her medication.
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> ***Health Insurance reinstated retroactively despite consumer error.*** At the end of November, a consumer contracted COVID-19. While dealing with her illness, she was delayed in paying the December insurance premium for her husband and herself. She contacted her health plan in the first week of December by phone to arrange payment. She believed she accidentally provided them with one incorrect digit in her member identification number. Her health plan canceled her policy. Believing that the couple still had coverage, her husband underwent a surgery that same December. After OAG involvement, the couple's coverage was restored and they saved $31,645.24.

About OAG's Health Care Bureau

The Health Care Bureau is part of the Social Justice Division[4] in the Office of the New York State Attorney General. HCB's principal mandate is to protect and advocate for the rights of health care consumers statewide through:

Operation of the health care helpline. The toll-free telephone helpline (1-800-428-9071) provides a direct line between consumers and OAG. The helpline is staffed by intake specialists and advocates trained to assist New York health care consumers. Assistance ranges from providing helpful information and referrals, to investigation of individual complaints, to mediation of disputes to help protect consumers' rights within the health care system. Consumers can also receive assistance from the helpline by submitting a complaint form, at https://ag.ny.gov/file-complaint/health-care.

Investigations and enforcement actions. The HCB conducts investigations of, and litigates against, health plans, health care providers, and other individuals and business entities that engage in fraudulent, misleading, deceptive, or illegal practices in the health care market. HCB also includes a specific section focused on tobacco compliance and enforcement (TCE). TCE has continued steadfast efforts to reduce tobacco consumption in New York state through monitoring compliance with, and enforcement of, the Tobacco Master Settlement Agreement. In addition, TCE is responsible for implementing and enforcing numerous state laws and policies, and for enforcing certain federal laws relating to cigarettes.

Consumer education. Through outreach and dissemination of information and materials, HCB seeks to inform New Yorkers about their rights under state and federal health and consumer-protection laws.

Legislation and policy initiatives. The HCB promotes legislative and policy initiatives to enhance the rights and well-being of consumers and their ability to access high-quality and affordable health care in New York state.

Conclusion

The Health Care Bureau, through its team of knowledgeable and dedicated advocates, attorneys, and support staff, remained active during 2022, working to protect the rights of health care consumers in New York and to help consumers to navigate the complicated system of health care.

We encourage New Yorkers who need help with sorting out confusing medical bills, insurance claim denials by health plans, or fraudulent practices to contact the HCB helpline. Helpline advocates work to resolve consumers' problems where possible. When there is no error or violation, advocates help consumers understand the health care system. Many of OAG's investigations in the health care realm started with a consumer complaint. We thank the individuals who brought important matters to our attention in 2022. We look forward in 2023 to bringing our skills and energy to champion the rights of consumers and enforce the laws and regulations governing the health care industry to ensure that health care consumers are able to access quality, affordable care throughout New York state.

[4] In addition to the Health Care Bureau, the Social Justice Division includes the following bureaus: Civil Rights, Labor, Environmental Protection, and Charities.