

Surprise Medical Bills

What they are and how to stop them, while ensuring access to needed services and adequate payment to providers

APPENDIX



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POLICY & ACTION FROM CONSUMER REPORTS

INTRODUCTION

Consumers continue to suffer under the burden of surprise out-of-network bills

Across New Jersey, health care consumers continue to deal with the detrimental effects of out-of-network balance bills. Despite taking responsible measures to seek in-network care, they still often unknowingly and involuntarily receive care from out-of-network providers who, caring little for their financial well-being, send significant bills and take drastic steps to collect payment.

To further threaten consumers, the health care delivery landscape is changing. As New Jersey sees the formation of more narrow and tiered networks, and certain for-profit health care providers taking advantage of gaps in consumer protections, more and more consumers are at risk for finding themselves in situations that will increase their cost sharing and strain their resources. Additionally, large gaps in current protections against balanced billing exist for members of self-funded (ERISA) plans. It is imperative to provide consumer-aimed protections against these financial hazards. It is time to provide the disclosure of facts that will allow consumers to make informed and timely decisions about their care, and provide adequate protections for all consumers, including those covered under ERISA plans. The Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act helps to bridge almost all of these gaps.

However, until New Jersey legislators pass this legislation, consumer stories of surprise out-of-network billing experiences and financial harm – such as those we have shared previously and share now - will continue to surface. We must act now to stop consumer bleeding through higher premiums and significant cost sharing, incurred routinely and most importantly through balance billing.

Consumers Union and NJ for Health Care invited NJ residents who have experienced surprise medical bills to share their stories with us. Below are a further sampling of stories received.

Anthony

Saddle Brook

I went to an in-network hospital in Bergen County with chest pain. I am covered by an ERISA regulated plan. I had to have a stent inserted. When the hospital was registering me, I stated that I went to this hospital because it was in my network and that I only wanted to have network doctors treat me. The cardiologist that saw me in the hospital after the stent was put in was from a Medical group that is owned by the same company as the hospital, but their doctors are out-of-network.

The doctor saw me for five minutes for each of two days, and I received an out-of-network bill for over \$1000. When I called the hospital to challenge the bill, they said they have no control over what insurance doctors in the hospital accept, and that I had to pay the bill. [Story shared, October 2015]

Christopher

Berlin

I was in the hospital for months, and a certain doctor would visit me in my room. I forget what the doctor's title was, but he was out of my network. I had no idea at the time that he was out-of-network. He made a few visits to me. Never did much more than talk.

Well, time went on and I was finally released. I received a really weird bill from the hospital about something out-of-network. I thought it was a mistake. I just ran it through my insurance company again.

I never heard a word about it again, until I went to buy a car. My credit was messed up. I could not get a loan to buy a new car. So after many phone calls and letters, I finally got to the bottom of it. It was all from the out-of-network doctor that saw me in the hospital.

This was the shadiest thing ever. Not a single phone call letting me know that this was in collections. I learned the hard way that medical bills can affect your credit. So this out-of-network doctor -- that I did not authorize to see me in the hospital -- messed my credit up. The hospital just sends all kinds of different doctors to your room. You have no control over that. What a kick to the gut especially when you are sick. [Story shared, October 2015]

Robert

Glen Gardner

I did the proper checking prior to a scheduled surgery, making sure the doctor and the hospital were in-network. The insurance company even pre-certified the procedure. After the surgery, I received a large bill from the anesthesiologist who turned out to be out-of-network. Given that I never even met this person or was given the option of who to use, I was very shocked by the bill. Luckily, after a few calls, the insurance company understood my position and agreed to cover this. However, will I be as fortunate next time?

Angel**North Bergen**

I went to get a procedure. At the hospital my doctor asked if I objected to another doctor doing some of the work. I thought he was just being courteous. Later, the second doctor tried to charge me for out-of-network fees.

Michael**Fair Lawn**

I had a scheduled operation, with all doctors and hospital covered under my insurance plan. But, after the procedure took place, I received a surprise bill from a second surgeon, who was provided by the hospital without offering me any choice to decline.

Carole**Hardwick**

My son had a head injury requiring stitches on a Saturday night. His girlfriend took him to an emergency room. While waiting for the ER Doctor to stitch him up, a nurse came in and said a cosmetic surgeon was there on another call. She asked my son if he would prefer to have him do the work, since the injury was on his face. At no time did the nurse say anything about insurance (this is verified by his girlfriend who was in the room with him), so they said sure. The cosmetic surgeon didn't say anything to my son either.

I received a bill for over \$5,000 from that surgeon. He explained in his letter that he doesn't take our insurance plan, and that we needed to get our insurance company to pay up, and regardless he wanted his money within 30 days. I felt like we were being strong-armed by the mob. I contacted our insurance company, and they had to negotiate with the doctor to settle the claim. It was a horrible experience, since we were charged a \$5,000 fee for 10 minutes of his time. [Story shared, October 2015]

Jane**Parlin**

My husband and I had colonoscopies the same day. We have separate primary insurances, and I did the homework to make sure that the surgeon and facility were in-network. But I had no way to know that the anesthesiologist and pathologist were not in-network. We weren't given names ahead of time, or a choice to pick from. And it turned out that we paid about \$1,000 total because of that. [Story shared, October 2015]

Terri**Newark**

I was directed by my physician to have a preventive colonoscopy. I had the procedure at an in-network facility and it was performed by an in-network gastroenterologist. I understood that all charges would be paid since this was required under the Affordable Care Act. To my surprise, the anesthesiologist refused to accept the over \$700 paid to him by the insurance plan that I receive through my employment. Instead, he has filed a complaint against me for almost \$600 that I am now contesting in court, since I have since become unemployed and receive Medicaid.

Charles**Ocean**

I had a spinal epidural with our regular orthopedic doctor. But, unknown to us, the anesthesiologist was out-of-network, and charged \$1800 to us after insurance refused to cover all her charges. After months of back and forth, she turned the account over to a collection agency.

With the help of our orthopedic doctor we got the out-of-pocket charge down to \$500. The collection agency left calls for another three months until we asked the anesthesiologist to tell them to stop, since we had paid up. Out-of-network anesthesiologists seem to be a very common unexpected cost. [Story shared, October 2015]

Marty**Demarest**

I took my 21 year-old daughter for a routine GYN visit. When it finished, they told her to go next door to take blood. The test was done in 5 minutes.

Several months later she received bills from a diagnostic lab for over \$3,000! I called to see if it was some type of mistake; they responded that that was the charge for the tests that the doctor had prescribed, so they were just following instructions. Also, they said they don't believe [the lab] is in my network so I will be responsible for bill.

I called the doctor for an explanation, and the doctor stated these tests were routine for a woman my daughter's age. I asked why he had not given me the option to go in-network, and he didn't have an answer. The lab is re-submitting the bills, but we will likely still have to pay several thousand dollars in deductibles despite paying a \$1,500 monthly COBRA premium, as I was let go from my job, and my wife does not receive any benefits from her company. [Story shared, October 2015]

William**Annandale**

My hospital and surgeon were in my health plan, but the anesthesiologist assigned to the surgery was not. I received a bill for \$1800. After much complaining and many months, they agreed to accept what my plan allowed. [Story shared, October 2015]

Dennis**Browns Mills**

I had a heart monitor attached at an in-network hospital. Then, I received a notice from my insurance carrier that the company supplying the monitor was not in-network and was not covered. I was billed an additional \$725. [Story shared, October 2015]

Robert**Annandale**

My wife had scheduled surgery at our in-network hospital. While there, at least 3 doctors walked up to her bed, looked at her chart, and left. We were billed \$2,000 for their "consults". What a bunch of bull! Doctors just waltz up to your bed, and BANG! [Story shared, October 2015]

Joel**Jersey City**

I went to an in-network podiatrist, who charged me \$1000 after I paid my \$15 office visit requirement from the policy. The doctor's office claimed the particular podiatrist was not "in-network", even though the office was "in-network" for podiatry. I eventually won and never paid the bill, but I had problems with my credit for over a year, while challenging the bill. [Story shared, October 2015]

James**Spring Lake**

I had a broken wrist. I went to an approved doctor for my plan (Horizon BC NJ). I paid the copay. My in-network doctor set up the operation and facility. Weeks after the operation, I received a bill from the anesthesiologist because s/he was out-of-network. No one told me s/he was out-of-network until the bill arrived. [Story shared, October 2015]

Alec**Oakland**

My knee was operated on, but there was pain in the calf and they wanted a scan to check for a blood clot. Six months later, a bill arrived from a doctor we had not heard of for interpretation of the scan. NJ allows out-of-network doctors to be used without prior consent, even when the hospital is treating 'in-network. [Story shared, October 2015]

Edward**Hamilton**

I went to the hospital for chest pain. After a 5-day hospital stay, I was getting bills from everyone and their brother. The one that stood out the most was the emergency room doctor's bill. I didn't even see an attending doctor. I saw a resident in the ER and she was terrible. When I called my insurance company to complain, they said there was nothing I could do, except pay the bill. I told them this was an emergency situation, and I didn't think to ask if the ER doc accepted my insurance. I told them next time I will. I also did not know that I should have appealed this situation since the insurance company must pay the attending physician in an emergency situation.

Jason**Chatham**

It was 2 AM, and I woke up not being able to breathe easily -- almost like I was choking on a grape. It felt like an allergic reaction, so I called my allergist at home, and per his instructions I took Prednisone. I checked that the local hospital was "in-network" while waiting for the meds to take effect.

One hour later, my symptoms were getting worse, so I woke up my wife and went to the ER, where I asked to see an in-network doctor. By the time I saw a physician (having thrown up once due to gag reflex) at 4 AM, I was tired, and not particularly happy nor cognizant. I was "with it" enough to ask if the doctor was in my network. He said yes.

He wasn't. The bill for not running a test (which I declined because they admitted that it would not tell them anything or alter the course of treatment) and getting a cup of anesthetic (to stop the gagging) and a script was an eye-watering \$13,000 -- *after* meeting the deductible. For this I get to pay over \$1,000 a month.

I am healthy, and a 40 year-old male who doesn't smoke and works out regularly. My insurance in NJ is now \$1800/month and MANDATORY. I'm better off putting that money in the bank. [Story shared, October 2015]

Jon

Middletown

I was sick and went to the hospital to be treated. It turned out that the lab and technicians were not on my health plan, but the hospital was. I had pay out of pocket for all the blood work, and two other tests that were given – an MRI and a cat scan. This makes no sense. [Story shared, October 2015]

Richard

Waretown

At an in-network hospital, all costs were covered by insurance, except for a bill from an out-of-network nurse, who participated in the surgery I had for a kidney stone. [Story shared, October 2015]

Jason

Kinnelon

I went to an in-network hospital to have my son delivered. All the staff, including the OB/GYN that delivered the baby were in-network and covered. My son was seen by the hospital pediatric group prior to being released. I had no choice in who could see him, even though at that point he had been born already. It turns out that the pediatric group was out-of-network, and they sent me a \$1400 bill, which I appealed. The appeal failed, and the insurer's response was that this was allowable by law, even though I was not made aware that the group was out-of-network or had been given a choice in the matter. [Story shared, October 2015]

Fred

Westfield

I fell and broke my arm and wrist and was taken to the ER in an ambulance. After being examined by the ER staff it was obvious that I needed surgery. The hospital called my orthopedist, but he was not available so they contacted the on-call surgeon. He arrived close to midnight and informed me that the OR was not yet free so he would do some 'clean-out' work of the wound in the ER and then do the surgery when the OR was available in the morning. I did not discuss whether he was in-network since it was the ER and I needed immediate attention; plus, I knew that my ER costs were covered. Besides, I was on a morphine drip!!

But the real shock came when I got a bill for \$9,000 from the surgeon! He was out-of-network and the insurance company covered entirely the work he did in the ER, but applied a heavy deductible and co-pay to the surgery done in the morning! I am still fighting with them since this was all part of my ER visit---I did not have elective surgery nor did I choose the time, place or doctor for the surgery! (Story shared April, 2015)

Leigh

Hillsdale

I went to our local emergency room with dizziness and chest pains. They took me in quickly and were very compassionate and very professional. The medical care was excellent. Later, I found out that they were not in-network. The bill was \$25,000. My insurance company paid 80% and I was responsible for \$5,000. It may not sound like a lot but I did not have the money. The hospital never said they did not accept my insurer until I got the bill. Since it was a for-profit hospital, they told me they did not have to give any reduction on the bill and I was obligated to pay in full. I finally worked out an agreement to pay \$180 a month over the next few years. As this was not an elective visit but an emergency, it does not seem right that I would go into debt to pay for the visit especially since my insurance paid for a large amount of the bill. I guess it was my fault for not checking which emergency rooms AND doctors will accept the payment made by my insurance plan for emergency services as full payment. (Story shared April 2015)

Dana

Westwood

On December 14, 2009, my wife delivered our son Gabriel. We were in an in-network hospital and her doctor was in-network. Imagine our surprise when we received a bill from the anesthesiologist for over \$2,500 for her epidural. It took calling [the insurance company] three times before they said they were going to give us one-time adjustment and paid this bill. (Story shared December, 2014)

Steven

Morganville

Simple story. Needed a surgical procedure. Made sure that the surgeon, hospital and the procedure were covered. Unfortunately, the anesthesiologist was not. Was I supposed to ask him if he was in my plan? What if I had asked and the hospital refused to provide a different anesthesiologist? (Story shared December, 2014)

Arthur

Union City

My wife needed a small but significant surgery, originally scheduled on Dec. 31, 2014. The doctor said that he needed to reschedule to a later date, because he was missing a piece of equipment. We rescheduled for Jan 16, 2015. The doctor requested that I call the insurance company myself to ensure that the procedure is covered. I do as told, even though I later learn that he was the only person who is supposed to call. I scheduled the appointment and was told that everything was fine. I was not given any information about any procedure or service being out of network.

Weeks later after the surgery was completed, we got stuck with nearly \$20,000 in hospital bills, because as of January 2015 the hospital and its associates (not the doctor) had become out-of-network. I have appealed this to my insurance company and now to the Union Appeals Committee. No word yet on the final outcome. (Story shared April, 2015)

Valerie

Hamburg

My husband had his prostate and adjoining lymph glands removed this past September for prostate cancer. He was in an in-network hospital for which he worked, and he had an in-network surgeon. My husband received a bill for \$9,000 from the physician assistant who helped in the OR. The sad thing is that when you sign in there is SMALL PRINT saying there is a possibility that an out-of-network physician will be involved. You don't have a choice as to who that person is, and even though you do everything your insurance company wants, you can still get screwed. It's obscene. (Story shared December, 2014)

Angel

North Bergen

Right before my nephrostomy tube operation, my urologist asked if it would be all right to allow another doctor IN HIS OFFICE to do the placement of the tube. At the time, I didn't think anything of it, but months after the procedure, I received a bill from that 2nd urologist because he was out-of-network. At no time did the primary urologist tell me that the 2nd urologist was out-of-network. I have refused to pay it; but unfortunately I'm on solid legal ground because thanks to this man's handy work --- i.e., malpractice, I began urinating from my back and had to sleep in a urine soaked bed. I was on a drip pain killer and nobody ever came around to check up on me. (The tube had been placed through my back to access the large stone in the kidney). (Story shared December, 2014)

Nebil

Allendale

My son had to have multiple operations due to an emergency by an in-network doctor at an in-network hospital. Unfortunately, I was asked to pay an unexpected bill for some hardware provided by a supplier that is not in-network. So, now I am disputing these charges (Story shared March, 2015)

Cindy

Williamstown

I had bariatric surgery in October of 2014. Prior to the operation, I received a notice from my insurance company telling me that the plan covered the procedure. I paid several co-pays to doctors during the testing that was involved and I expected those costs. Recently I got a notice from my insurance company showing that I would most likely be responsible for over \$600 in bills from the anesthesiologist. I was shocked. The surgeon and hospital were "in-network", so I "assumed" that all of the doctors would be as well. It never occurred to me to check to see if the anesthesiologist was in-network. (Story shared March, 2015)

Joseph**Sea Girt**

A few years ago, I developed an infection in one of my left toes, which very quickly spread into my lower left leg. I was admitted to the hospital and put on IV antibiotics via a PIC line. When there was no improvement, a cat scan and/or MRI showed that two of my three arteries in my lower left leg were 100% blocked and I needed either angioplasty or grafting to save the leg. I had less than 24 hours to decide if the leg was to be saved. The hospital was in-network. My primary doctor was in-network, my podiatrist was in-network, and the surgeon who all these providers said would do the surgery appeared to be in-network because he worked for the hospital. Imagine my surprise when I got the surgeon's bill for over \$60,000! (The insurance company had paid him about \$6000 as I recall). He demanded I pay the balance. I got a lawyer who resolved the case for me at no expense whatsoever. I was VERY lucky. (Story shared April, 2015)

Emilio**Bergenfield**

Last December, I had my wisdom teeth removed and my doctor ordered pathology tests after I was told by the doctor and surgical facility that everything in the procedure was covered by my insurance company. A couple of months later, I receive a \$400 bill from the pathology lab for services not paid by my insurance due to 'out-of-network' status. It seems that the surgical procedure facility did not send my specimen to an 'in-network' facility or did not check (although all insurance information was provided prior to the oral surgical procedure). After some phone calls to the oral pathology lab, it reduced the bill in half and then I took the matter up with the surgical facility, which was very kind and understanding of the situation and possible error made. Accordingly, the facility paid the remaining balance to the oral pathology lab. (Story shared March, 2015)

Linda**Dennis**

I was approved for an electrocardiogram, but apparently not the cardiologist that interpreted it. Fought and won. (Story shared December, 2014)

Ellen**South River**

I was horrified a few years ago when I went for a routine colonoscopy and received a bill from the anesthesiologist for over \$1,000! At first, I couldn't figure out for why I was being billed until I made a phone call only to find out that the anesthesiologist was out-of-network. Who would have thought that I needed to make a request for an IN-NETWORK physician for this? Needless to say, I'm STILL paying for this years later through a payment plan with the provider! (Story shared April, 2015)

Carolyn**Fords**

I went to an in-network hospital for a test. I called the insurance company beforehand to find out if authorization was needed. It was not. The hospital verified the in-network benefits and called me to say no authorization was needed, only a referral. I obtained the referral. I went for

the test and received a denial of the bill for the services of the doctor who performed the test. The doctor worked for a separate group, not the hospital. The bill was for \$2,350. When I called my insurance company, they were able to arrange for the doctor to accept the in-network rate, which was about one tenth of the original charge. (Story shared March, 2015)

Conrad**Montville**

My wife received a bill for lab work that she was not expecting because she has had the same lab work done many times before with our same insurance and same coverage (supposedly) for the past 4 to 5 years. When she called to tell them that the charge was incorrect, they told her that it was correct because the lab technician was not in our network. When my wife told them she had no idea where the facility sent the specimen for testing nor was given a choice of where it was sent, the plan told her that she had no choice of who does the lab work and if it goes to someone not in the network we nonetheless have to pay for it personally. I actually could not believe it. It is truly unfair by any definition. No choice, no knowledge, no say in the amount, nothing. And if we didn't pay our credit would be ruined. Total BS!!!! (Story shared April, 2015)

Donna**Towaco**

I went to an in-network hospital for an ultrasound. This was the same hospital that I have been going to for 10 years and it has always been in my network. My doctor who ordered the test is in-network. All providers took my co-pay and sent me on my way. I never saw another charge from anyone. I even have a PPO on top of the in-network benefits. Almost a year later, I get a bill from someone in the radiology department that "read" my ultrasound, but who was not in my network. This radiologist was expecting me to pay almost \$400 just to "read" my test. What recourse did I have? None! How was I to know that the person reading my tests had to be in network as well? I am now paying that charge on a payment plan. (Story shared April, 2015)

William**Hardwick**

My wife recently had testing done on a breast tumor biopsy. The surgery was performed in the office of an in-network surgeon affiliated with an in-network hospital. The biopsy was sent to an out-of-network laboratory.

We received notice from our insurance company that the \$1300 charge was denied because this lab services were only covered if the services were performed in an emergency situation. When we asked the doctor why this lab was used, we were told that the hospital has a contract with this lab, and she was required to use them for all biopsy analysis. (Story shared April, 2015)

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As these stories indicate, New Jersey consumers are in urgent need of relief from surprise out-of-network bills. Whether because of provider business models that seek increased profits or inadequate networks or lack of disclosure, we need to protect consumers against these unfair and unexpected medical bills.

These bills abuse of our health care system and our consumers and cannot continue.