



Office of the New York State
Attorney General Letitia James

HEALTH CARE BUREAU 2020—2021

Real Solutions for New Yorkers

Each year, the Office of the Attorney General Letitia James (OAG) helps thousands of New Yorkers navigate the health care system. Through its Health Care Bureau (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 OAG¹.

In 2020 and 2021, **OAG secured over \$4 million** for health care costs in restitution and savings **on behalf of New Yorkers**. This report covers health care concerns facing New Yorkers in 2020 and 2021, which includes the beginning of the COVID-19 pandemic in March 2020. As our State continues to face serious challenges, OAG's Health Care Bureau and Helpline have remained active in helping New Yorkers sort through existing and new health care issues, including those related to COVID-19.



¹ For further information about the HCB, including press releases on our most recent enforcement actions, consumer brochures, and HCB reports, please visit ag.ny.gov/bureau/health-care-bureau.

2020–2021 at a Glance

The Health Care Bureau's Helpline is the OAG's front line for health care – making it easy for New Yorkers to notify the office about their health care concerns by submitting complaints for review and resolution by the Helpline's team of Advocates.

In 2021, New Yorkers filed 4,032 complaints with the Helpline, requesting assistance or information about health care, and other inquiries. During the year, the Helpline received **2,036 complaints** that were evaluated and handled directly at the advocate level. The remaining **1,996 complaints** were assessed and New Yorkers were provided with information or referrals to the agencies best equipped to handle the inquiry. In 2020, New Yorkers filed **3,850 complaints** with the Helpline. Staff directly handled **1,789 complaints** and provided information or referrals to the additional **2,061 New Yorkers**.

The complaints handled by the Helpline highlight the challenges faced by New Yorkers and are an important means of identifying systemic problems in New York's health care system. In addition, these complaints often provide the basis for further investigation and enforcement actions against health plans, providers, and other entities operating in the health care market.

During 2020 and 2021, OAG secured more than \$4 million for New Yorkers in restitution and savings. These recovered and saved funds were achieved by correcting erroneous medical billing, reversing the wrongful rejection and processing of health insurance claims, and rectifying companies' wrongful business practices.

In addition, through the Helpline, OAG assisted New Yorkers with obtaining medically necessary care and prescriptions where the health plan had denied coverage, and also assisted in the reinstatement of health insurance where health plans had incorrectly terminated coverage.

The main issues for which New Yorkers call the Helpline are

- (i) incorrect billing;
- (ii) health plan errors;
- (iii) uncertainty about their benefits,
- (iv) the rules to follow to obtain coverage for care,
- (vi) appeal rights, or
- (vii) referral information to other agencies that might deal with health care issues that are out of the scope of our jurisdiction.



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

While not all complaints and inquiries can be resolved favorably, the Helpline plays a crucial role as a source of reliable and objective information for New Yorkers.

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, and insurance coverage. During 2020 and 2021, the COVID-19 pandemic presented novel health care issues across New York State, and the OAG worked to identify, track and resolve those complaints.

COVID-19

About 8% of the complaints in 2021, and 7% of the complaints in 2020 concerned COVID-19 issues. In 2020 and 2021, COVID-19 issues included complaints about improper billing for COVID-19 tests and vaccine administration fees. During this time period, Helpline staff worked hard to ensure that New Yorkers were not improperly charged by medical providers and were not improperly assessed cost-sharing by their insurers. Helpline staff uncovered provider coding errors, health plan claim processing errors, deceptive business practices, and provider staff and training deficiencies.

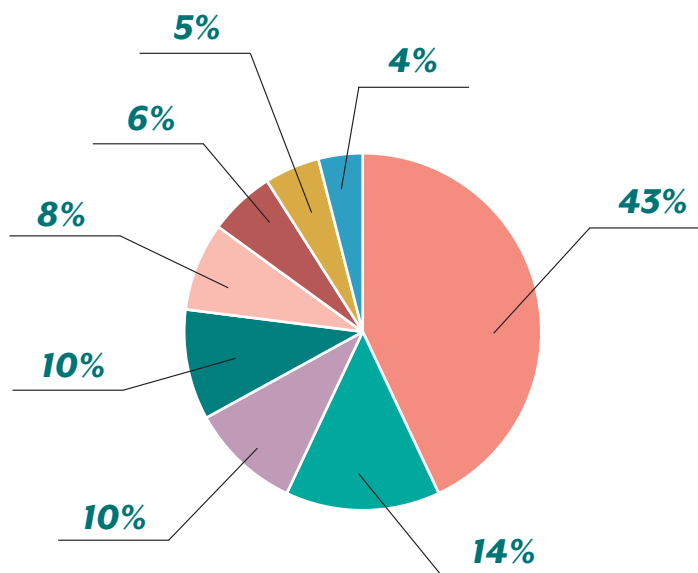
Some complaints were resolved by Helpline staff or OAG attorneys, and others formed the basis for ongoing enforcement actions. OAG sent cease and desist notices to pharmacies for overcharging for, or improperly selling, rapid tests that were not authorized for home use, as well as for improperly charging consumers a vaccine administration fee. OAG also sent cease and desist letters to mask manufacturers for fraudulently claiming their masks were properly certified, and to other companies and individuals for deceptively marketing products (such as toothpaste, dietary supplements, creams and colloidal silver) as treatments or cures for COVID-19. As a result of OAG efforts, provider billing and insurer claim processing errors were corrected, and fraudsters were stopped from misleadingly marketing their products in New York. OAG continues to work to identify and resolve deceptive and unfair business practices concerning COVID-19.

Complaint Category Data

In 2020 and 2021, most complaints to the Helpline were about incorrect medical billing (including by private physician practices and hospitals). These issues typically include when a patient is incorrectly “balance billed,”² when a provider fails to, or incorrectly, submits claims to an insurance company, or duplicate billing.

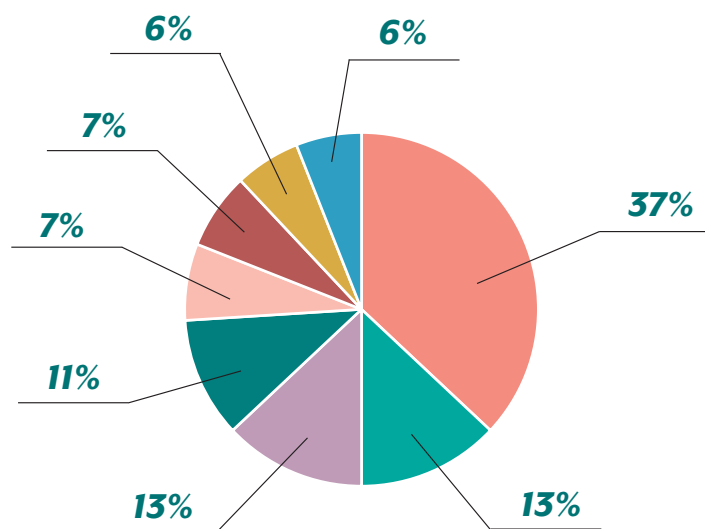
Incorrect billing has been the number one issue raised by New Yorkers to the Helpline since 2011. The graphs below show the breakdown of complaints for 2020 and 2021.

Complaint Categories 2021



- Provider Billing
- Claims Processing
- Health Plan Denials
- Wrongful Practices
- COVID-19
- Coverage
- Prescription
- Other

Complaint Categories 2020



- Provider Billing
- Health Plan Denials
- Wrongful Practices
- Claims Processing
- Prescription
- COVID-19
- Coverage
- Other

² “Balance billing” occurs when a provider bills a patient for the difference between the amount charged and the amount that the patient’s health plan paid. When a provider is in-network, there is an agreement to accept the insurance payment as payment in full, and the provider is not permitted to balance bill the patient (except for coinsurance, copayment, and deductible). Balance billing is not improper, 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/Actions

The following provides further details on the most common issues prompting calls to the Helpline, and how OAG can assist in resolving those issues.

Provider Billing Practices

Erroneous provider bills are, unfortunately, not uncommon, can be costly, and even lead to referrals to collection agencies or legal judgments. In 2021, a significant number of complaints (43%) concerned provider billing practices. This was an increase of 6 percentage points from 2020.

- **Consumer Reimbursed for Cost of COVID-19 Rapid Test.** The consumer went to a provider for a COVID-19 test. He was told that his insurer did not cover COVID-19 rapid tests, so he paid \$175 out-of-pocket for the test. He later called his insurer to verify this information and was advised that this was incorrect. He made multiple attempts to get an itemized statement from the provider to submit to his insurer to be reimbursed, but he was never able to get through to a person in the billing department, and the provider was unresponsive to his messages. He contacted the Helpline and after OAG intervened, he was fully reimbursed.
- **Provider Updates Policy to Bill In-Network Insurer for COVID-19 Tests Instead of Patients.** A nursing home employee was directed by State law to get twice-weekly COVID-19 testing. When she went to a provider that was in-network with her health plan, they advised that her insurer would cover the first weekly test, but that she would be billed \$100 for the second weekly test. She contacted the Helpline and with assistance of the OAG the provider updated its policy to bill the insurer for COVID-19 testing for all of its nursing home employees.
- **Nursing Home Provider Refunds Deposit Based on COVID-19 Extraordinary Circumstance.** In mid-March 2020, a 91-year-old patient was going to move from her current nursing home to another one due to affordability. Her move-in date was to be the week of March 16, and on March 9, her family paid one month's rent of \$4,635 to the new home. On March 15, the current nursing home told the family that the transfer had to be delayed because they were in lockdown due to COVID-19. The family informed the new home about the delay, and the home refunded them \$4,046.60 of their payment, but held \$588.40 as a non-refundable deposit under the contract. The family contacted the Helpline and OAG was able to recover the entirety of the deposit.

• **Rehabilitation Center Corrects Billing Error of \$30,000.** After a stay in a nursing center, the consumer received a bill for approximately \$30,000 for rehabilitation services. She struggled to make payments on this bill before reaching out to Helpline. OAG uncovered that the nursing center—without informing the consumer—had placed her on private-pay status and decided not to send her bill to Medicare. Because of their own internal error, the center was unable to subsequently submit the bill to Medicare. However, after OAG became involved, the facility agreed to refund the total amount that the consumer had already paid towards the bill, \$15,026.00, and waived the remaining balance.

• **Hospital Bill of Over \$200,000 Is Rescinded.** A child needed emergency behavioral health services, which led to two hospitalizations at an out-of-network hospital. The mother received an explanation of benefits from her insurer, which indicated zero patient responsibility, but she was subsequently billed more than \$200,000 for the two hospital stays. She contacted the Helpline after one of the bills was sent to collection. OAG asked the insurer and hospital to resolve the matter and the mother now has zero financial responsibility.

• **Embassy Pharmacy Reimburses Administration Fees Improperly Charged to Recipients of COVID-19 Vaccine.** This investigation arose from consumer complaints about the imposition of a vaccine administration fee at Embassy Pharmacy for the COVID-19 vaccine. As a result of the investigation, by settlement agreement entered into with Embassy Drugs in October 2021, Embassy Pharmacy was required to reimburse about 275 consumers the improperly charged \$25 fee. In addition, Embassy Pharmacy agreed to institute new requirements that strengthen training for all staff involved with the administration of COVID-19 vaccines, as well as signage requirements associated with vaccine administration.

Health Plan Denials of Coverage for Care

Denials for coverage most often occur when an insurance company determines that the care was not medically necessary, even though a physician determined that the care was needed. In 2021, approximately 10% of all Helpline complaints involved health plan denials of coverage for care. This is a 3 percentage point decrease in comparison to 2020, and represents a 6 percentage point decrease from 2019 when 16% of the Helpline complaints involved health plan denials of coverage for care.

• **Plan Reverses Denial of Coverage for Hospice Care.** On Christmas Eve, a patient with stage 4 metastatic lung cancer was in a hospital, and a doctor determined that she could no longer care for herself and needed hospice or skilled nursing care. The insurer denied coverage for hospice care or skilled nursing care because of documentation showing that she could perform daily tasks before she was in the hospital. Her health care proxy contacted the Helpline for urgent assistance and OAG was able to get the insurer to cover the necessary care.

• **Spinal Radiofrequency Ablation Approved.** A doctor deemed it necessary that a woman receive a spinal radiofrequency ablation necessary to reduce her intense pain. She had previously received this procedure, most recently about six months prior, with an over 80% success rate. The insurance company denied the claim and denied multiple appeals from the doctor. OAG intervened and was able to get the insurer to cover the procedure.

• **Insurer Reverses Denial of Coverage for Care at Home for Aged.** Consumer was at a senior living center when she developed COVID-19, and her health rapidly declined. She was unable to walk on her own and could no longer do physical therapy (PT) or occupational therapy (OT). In response, her insurer stopped covering her stay at the home, finding that the therapies were not needed, when in fact, PT and OT had only been discontinued by the patient due to COVID complications. This resulted in charges of \$10,000 for the family. The family appealed, but the denial of coverage was upheld. They contacted the Helpline, and OAG was able to get the insurer to overturn its determination and provide coverage for her stay.

• **Health Plan Reverses Denial of Coverage for MRI.** The consumer was experiencing significant pain that she felt was related to breast implants, and she requested a physician remove the implants. Because she had a family history of breast cancer, the physician would not remove the implants without first ruling out breast cancer with an MRI— which the insurer denied. The consumer contacted the Helpline, and OAG was able to get the MRI covered within one day.

• **Health Plan Reverses Denial of Coverage for Shoulder Surgery.** Consumer's shoulder surgery was scheduled in six days and her insurer denied coverage as not "medically necessary." The insurer's denial letter stated that it required the consumer to receive physical therapy (PT) prior to approving surgery, even though her doctor had determined that PT would exacerbate the problem. The consumer contacted the Helpline, and the OAG was able to get the procedure covered in time for the original surgery date.

• **Fidelis Reprocesses and Pays over \$1 Million in Claims After Improperly Denying Coverage for Inpatient Detoxification.** A health care provider contacted the Helpline with concerns that patients' claims for inpatient detoxification were being denied by Fidelis without a clinical reason. The OAG launched an investigation and found that most of Fidelis' initial adverse determinations issued during a five-month time period were deficient because they did not provide the reasons for the denial, including the clinical rationale as required by New York's Public Health Law. As a result of OAG's investigation, Fidelis agreed to reprocess and pay over \$1 million on claims that were improperly denied.



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 2021, complaints concerning access to prescription medication constituted about 5% of all cases handled by Helpline advocates (representing a 2 percentage point reduction from 2020).

- **Denial of Coverage for Mental Health Medication is Reversed.** A woman contacted the Helpline after her insurance denied coverage of her medication prescribed for mental health treatment. The insurer indicated that the woman needed to first try other medications that were on its formulary, even though she had already tried one. OAG asked the doctor to write a letter of medical necessity, indicating the woman's need for the medication, and advocated for the medication with the insurance company. The insurer overturned its denial and approved authorization of coverage for the medication.
- **Consumer Receives System to Help Manage Diabetes.** Consumer, a type-1 diabetic, used a wearable glucose monitor that checked her blood and hooked up to her insulin pump overnight. The device was discontinued and the woman's pharmacy did not supply the newer model glucose monitor. The pharmacy refused to release its authorization for the device to another pharmacy that could supply the newer model. Consumer contacted her insurer, which claimed it couldn't help. She then contacted the Helpline, which was able to intervene and get the insurer to issue a new authorization for the pharmacy that could supply the newer equipment.

Wrongful Practices

These complaints included improper refund processes, general inefficiencies, and improper collection activity. Cases described under the wrongful practice category may also fit into one of the categories above. In 2021, about 10% of complaints were based on an individual's assertion of a wrongful or fraudulent business practice (representing a 3 percentage point reduction from 2020).

- **Company Issues Refund for Medication.** A man ordered and paid for an HIV medication online in 2020. The medication did not work for him, and so he did not order it again in 2021. However, despite not ordering or receiving the medication, the company charged his credit card in 2021. He was unsuccessful in resolving this on his own and contacted the Helpline. After OAG intervened, the company responded and issued a full refund to the man.
- **Collection Agency Removes Negative Information.** A man found a bad debt notice on his credit reports for \$300. The source of the debt was a bill for ambulance service from 2019. He had not previously been billed. He contacted the debt collection agency and determined that billing notices had been sent to an incorrect address. He did not dispute the debt, just the bad credit report. The collection agency refused his repeated requests to have the negative information removed, so he contacted the Helpline. OAG intervened and the collection agency agreed to remove the negative report.

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

• **UnitedHealthcare Paid More than \$14 Million to Consumers Who Were Denied Mental Health Care Coverage.** Alongside the U.S. Department of Labor, OAG secured \$14.3 million to consumers with behavioral health conditions who received reduced reimbursement or claim denials under United's policies, including \$8 million to more than 20,000 New Yorkers. The agreement resolved allegations that United unlawfully denied health care coverage for outpatient mental health and substance use disorder treatment for thousands of New Yorkers. The settlement also requires United to end its policies that violated behavioral health parity laws, which require health insurance plans to cover mental health and substance use disorder treatment the same way they cover physical health treatment. United also paid \$1.3 million in penalties to New York State. The agreement was the product of the first joint federal-State enforcement of behavioral health parity laws.

Claim Processing and Payment Problems

These issues included health plan errors, such as a plan's failure to pay claims, processing errors, payment of incorrect amounts, or deductible and/or copayment errors. In 2021, 14% of all Helpline complaints related to claim processing and/or payment errors (representing a 3 percentage point increase from 2020). Some of the most common complaints relating to health plan claim and payment processes include:

- » Issues with timely claim processing; and,
- » Lack of clarity and understanding about out-of-network coverage, reimbursement, and liability for seeing an out-of-network provider.

• **Erroneous Assessment of Cost-Sharing for Tests Administered During COVID-19 Doctor's Visit.** After having a fever for three days, a woman went to a medical provider for a COVID-19 test. Tests for other illnesses were performed in addition to the COVID-19 test, and the insurer assessed \$852 to her deductible for the visit. She contacted the Helpline, which reminded the insurer that medically necessary COVID-19 tests and all items and services received during visits that result in the administration of a test should be covered by health plans with no cost-sharing assessed to the patient when the patient is receiving medical care because of illness. After hearing from OAG, the health plan reprocessed the claim to assess the woman zero cost-sharing for the visit.

• **Claim Processing Error Is Corrected for 512 Consumers, totaling over \$52,000.** After receiving a birth control implant device from a medical provider, a woman was billed \$112.43. She was under the correct impression that birth control and related services would be 100% covered with no cost-sharing under her plan, but her insurance could not explain why she was charged. She contacted the Helpline, and OAG reached out to the insurer. The insurer informed OAG that the matter was handled inappropriately due to an administrative error, and adjusted the claim with zero cost share and paid the provider an additional \$112.43. OAG followed-up with the insurer and discovered this was not an individual error. After the OAG intervened, 566 claims were reprocessed for 512 consumers in similar situations, for a total of \$52,126.

• **Health Plan Reprocesses and Pays Over \$700,000 for Baby's NICU Care.** A new mother was billed \$720,342 by a hospital for her baby's NICU care. The baby was covered under both parents' health plans plus Medicaid after the baby's 30th day of life. The two health plans were in dispute over which one had to pay as primary, resulting in incorrect claim processing. The mother had been going back and forth for months trying to resolve this herself, and ultimately contacted the Helpline. After OAG intervened, the primary health plan acknowledged that it had incorrectly updated the baby's Coordination of Benefits (COB). The plan corrected the error, and then reprocessed the claims to pay the full \$720,342 billed by the hospital, and the member's responsibility was zero.

Oscar Insurance Pays Restitution and \$50,000 Penalty for Improperly Assessing Cost-Sharing for Contraceptive Coverage. As a result of a Helpline complaint, OAG initiated an investigation into Oscar Health's assessment of cost-sharing for contraceptive counseling. OAG's investigation uncovered that Oscar improperly assessed cost-sharing thousands of times for contraceptive counseling and for ultrasound when used for insertion, follow-up and removal of IUDs, costing consumers tens of thousands of dollars. As a result of the investigation, Oscar paid restitution to affected consumers and a \$50,000 penalty.

EmblemHealth Pays \$50,000 Penalty for Claim Processing Error Resulting in Denials of Coverage for Laboratory Services. As a result of a Helpline complaint, OAG initiated an investigation into EmblemHealth's denial of coverage for laboratory services provided by an in-network provider, Quest Diagnostics, that resulted in a \$1,750 bill to a consumer. OAG's investigation revealed that EmblemHealth improperly denied coverage of similar claims to 70 members, with charges totaling \$156,351. Despite learning of this problem in April 2019, EmblemHealth did not reprocess and pay those claims until September 20, 2019, and only did so after OAG began its investigation. In addition to paying the claims, EmblemHealth was required to provide outreach and assistance to members to ensure that any members who paid more than their cost-sharing for the lab work were reimbursed with interest. EmblemHealth was also required to establish a complaint system for responding to and tracking member complaints, and audit how complaints are handled and resolved. Finally, EmblemHealth was required to pay a \$50,000 penalty.

Obtaining and Keeping Coverage

In 2021, 6% of consumer complaints involved issues relating to obtaining and keeping coverage. This percentage was the same in 2020. In 2021, of these complaints, 36% were due to health plan error and 15% were due to employer error.

• **Health Insurance is Reinstated Retroactively Despite Missed Premium Payments.** The consumer contacted the Helpline after his wife's health insurance coverage was cancelled for a two-month period, resulting in tens of thousands of dollars in patient responsibility for his wife's medical services. The health plan stated that it had not received premium payments, but the consumer was adamant that he had never received a billing notification for those premium payments. He contacted the Helpline for assistance, and after OAG intervened, the insurer agreed to provide coverage for the months previously cancelled and to process claims from that time period.

• **Health Insurance is Reinstated Retroactively Where Improperly Terminated.** Consumer reported that he had resigned from his job at the end of March 2019, but his health insurance coverage was terminated February 28, 2019, even though premiums were still being deducted from his paychecks in March 2019. This resulted in numerous unpaid claims. Prior to contacting the Helpline, he appealed directly to the insurer, who denied the appeal stating he should contact his employer. He did so, but never received a substantive response. OAG was able to intervene and the employer reinstated the coverage, and the previously denied claims were reprocessed, totaling over \$10,000 in savings for the consumer.

About the OAG Health Care Bureau

The HCB is part of the Social Justice Division⁴ in the New York State Office of the Attorney General. The principal mandate of HCB is to protect and advocate for the rights of health care consumers statewide through:

• **Operation of the Health Care Helpline.** This toll-free telephone Helpline (800-428-9071) serves as a direct line between consumers and the Office of the Attorney General. The Helpline is staffed by intake specialists and advocates trained to assist New York health care consumers. Assistance ranges from providing helpful information and referrals to investigation of individual complaints, and 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 online or by mail. The online complaint form is easy for consumers to submit and can be accessed at www.ag.ny.gov/health-care-bureau. There are also instructions on the website for submitting a complaint form by mail.

⁴In addition to Health Care, the Social Justice Division includes the following bureaus: Civil Rights, Labor, Environmental Protection, and Charities, each of which enforces the relevant laws to protect consumers in New York.

- **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. The 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

During 2020 and 2021, New Yorkers and health care in our State have faced serious challenges, many of which have never been experienced before, and were as a result of the COVID-19 pandemic. The Health Care Bureau, through its team of knowledgeable and dedicated advocates, attorneys, and support staff, remained active during these two years working to protect the rights of health care consumers in New York, and 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. Once a complaint is taken, consumers can expect a prompt response from a Helpline advocate, who will work to resolve a consumer's problem where possible and to help a consumer understand the health care system where there is no error or violation. If warranted, an advocate will go further, escalating an issue for higher-level review and possible investigation. Many of the 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 2020 and 2021. We look forward in 2022 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 in New York State.