



March 20, 2019

Chairman Alexander
Health, Education and Labor Committee
428 Senate Dirksen Office Building
Washington, DC 20510

Ranking Member Patty Murray
Health, Education and Labor Committee
428 Senate Dirksen Office Building
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray,

On behalf of the National Association of Health Underwriters representing 100,000 licensed agents and brokers who are engaged in the sale and service of health insurance and other ancillary products and serving employers and consumers around the country, we have compiled a number of surprise billing stories that traverse the United States. The members of NAHU work daily to help consumers navigate a labyrinth of health care coverage options that work best for them, but we also expend an extraordinary amount of time assisting consumers who use their benefits, particularly around claims adjudication. The stories we present here, are a fraction of the stories we have and represent a wide range of balance billing situations from lower dollar amounts to balance billing that reaches 7,000% above the usual and customary commercial rates. It is not uncommon for the agent to spend many months working to resolve billing issues. Our agents have found offers to negotiate to 125% of Medicare are routinely refused. The time expended on these negotiations between the carrier and the provider can be lengthy for even amounts as small as \$300. One agent reported that 66 touches with the billing office were made on one issue. Some claims have required as many as 115 or more contacts over several months. On the bright side, one agency reported some success in negotiating down the bills, saving consumers over \$2.1 million in 2018. This reflects the amount those consumers would have paid if the agency had not taken action regarding these surprise bills.

What we found is a system stacked against the consumers who have no leverage with the provider or the hospital that typically does little to negotiate or assist the insured. Patients are asked to sign paperwork that allows such billing with vague and ambiguous language, sometimes under duress, during an emergency. Often the patient is asked to sign these papers while actively preparing for a procedure. If you are in the unfortunate situation of not being conscious at the beginning of care, as one 24-year-old male was at the time, you may find that you have received almost all of your care from out-of-network providers from the ambulance to the ER doctor and hospital. In this case, the patient's meager wages would never be able to cover the level of expenses, resulting in collection action and a damaged credit report.

The next two stories come from a health insurance agent's recent testimony in Colorado.

Hospital and out-of-network equipment

The first claim is from a scheduled surgery where the insured did their due diligence and made sure the hospital (Sky Ridge), the surgeon, the anesthesiologist, and anyone else that was going to be involved in the surgery was in-network. About a month after the surgery the insured received three out-of-network bills. One from the surgeon, one from a company that provided technical equipment in the operating room, and one from a provider that was not in the surgical room to monitor the technical equipment. The surgeon, whom the agent confirmed was in the network has two tax ID's,



one for regular working hours (in-network) and one for outside of regular working hours (out-of-network). Of course, the surgery was scheduled during the out-of-network hours and resulted in total billed charges of \$26,161 from the surgeon. If the surgeon had billed within the network, he would have been reimbursed roughly \$3,500. The technical equipment had its own tax ID (out-of-network). The billed charges for the equipment were \$258,400. If costs had been billed in the network; the company would have been paid around \$1,000. The physician to monitor the equipment (out-of-network) billed \$154,250. If charges had been billed in network; the provider would have received around \$1,000. To recap the numbers, the total out-of-network claims billed to the insured, which the carrier had to pay in total because of out-of-pocket limits, was \$438,811. Had these services been in the network, the paid charges would have been approximately \$5,500. When carriers are required to pay these abusive and usury charges, they are passed along to all of our premiums in future years.

The second claim resulted from an insured being taken by ambulance, after a bicycle accident, to an out-of-network hospital emergency room (Boulder Community Health). There were eight different billed charges, including two different hospital miscellaneous fees totaling \$15,721, and an emergency room fee of \$11,174. The eight total billed out-of-network charges were \$53,968. If costs had been billed within the network; the reimbursement would have been approximately \$5,050.

The carrier has tried to negotiate, but the hospital will not budge on the out-of-network charges. The carrier is only responsible for paying usual and customary when negotiations breakdown and therefore the insured is being balance billed roughly \$48,000. The consumer has retained an attorney, and this is still pending.

Laboratory

This story comes from Lutz, Florida where an insured experienced a surprise bill after going to an in-network emergency room and being admitted to the in-network hospital. Laboratory tests were ordered including advanced imaging. The reading and review of the tests were completed by out-of-network radiologists. The patient had no control over which doctors saw her or read the results of her tests. The agent attempted to go through the carrier to see if they could assist with getting this claim reprocessed, but an appeal was the only next step. With the insured's permission, the agent submitted a member first level appeal on behalf of the insured and the appeal was upheld.

In another case, a child age 5 who was severely dehydrated and was taken by her mother to the closest emergency room to their home, Inwood Emergency Room. The total bill was \$8,476.36. The bill was presented to the carrier for processing which allowed \$2,325.84 minus an emergency room copay of \$450 and \$817.00 to the deductible, plus coinsurance of \$217.76 for a total payment of \$841.08. After paying the legitimate cost-sharing expenses of \$1,484.76, the insured was balanced billed \$6,150.52.

Hospital specialists

This case involved an insured who went in for a pancreatic biopsy. His primary care provider was an in-network doctor, who referred him to a network specialist. The specialist scheduled a test at a network hospital. The procedure went through without a hitch, and the insured was very satisfied with the care but then the bills came and he learned that the hospital sent the tissue sample out to a non-network lab, and the lab was billing the insured for \$5,800 in cancer screenings of which the insured said the insurance company paid approximately \$800 because some of the tests done were



deemed experimental by the carrier. The insured was livid because: 1) he had no choice of the lab chosen, 2) he did not know what tests were being done and or if the tests indeed were experimental and had he known he would have declined them upfront, 3) He had no idea what the fee schedules were going to be once the out-of-network lab received the sample. The insured complained to the hospital. The hospital pointed to the admitting paperwork it was disclosed "we may use out-of-network labs/contractors during your care and we can't be held responsible" and it was signed by the insured (of course because the insured had no choice but to sign the paperwork or the procedure would not get completed as scheduled).

ER

In Tennessee, two carriers are fighting over out-of-network emergency room charges, and the patients are losing. Agents report that people with real emergencies are now receiving \$50,000+ outstanding emergency room bills due to balance billing.

Anesthesiologist

A baby born in a hospital in Georgia and the mother had health coverage. After two days in labor and an unscheduled C-section, the mother was discharged with a healthy baby. The bad news is that the anesthesiologist was not a contracted in-network physician at the in-network hospital where the delivery occurred. The result was a balance of \$8,000 for anesthesia. The agent made several calls to the provider's office and assured the carrier would pay more. They didn't, and the provider would not negotiate. Anesthesia services rendered should be mandated that an in-network hospital is considered as in-network and the carrier should negotiate these fees on behalf of patients. The provider claimed he had to stay at the hospital 24/7 to monitor the patient and the fee was reasonable. At the very least, hospitals should be required to disclose the in or out-of-network status of anesthesiologists practicing at their hospital.

Pediatric Anesthesiology in Alabama

Agents have had issues with clients in Birmingham, AL with pediatric anesthesiologist services at Children's hospital that are not a participating provider with the same providers as the hospital. This issue prevents patients going to this hospital because they know the hospital is participating in their network, they later find out with a surprise bill that the anesthesiologist group is non-participating, and they have a large bill to pay. The same goes for an anesthesiologist Group in West Alabama- Auburn, AL.

We sincerely appreciate the opportunity to provide the Committee with these real-life situations faced by consumers. If you have any questions about our comments, or if NAHU can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0639 or jtrautwein@nahu.org.

Sincerely,

Janet Stokes Trautwein

CEO

National Association of Health Underwriters