



Testimony of
Charles Bell, Programs Director
Consumers Union
before the
Pennsylvania Insurance Department
Regarding Surprise Medical Bills
October 1, 2015

Good morning, Commissioner Miller. Thank you very much for providing me the opportunity to come before you today. I am Chuck Bell, Programs Director for Consumers Union, the policy and action arm of the nonprofit *Consumer Reports* magazine.¹ Since 1936, our mission at Consumer Reports has been to test products, inform the public, and protect consumers. We participate in advocacy regarding health insurance issues as part of our consumer protection function.

Consumers Union commends the Pennsylvania Insurance Department for your interest and commitment to investigating consumer problems with surprise out-of-network medical bills. This is an issue that we believe that strongly resonates with Pennsylvania residents. We recently created a national online Insurance Complaint Tool (<https://consumersunion.org/insurance-complaint-tool/>), and to date we have heard from over 50 Pennsylvania patients who have received surprise medical bills, some for as much as \$6,000, \$10,000 and even \$35,000.

Surprise medical bills are harsh, unreasonable and unfair hardships for patients and their families. And consumers – more than anyone – realize that they can be hit with unexpected medical bills, after visits to medical providers and hospitals. The bills may appear in the mail, despite the patient’s best efforts to consult provider directories, ask questions about whether all providers were in-network or out-of-network, and follow the rules of their health plan. So we feel that we are key stakeholders in this debate, as it we in the end who get saddled with these bills, and also must bear the burden for rising health insurance premiums and out-of-pocket costs.

A comprehensive solution is needed to improve information disclosure and price transparency for patients, improve network adequacy, protect consumers against out-of-network charges in emergency settings, strengthen protections when no suitable provider is available, reduce the incidence and severity of any unexpected medical bills, and create fast, efficient dispute resolution processes when the plan and provider can’t agree on how much is to be paid for a procedure or service. And, there is a urgent need to implement solutions that reach patients who have different types of insurance, including consumers in self-funded employer plans.

In a recent national survey of 2,200 U.S. adult residents, Consumers Union found that nearly one-third of Americans report having received a surprise medical bill in the last two years. This included one out of four Americans who said they received a surprise bill from a doctor they did

¹ Consumers Union is the public policy and advocacy arm of Consumer Reports. Consumers Union is an expert, independent, nonprofit organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves. It conducts this work in the areas of telecommunications reform, health reform, food and product safety, financial reform, and other areas. Consumer Reports is the world’s largest independent product-testing organization. Using its more than 50 labs, auto test center, and survey research center, the nonprofit organization rates thousands of products and services annually. Founded in 1936, Consumer Reports has over 8 million subscribers to its magazine, website, and other publications.

not expect to receive a bill from. It also included 37% of patients who had recent encounters with hospital or emergency room care.

According to the survey, only 28% of privately insured Americans with who received surprise bills were satisfied with how the issue was resolved. For more than half of those surveyed (53%), the issue was either not resolved as they liked (30%) or not resolved at all (23%). Of this group (*issue not resolved to satisfaction/at all*) most (75%) either paid for the bill in full (57%) or through a payment plan (18%).²

While the circumstances of each case are different, one common thread is that it generally is never pleasant to be in the middle of a medical billing dispute, especially a protracted dispute that goes on for many months. Consumers often report frustration in having to spend time resolving billing problems after emergency care or a medical or hospital procedure, at the very time that they are recovering and trying to resume their ordinary activities. In some cases, the surprise medical bill greatly exceeds what the consumer can afford to pay from savings or monthly income, and the bill may be sent to collections and damage the consumer's credit rating. In other cases, surprise medical bills are reduced or waived by providers, but only after considerable time and expense is expended by the patient or patient's family in complaining about the bill and negotiating a solution.

Our national survey findings also suggest that consumers overall seem largely confused when it comes to their rights to fight surprise bills. Nearly three-quarters of survey respondents were unsure if they had the right in their state to appeal to the state or an independent medical expert if their health plan refused coverage for medical services they think they need. Most consumers (87 percent) did not know which agency or department in their state government is tasked with handling complaints about health insurance.

To this point, Consumers Union believes that it is critical that Insurance Departments play an active role in investigating consumer complaints about medical billing issues, and being a go-to source of help for information and problem resolution for surprise bills. ***Consumers need to know that there is someone who cares, and can help them with this problem.*** For example, in its report on surprise medical bills, "An Unwelcome Surprise," in 2010 and 2011, the New York Department of Financial Services reported that it was receiving about 2,000 complaints from consumers every year about medical billing issues, and that health plans in New York were receiving an additional 1,400 complaints.³ This made medical billing issues the top insurance complaint in New York in those years, and it prompted the department to escalate its efforts to seek a comprehensive policy solution to the problem. We can create all kinds of new consumer protections – but if there is no active public oversight, and enforcement, and active consumer problem resolution – they will not matter nearly as much.

So what we say is, that if you get a surprise medical bill – speak out!! And seek help from our state insurance department. Don't suffer in silence! Patients can help expose the problem and be a catalyst for creating better consumer protections that will greatly reduce the number of

² Consumer Reports National Research Center, "Surprise Medical Bills Survey," May 5, 2015, available at: <http://consumersunion.org/surprise-medical-bills/surprise-medical-bills-resources/>

³ New York Department of Financial Services. "An Unwelcome Surprise: How New Yorkers Are Getting Stuck with Unexpected Medical Bills From Out-of-Network Providers," 2012. Available at: <http://www.governor.ny.gov/sites/governor.ny.gov/files/archive/assets/documents/DFS%20Report.pdf>

surprise medical bills. We can help each other, by sharing what is happening and letting the medical system know that these practices are unfair, and need to change. There are very concrete ways in which both health plans and medical providers can contribute to a fair solution for all, by fair and reasonable changes in their operating procedures that would create a much better patient and customer experience, that is free (or mostly free) from “medical sticker shock.” This issue does not have to devolve into a civil war between insurance companies and provider groups. If both sides come to the table, a fair solution for all can be found, that would save time, expense, and aggravation for all of us. It can help ensure that our premium dollars are more effectively used for medical care, rather than administrative costs and arguments about medical bills.

And, anyone can get a surprise bill. We have also heard a few stories from nurses, doctors and surgeons around the country who have received surprise medical bills -- and they were not happy with them either. And, we expect, this problem can also happen to insurance executives and health plan staff. So this tells us, we can create a fairer system -- truly for all of us -- that improves the rights of patients across the board.

As discussed by the New York Department of Financial Services in its report, consumers receive surprise bills for many different reasons:

1. Comparison shopping for insurance policies is difficult
2. Lack of disclosure of provider status for non-emergency care
3. Excessive bills for emergency room care
4. Missing protections for inadequate networks
5. Reduced insurance coverage
6. Difficulties in submitting claims

Consumers Union worked hard to enact protections against surprise medical bills in New York state that passed last year and took effect on April 1, 2015, that addressed each of these issues in a systematic way. The bill also provided for an Independent Dispute Resolution process when the health plan and provider cannot agree on how much is to be paid. This provision was very important to our consumer coalition, because we were concerned that patients are often caught in the middle of protracted disputes between health plans and providers, that they have little power to influence or resolve.

Similar protections against surprise medical bills were passed this year in Connecticut, and we are also working closely with New Jersey consumer organizations to pass comprehensive new protections for New Jersey residents.

We believe that some of the issues regarding surprise bills do vary from state to state, so it is important to investigate the specific conditions in the state, and develop policy recommendations based on the input of patient and consumer organizations, medical providers, health plans, and the insurance department staff, among others. However, many of the issues identified in the New York report are broadly a problem in most states.

Also, we do have a concern that while improving disclosure of network status can help, it has to be meaningful disclosure that gives you sufficient notice and time, and really empowers you to protect your rights and make the choice you want to make. Beyond that, consumers urgently

need a health care system that is simply easier to navigate, and is not a game of “20 questions,” so that it becomes difficult to impossible to receive unexpected bills. For example, if it is possible to ensure that all providers in an in-network facility are in-network services to the consumer, as is being discussed in California, that protection would be extremely popular, and could in itself help to prevent many surprise bills.

Here’s a sampling of some of the stories we received from consumers in Pennsylvania, which we share with the permission of the patients involved.

Llyn

My insurance plan changed in 2013 when I retired and went onto my husband's plan. Turns out my doctor is in-network, but the lab he uses for my bloodwork is out-of-network for this new plan. So, when I had my annual bone marrow biopsy, I was totally shocked to get a bill for thousands of dollars!

I was fortunate that the lab appealed. The insurance finally granted a increased payment because the in-network doctor ordered the blood work done at the out-of-network lab. I had no choice. The bigger problem here is that when you have a diagnosed blood disorder and leukemia you do not want to change labs in the middle of treatment. Changing labs means you need to establish a whole new baseline and it takes time before you can tell if your treatment continues to work. It is critical to stay with the same lab.

Emil

My medical insurance falls under [insurance company]. I received a call from my Doctor's office, letting me know that my colon exam was due. I was given choices where I could have it done. Before making a decision, I asked if these places accepted my insurance, the answer was yes. After the procedure at [hospital], I received a bill for over \$1400.00 that my insurance didn't cover because they weren't in the [insurance network]. The doctor was paid.

Just recently, [in 2014] I had an examination that tested positive for prostate cancer. The doctor was paid for all my visits prior to that exam. [The insurance company] paid a portion of the bill and left us with \$355.00 to pay. We are working with the doctor's office personnel in getting it paid. [This] doctor was outside [the insurance network], but I had a referral my from my primary doctor.

Roger

About 15 years ago, I was informed that I needed to have a polyp removed from my nose. I had been contemplating cosmetic surgery for a wart and gigantic pore on my nose, but my dermatologist had discouraged it. I brought this up with the surgeon to whom I was referred and he quoted me a price. The good news was that the surgery was a total success. The bad news was that the surgeon had neglected to inform me about a \$600 anesthesiologist bill. I was lucky that this was not a real hardship for me.

Mark

My wife used to work in case management for a large Philadelphia-based insurer (ten years ago), so she knows the drill from both sides. Therefore, when she needed to get a procedure done, she double-checked to make sure both the facility and doctor were in-network. Surprise, we get a large bill from the anesthesiologist group, who were NOT in-network. What's next, do we need to make sure the medical supply company and the janitors are in-network?

Richard

On June 29, I underwent a quad by-pass operation in [hospital]. It was on July 22 that I received a bill [for \$100] from a group called [provider group]. The bill covers hospital care, advance care planning and hospital care evaluation and management. I feel this bill, although very official looking, is a total scam as I have never heard of them.

Judith

I find it frustrating [to find out about] all of the additional charges for a procedure. You ask how much a procedure, like an injection is going to cost and you get an amount. Not mentioned is the charge for the procedure room, the separate charge for the doctor to do the injection, the assistant that will help the doctor and the scan needed to place the needle. They should have said that it will cost \$3600 instead of \$600. MRIs are over the top!

Joanna

When I had my son, my OBGYN was in network with my insurance company. The hospital was also in network. When I had my oldest child, almost everything was covered (I just had to pay for the TV in my hospital room), so I was surprised to get a bill for my newborn's hearing test given at the hospital shortly after birth.

I called to explain that I had insurance and was told that the hospital where I delivered had contracted with an out-of-network neonatologist. I had no idea, nor would I have known to ask this.

Other than the OBYN and the hospital, I do not know the list of doctors who run tests and screenings on newborns. I don't believe if I had known to ask if the hospital was contracting with anyone out of network that I would have had the option to refuse the test, take the baby somewhere myself, or request that the hospital use someone else who was in-network. I appealed to my insurance company to cover the test, but my appeals were denied.

Richard

Radiologists have been a big surprise. Often MRIs, X-Rays or CT scans are read by radiologists that I've never met, but I get a bill and I don't know why, but their charge is not covered by my insurance, or they are covered at out of network rates.

Francis

My wife and I have a high-deductible plan and had used up the deductible. She had an endoscopy and the anesthesiologist submitted a bill for \$630, but it was labeled "XXX Cardiology Associates" (apparently they have a deal with a cardio practice that handles their billing). The insurance rejected it, twice. They sent me the invoice. When I called to discuss, they said we needed to talk to the Cardiology guys and explain it to them. That's where I stopped, [and paid the out-of-network bill.]

John

Received bills from various doctors for [\$2,000] for a covered procedure at the hospital. Doctors were not in my approved doctors' network.

Linda

[My] covered dermatologist sent several samples to the lab. When I got the EOB, I discovered that they weren't covered, called the insurance co., got the information, then called the doctor's office to request the lab that would be covered. His office basically refused to do that. I know this is a small charge [\$120] in comparison, but it was a big lesson to me.

Carol

[I was] charged a facility fee on top of a routine doctor's appointment. [There was a] copay on doctor's charge, and a copay for the facility.

Brett

I ended up with over \$10,000 of medical bills (rejected by my [insurance company]), not because of any fault of the Insurer, but in several situations, because of the carelessness and lack of communication on the part of the Provider. Yes, my Providers, including surgeons, hospitals, and physical therapy, have been responsible for my debt; not the Insurers. And I find this is the case more often than not.

Why? Because Providers are not careful about checking Plans, or counting the number of visits, or using parallel Providers (e.g., Anesthesiologists, Surgical Centers, etc.) that have not been qualified by my insurance plan! In 2014, I logged over 27 hours on the phone with Providers and their Billing offices!

The problem in America is NOT the Insurance companies! It is the providers (and I should say, their Billing processes, too) that are at fault for patients' substantial debt. Why can't we see this problem? As a business person, for me it has been very easy to spot.

Henri

My wife went for a sonogram of her breathing function. This was represented by the doctor as a simple non-invasive test covered by insurance. The hospital refused to quote the cost of the test ahead of the test time. The test was simple and took only a non-invasive 15 minutes. Imagine our

surprise when the bill was \$4,800 reduced to an "in network" payment of \$2,800 for us! To top it off, the test was inconclusive! No result! We were outraged and made poorer. After the fact, [we found that] none of the hospitals in the Philadelphia suburbs would release their charges for this test. All hospitals should be required to publish their in network and out of network test and other charges. Competition must be mandated to protect consumers.

Keith

This was about 3 years ago. My doctor referred me to the local hospital to have an ultrasound done on my thyroid. I called the hospital, scheduled the surgery, and at that time, gave them my insurance information. They told me everything was good with the insurance, although I hadn't thought to specifically ask if they were in my network. I went to the appointment, had the tests done, and paid my co-pay at the end, and went home.

My doctor was not happy with the results and referred me to have a cat-scan done at the same location. I did the same thing- called the same hospital, scheduled it, went over the insurance info, etc.

The day before my appointment, they called me and informed me that I was out of network and that they required payment in full BEFORE the procedure and that I would have to work out reimbursement with my insurance company afterwards. They wanted \$13,000. I lived check to check, so I canceled the appointment, not that I would have paid \$13,000 under ANY circumstance, even if I were a millionaire. It's insane.

A few weeks later, I got "the bill" for my ultrasound. About \$400. I refused to pay it. Still to this day, it haunts my credit report as an unpaid medical bill. I get occasional mail and calls from collectors for it.

Debra

I had a routine follow-up ultrasound. I had no copay on previous ultrasounds, but the place I normally go was booked solid. I found another in-network facility & made an appointment. The test was done in a building in the parking lot of a local hospital adjacent to the doctor's office pavilion. 3 months later (after the deadline for submitting receipts for our health savings account had expired) I received a bill for approx \$200. Why was their a copay for this ultrasound when none of the others did? Because the facility billed it as an in-patient test. I had not been notified, there was no sign inside the facility that they would be this way, & more importantly, if it WAS an in-patient procedure, wouldn't I have had to go through the admissions department?? Wouldn't I have a patient wristband? Not only is this dishonest & misleading, I believe it is also FRAUD! I am willing to play by the rules, but so should they. No other business can change the price on you. Even car rental companies have to disclose not only their rate, but also any fees, taxes, surcharges, etc. Why don't healthcare providers have to do the same?

Carol

My husband was brought to the emergency room and then hospitalized at [hospital] several years ago with atrial fibrillation. [This hospital] was in-network for our healthcare plan at the time. Several months after discharge we received a bill for over \$500 for the Attending Physician that

the hospital had assigned to us. I was sure this was a mistake, so I called his office only to find that indeed he was out of network. This was at a time that my husband was seriously ill and it was extremely frustrating because up until that time I had assumed that if an in network hospital called on a physician to treat you - particularly the Attending! - that person would be in network. Now I know that once we are hospitalized we have no control over whether our treatment costs associated with a hospital-affiliated physician are in network.

Jeffrey

I worked away from my house for a few months or more a year this year. I had a heart attack, and since the hospital was not in my system, I keep getting all sort of outrageous bills [approx.. \$6,000]. That is why I thought I had health insurance in the first place -- to pay the co-pay and be done with it. But that not the case with [insurance company.] I guess I should have driven three or 4 hours to get close to home to have the heart attack so my expense would be covered.

Nina

My mother had been being treated by her podiatrist for a slow-healing wound above her ankle. He had been debriding and dressing it at his podiatry office. At her June appointment, he suggested she be seen at the "wound clinic" where it would be easier to treat it. She was seen twice at the wound clinic by the same podiatrist for the same debridement and dressing change as was done at his office.

I stopped at the desk to pay the co-pay and was told the billing would come from another place. (The doctor used a billing service...although we had previously paid \$30 co-pays at his office.) When I got the EOB for July (at the end of August) there were 2 \$150 co-pays listed under "operating room services."

A few days later I received a bill from [the hospital] for the services provided at their off-site wound clinic. I called to question "operating room" as it was just an exam room and I was present in the room in my street clothes during the exam and debridement. I was told that the visit was coded correctly in that my mother had a "surgical procedure" at their clinic. She was not being billed for operating room "time", but rather the surgical procedure. I protested that her co-pay was 5 times what it would have been at the podiatry office, but got nowhere.

If I had had the information about the "upcoded" billing, I would have switched my mom's appointments back to the podiatry office immediately. When I got the EOB at the end of August, she had already been seen at the wound clinic 3 times, so she now owes \$450 in co-pays vs \$90. I told the billing person at [the hospital] that we were not going to pay the bill and was told I could appeal the charges. This is far as I've gotten to date. I have not filed an appeal yet.

Kathie

Our insurance covers lab tests 100% after deductible but we received a bill for \$10.48 after having routine blood work at our in-network hospital. I called the insurance company to inquire about this charge. Although this was a small fee, I wanted to find out why we had to pay. I was told that it was a facility fee that some facilities are charging to perform these services and that it is not covered under my policy. The representative was kind enough to give me a list of facilities

that are in-network that do not charge this fee, but I would've thought a hospital would be the last place to do something like this. I feel if it is an in-network facility these charges should not be allowed.

Steven

[Reports he received a surprise medical bill for \$1,000]. If you are staying at a network hospital for treatment or surgery with network doctors, it may be that almost any doctor who comes and just looks at your chart can be considered a "consultation". Don't be surprised if you get a bill from this doctor and have no clue who he was or what he did - but he saw you in the hospital!

David

[Reports he received surprise medical bills for \$2,000]. We have a child who had trouble tolerating blood draws for lab tests in a commercial lab; she passed out and the lab had no personnel for dealing with complications in children. These tests were ordered by the hospital, and their own lab charged \$700-800 each time they were done, three times in the past year, many times higher than the commercial lab or what the insurance would pay for the same test.

John

After paying my co-pay for services, I received a second bill for co-pay for additional radiological services performed at the same time on the same visit, and without my being informed at the time that it constituted a second service. This was at [hospital #1] in Philadelphia, and was not the first time they have done this. In so far as my wife has also been "double-billed" by [hospital #2] facilities in Philadelphia, I would infer that there is a "community" of collusion among erstwhile competitors AND that the institutional cultures of these facilities develop - quite knowingly - a systemic inclination for such double-billing.

As we have health insurance, the amounts in question are not significant; but it does raise the issue of either similar practices towards the uninsured and/or lesser insured within this malicious American "system"(sic.) of health care OR a conspiracy by providers to "soak" insurance firms, and thereby cause greater premiums for all.

Alice

I've been on disability since August of 2014, when the physical requirements of my job exacerbated existing medical conditions, some of which I hadn't been aware. After 12 weeks, my employer ceased to provide medical benefits, so I purchased a marketplace plan through the Healthcare.gov website. Before choosing the plan, I checked with [insurance company] representatives on 3 separate occasions to make sure that my doctors were in network with the custom PPO plans offered and was assured that they were.

On Jan 5th, 2015, I had appointments with my neurologist and my primary care physician. I subsequently received bills from both doctors' offices for a total of almost \$300. When I questioned this with [the insurance company], they said it was because these doctors do not bill through an allowable hospital network.

I filed for an appeal on their decision, asking that these bills be covered since their reps had told me these doctors were in network. I'm still awaiting their decision and these two doctors are waiting for payment. I should mention that I've been seeing this primary care physician since 2001. I trust her and don't want to see another PCP. One of the reasons I took this plan is that I was told she was in-network.

Another problem is that the neurologist sent me for a CAT scan at a hospital which is part of the custom PPO and therefore covered as in-network. [The insurance company] pre-approved the procedure. I was fully expecting the entire cost to be covered as I've already satisfied my deductible.

I recently received a bill for \$486 from a doctors' billing exchange. It's for a doctor's service related to the CAT scan. It doesn't even list the doctor's name. Since this doctor doesn't bill through the allowable hospital network, [the insurance company] won't cover it.

I think hospitals should tell you up front if one of the doctors or technicians working on your procedure is out-of-network..... or there should be an option on their release form to sign if you want to refuse treatment from any out-of-network provider.

I have been surviving on disability income since August 2014 and there isn't even enough left over to handle an increased electric bill due to the exceedingly harsh winter. The medical bills I was expecting are bad enough. These unexpected bills are pushing me over the edge. I already had to cancel a follow-up appointment with my PCP because I simply don't have the money to pay for it. I know that putting off medical treatment when you have a disability is not a good idea, but I feel I'm backed into a corner.

Alfred

I have run into this problem twice with the anesthesiologist not being in network when I was in a network hospital. I explained I had no idea who the person was or whether or not he was in network. Insurance paid claim both times. I think this network crap [is] wrong, as any doctor who accepts Medicare assignment gets paid the same amount whether or not he or she is in network or not.

Sandra

I slipped backward downstairs, carrying a basket of clothes to be washed. The banister was old-fashioned, tight against the wall, and I couldn't grab it, ended up tapping the back of my head against the door and badly bruising my back on a low step. I had no idea my brain had hemorrhaged but thought my back or kidney might be injured, so I phoned a nearby friend who drove me to the closest hospital covered by my Medicare Advantage insurer.

I didn't know this hospital hired ONLY outside radiologists or that it had such a bad general reputation, and ended up with \$2,500 in bills for 4 or 5 lines of careless readings. Negotiations with my insurer and the hospital lowered the bill somewhat but I ended up paying most of it. I healed well, but no thanks to these radiologists. Afterward, I became active in the "Single Payer for All" movement. Obamacare, for its collusion with health insurers and providers, is no answer

CONCLUSION

From the foregoing, it is clear that consumers deserve accurate information and fair treatment when it comes to medical billing. They especially deserve protection from OON charges in the Emergency Room, where they are in no position to “shop,” call their health-plan to find an in-network provider, and/or drive to another facility. Disclosure is clearly unhelpful in that situation, and does not cure the problem. They also deserve protection from “drive-by doctors,” especially providers and specialists who provide services with no advance disclosure or warning of network status. Some consumers we heard from in Pennsylvania also expressed concerns about charges for facility fees, and lab fees, which are not necessarily transparent, and hard to compare and avoid.

Consumers are working hard to play by the rules of their health plan and visit in-network providers and hospitals. However, the current lack of protections regarding provider network status and medical costs makes it extremely difficult to consistently stay in-network, and avoid surprise charges. It is almost always better for consumers to stay in-network and avoid the stress and uncertainty of additional cost-sharing and billing hassles in going out-of-network. Consumers who visit in-network hospitals and in-network health facilities should be secure in their knowledge that they can stay in-network and avoid medical “gotchas” that leave them with an unexpected bill for unplanned, undisclosed, out-of-network service, especially when more affordable, in-network options were available. If no suitable provider is available, we need to make sure that consumers are protected in that situation as well.

If all parties to this debate are reasonable and fair-minded, the surprise medical bill issue can be solved, and consumers will have better financial security and peace of mind. With these new stronger protections in place in Pennsylvania, the incidence of surprise medical bills can be greatly reduced, relieving consumers and their families of unwanted administrative and financial hassles, while freeing up health system resources to improve quality of care and medical outcomes. This issue offers a great opportunity to help improve the patient experience of health care, on a hot-button issue that really matters to the people that you serve.

Commissioner Miller, thank you so much for the opportunity to testify here today about this critically important consumer protection issue. We thank you for your efforts to protect consumers against surprise out-of-network medical bills. We look forward to working with you as you move forward in addressing these issues.

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