**SURPRISE MEDICAL BILLS *I* – PRE-EXISTING CONDITION:**

I have my own nightmare of surprise medical bills. Mine was a bill of $53,000. I am 55, lead an active life, have biked the entire Greater Allegheny Passage and many other trails with my family, work full time, *and* have had rheumatoid arthritis for 27 years. In 2014, I needed a shoulder replacement due to rheumatoid changes:

- My Surgeon went through PRIOR AUTHORIZATION with carrier (Coventry WV – part of Aetna) and OBTAINED prior authorization number. My surgeon advised me that to obtain prior authorization, he advised why I needed the surgery.

- Prior to my surgery I had TWO appointments with my Rheumatologist BOTH of which were covered

- Surgery (this was IN-Network) May 21, 2014

- Years ago I had to worry about pre-existing conditions – then changes COBRA, HIPAA, and now PPACA/HCERA; I haven't thought of pre-existing conditions for over 15 years

- Health Care Carrier became Coventry January 28, 2014 due to husband's employment change

- About 6 weeks after surgery, hospital called having received EOB DENYING COVERAGE BASED ON PRE-EXISTING CONDITION

- Called insurance carrier and carrier <u>told me prior authorization has nothing to do with pre-existing condition</u>; but would check into situation

- Weeks into months spent waiting with me advising doctors and anesthesiologist and providers of this insurance issue and imploring them to be patient (they were)

Ultimately what saved me from the $53,000+ bills was the generosity and graciousness of my husband's employer.

- January 1, 2014 PPACA removed denial for pre-existing condition

- A provision apparently buried in PPACA is that IF A HEALTH CARE CONTRACT IS IN PLACE then the CONTRACT *END DATE* IS THE EFFECTIVE DATE and not January 1

- Employer's contract end date: June 1, 2014 (surgery May 21, 2014)

- I gathered information from my surgeon including authorization code, reviewed my prior appointments with my Rheumatologist and accompanying labwork (all covered and paid by

the carrier), reviewed the various laws, and prepared for battle with Coventry and its gargantuan parent Aetna (my authorization code started with HA – Coventry initially (nastily) told me this was a Health American code and not valid for Coventry; ultimately the code was valid – carrier told me HA codes are used for Pennsylvania residents – employer was located in WV-----yet another issue with the validity of health insurance carriers)

- I was anxious, nauseated, nauseous, panicked, stressed, nervous, frustrated, frazzled, and very, very angry

- Carrier ultimately told me employer was unilaterally renegotiating contract date to take back to January 1 and to wait; Employer ultimately did renegotiate back to January 1

- Coverage was ultimately granted based on renegotiated date

**SURPRISE MEDICAL BILLS *II*– OUT-OF-NETWORK & PRIMARY/SECONDARY:**

I had another nightmare medical bill issue related to out-of-network facility. This is another situation which frustrated me which didn't need to cause the stress it did. My husband and I were foster parents to a wonderful child. We had hoped to adopt the child and had her on our primary coverage through my husband's employer – at this time, UnitedHealthcare. She also had coverage through the state DPW/Medical Assistance which was secondary-UPMC for You.

- Our foster child needed emergency treatment and CYS directed us to take her to a specific UPMC hospital in Pittsburgh

- UPMC hospital took both our primary and secondary carrier information

- UPMC hospital was Out-of-Network for our primary coverage; UPMC was In-Network for secondary carrier – UPMC for You

- UPMC –the hospital - required that we guarantee payment of the accumulated $10,000 bill and out-of-pocket expenses for the out-of-network treatment or it would discharge our foster daughter

- Panicked, I contacted both of the health care carriers and both advised that primary pays its contract share as out-of-network and secondary picks up the remaining. BOTH CARRIERS ADVISED THAT BILL WOULD BE PAID

- We have another daughter who has secondary UPMC for You coverage – and this is how her coverage has worked

- UPMC hospital INSISTED (nastily) that since primary did not cover as in-network, secondary would not cover *at all* and we needed to guarantee out-of-pocket costs.

- Stress from worrying about our foster daughter's health and treatment, and panic over the payment of hospital bills literally sent me to the ER with CHEST PAINS and SUSPECTED HEART ATTACK

- Foster daughter was released as part of a treatment plan. CYS guaranteed payment. Being only a foster mom we didn't get bills, but ultimately payments were made as carriers had told us

- Can only surmise why UPMC created such a mêlée when carriers treated this as expected

**HOPES & DREAMS FOR CARRIERS and PROVIDERS:**

I cringe and want to scream every time I need to call my carrier and ask about coverage – when I am forced to listen to the recorded message that ***nothing I'm told by the representative is binding and all decisions will be made upon submitting bill***—which of course is AFTER the surgery. AFTER fees are incurred. AFTER a child is admitted. AFTER a wait of ten days could solve the problem. AFTER the surgeon can submit supporting documentation.

Like the PPACA, even if one reads the applicable section, for example, NO DENIAL FOR PRE-EXISTING CONDITIONS, the law has other sections buried in the voluminous pages which change the interpretation. Frankly, insurance coverage contracts are the same way – provisions buried elsewhere that denied certain coverage. I want to read contract myself, but MUST RELY on calling insurance to check on coverage AND THEN ONLY TO BE TOLD DECISIONS WILL ONLY BE MADE *AFTER* TREATMENT WHEN BILL IS SUBMITTED.

WHY CANNOT HEALTH CARE CONSUMERS HAVE THE SAME PROTECTIONS AS CONSUMERS OF OTHER GOODS & SERVICES??

***At the very least, patients should be provided:***

- List of standard charges for hospital services

- Doctor Providers anticipated charges

- Anticipated out-of-pocket expenses for patient by carrier (I recognize carriers have contracts with providers for standard services (contracts they likely would not want others to know) – and this could be difficult, but why should a consumer NOT KNOW what charges will be for a service?)

- Surgery calculator didn't include shoulder replacement surgery. Expense calculators don't work.

- For surgery or treatment – provider verifies that patient's health plan participates with provider when issuing authorization

- For surgery or treatment – provider verifies whether or not pre-existing conditions exist prior to issuing authorization

- Hospital cannot KICK OUT A PATIENT when patient's health care carriers acknowledge coverage

- Basic rights consumers have in all areas except medical bills

- AN AUTHORIZATION NUMBER authorizes all aspects of the surgery. If there are any outstanding issues – incumbent on Carrier to determine prior to surgery – not simply deny after surgery (we're NOT talking a workers compensation issue…).

If one buys a house, a loaf of bread, *Starbucks* coffee, gasoline or even a car, she knows the list price. Think about gasoline and laws for posting correct price. Should not a patient undergoing surgery have the same protections? One having surgery is at the mercy of the hospitals, doctors (to a lesser extent) and the insurance carriers which know what they have contracted with the providers to cover. I recognize there are some hot-button issues here, which hopefully some basic provisions providing basic info can skirt. This needs to be made a priority.

My two nightmares may seem to have ended well. But not without great panic, frustration and stress. One caused by a "trap" in PPACA language. The other by what must only be a Pittsburgh hospital exerting it might. Obviously, I have lingering infuriation, exasperation, aggravation, frustration and annoyance and want to make sure this DOES NOT HAPPEN TO ANYONE EVER AGAIN.

Thank you so much, Kathy Johnston