Testifier: Pamela Jo Ginsberg

I would like to bring to your attention a situation that I have recently been confronted with regarding my Health Insurance. I believe this policy that I have detailed below, has been adopted by the insurance industry to be very self-serving and fiscally rewarding, while placing patients with the onerous task of micro-managing areas of their Health Care. The result being undue hardship to the patient, not only financially but also emotionally. Creating an administrative nightmare for anyone finding themselves compromised by a health crisis, while at the same time trying to administrate aspects of their health insurance to insure they are receiving the benefits that they are entitled to.

I received my explanation of benefits from my Insurance Company after going for a routine Pap test. Prior to making the appointment, I went on line to the Blue Cross/ Blue Shield web site in order to insure that my Doctor was indeed a preferred provider. Having confirmed this, I believed I had done my due diligence. When I received my explanation of benefits, I was puzzled as to why I had incurred a charge to the provider of $46.11. When I called to question BC/BS it was explained to me that my Gynecologist had sent my Pap test to a laboratory for pathology that did not fall into the " in-network" category. When I asked them whose responsibility it was to insure which laboratory it should go to, their reply was that this was my responsibility. To add insult to injury, not only does this fall back on the patient, to insure that every test sent out from a "Preferred Provider's office ", be checked for in/out of network status, but the dollars that I, the patient have to pay to the provider goes towards satisfying the out-of-network deductible a much higher threshold. The insurance company can delay any financial outlay that they may have incurred by having this two-tiered network and placing the burden upon the patient. Remember also that this service is currently a preventive service, per the Affordable Care Act, that should be provided at no charge to the patient.

Having said all of that, the monetary portion of this bill, is only secondary to the overall policy. In further questioning of the Insurance Company I came to find out that although I may receive care at an approved hospital, if that hospital is a satellite hospital of a much larger network, (case in point "Geisinger Medical Center, Wyoming Valley"), I need to verify that any doctor treating me needs to be verified as a preferred provider as well as verify that none of my tests are sent out to Geisinger campus in Danville which is the corporate main campus, because that would be out-of-network. Having had first hand knowledge of how things work at Geisinger, (my husband is a Leukemia patient, and receives care at Geisinger Wyoming Valley), I am very aware of how often they use the courier system daily to send specialized tests to the main campus at Danville.

Now I have no problem administering certain diagnostics that are ordered by a physician, such as mammography, MRI's, CT-Scans etc. I have no problem using their system to find preferred providers. What I have a problem with is that there are no asterisks next to the names of provider's or hospitals letting you know that your responsibility extends to even the smallest of testing in which you have absolutely no control over. I can only imagine being in an emergency situation, perhaps not even conscious and being expected to handle this entire verification process in such a compromised condition. Finding out on the other side of it all that I am left with a financial burden that I believed I was protected from. In essence the Insurance Company

can shift back and forth between all kinds of “gray” areas in order to insure that the financial outcome is weighed heavily in their favor thereby delaying their cost outlay.

I believe as a consumer and patient that I do have some responsibility in the administration of my health care. For many years I have had and individual health policy, that served me well. When the ACA went into effect my policy was cancelled. I now find myself in the system that has been created by Washington. I accepted the terms and conditions of my policy on good faith. If I go to a preferred provider I believe my responsibility should end there, the benefits that I am entitled to should follow the preferred provider. If a satellite campus is acceptable as a preferred provider hospital, any testing that takes place at a main campus should be linked to the original “preferred provider” campus, the onus should be on the insurance industry to insure that their contracts with physician’s and hospitals are written specifying what labs are to be used when the patient is not in charge of what is going out for testing. Do we need to talk about the vulnerability of patients during Health care issues? When I have to make the appointment, then it becomes my responsibility to insure that I am going to a place that gives me the best benefit.

I am going for my yearly mammogram in eleven days. I have made an appointment to have it done at Geisinger Wyoming Valley, end of story, right? Wrong, in light of what has happened I will be calling on Monday to insure that my mammogram is read “in house” and not sent out to Danville. How sad that it has come to this.

Pamela Jo Ginsberg