

Support HB19-1174 and Protect Consumers from Surprise Medical Bills Consumer Stories

I scheduled my non-emergency surgery by choosing an in-network doctor at an in-network facility. I also spoke with my insurance and the hospital before the procedure about the cost and was told that my out-of-pocket cost would \$250, which I paid before the surgery. I wasn't told about any other costs. After the procedure, **I received a bill for \$7,000 from an out-of-network surgical assistant.** My insurance paid \$1,100 of the bill, but I didn't hear anything more until I got a notice from collections for the remainder.

—*Alexandra M.*

I'm fatally allergic to bees and go into anaphylaxis, so when I was stung most recently, I called 911 and was taken to the hospital in an ambulance. I was told that I had no choice which emergency room I would go to, and they took me to the closest one. My insurance apparently received the bill and the hospital said that they were paid, but my insurance never told me that they settled the bill. I received another notice from the hospital that they were "compiling my bill." After that, **I received a balance bill for \$3,411,** with a second statement that it was due shortly after. I had already hit my out-of-pocket max and I am sure that my Summary of Benefits and Coverage said that I was covered for out-of-network emergency situations.

—*Mark M., Denver, CO*

My husband thought he was having a heart attack and went to the hospital. It turns out he had a ruptured bowel and needed to go into emergency surgery. He was treated at an in-network facility, but **we received out-of-network bills of \$7,000 each from the surgeon and the assistant surgeon. The ambulance was also out-of-network and sent a bill.** My husband has to go in for a second surgery, and we're scheduled with an in-network surgeon, but I was told that the surgical assistant is out-of-network again. They refuse to ensure that an in-network assistant is used, the insurance company doesn't think an assistant is necessary, and the surgeon won't operate without one, so we're worried about getting yet another balance bill.

—*Cynthia B.*

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Juanita and Kevin Fritz—

Juanita Fritz says it takes a lot for her husband to feel too sick to work. So when he had the sweats and felt ill, as though he was having a heart attack, she knew something had to be wrong. They went to the hospital and after some tests, the doctors told them that Kevin had a twisted intestine, with the possibility of sepsis – he had to go into surgery that night.

When Juanita received the bill, she was shocked at the number she saw. She knew that the hospital they attended was in their insurance network, but it turned out that the surgeon who treated her husband was not, and **her insurance would not pay the over \$2,400 balance for which they were being billed.** No one told Juanita that the surgeon was out-of-network throughout the process, so she didn't even know what she had received was a balance bill. Soon they were being sent to collections, and since they couldn't pay the bill, a summons on their doorstep led them to county court.

Juanita tried calling the provider's office, but they sent her in circles between the collections agency and their legal representation. She saw a piece on 9News about sending in medical bills and contacted them. The team at 9News found out that Juanita and Kevin had a Division of Insurance (DOI) regulated plan, which qualified them to be "held harmless" under Colorado statute. Juanita filed a complaint with the DOI, and complained to their insurance company, and finally **after over a month** she was alerted that the insurance company would settle the claim on its own, leaving the Fritz family finally held harmless.

Because Colorado law does not prohibit balance bills from being sent to the patient, many consumers are put in the confusing situation of receiving a bill that they didn't expect or didn't think would be as expensive. According to a 2015 study, 57% of patients who encountered balance billing paid the bill because they didn't know they had the right to fight it. By a stroke of luck, Juanita Fritz saw the 9News report on balance billing and was able to get help – without this assistance, they might have been dragged into an even longer legal battle and might have paid a bill that they didn't legally owe. Other consumers are not so lucky.

HB19-1174 requires written, plain language notice from providers, insurers, and facilities to consumers on out-of-network consumer protections. **Please SUPPORT HB19-1174 to help inform consumers of their rights and prevent stories like these from happening.**

To learn more about Juanita and Kevin's story, see their 9News profile at:
<http://www.9news.com/article/news/investigations/medical-cost/you-have-no-obligation-to-pay-these-medical-bills-but-you-can-still-get-them-in-the-mail/73-492765310>

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Katie F., House District 31, Senate District 24—

On September 25, 2017, at 6:00 am, I fainted twice within a 15-minute time span, resulting in a large bleeding gash on my scalp and chin. I was at home with my two young sons and my husband was out of the country traveling for work. I was scared and nervous about what my next step should be.

After dropping off my sons with a neighbor, I remembered that there was a UC Health freestanding emergency room about 5 minutes away from our home. I had been a UC Health patient for approximately 15 years, having utilized their facilities and physicians both for primary care and cardiology. Knowing my history in the UC Health system, I thought it would be convenient to be seen at a facility in the same system, as they should already have access to my records and medical history. All of this care had been in-network with my insurance plan in the past.



When I arrived, I presented my Cigna health insurance card, filled out paperwork, and was seen by the doctor on duty. I was treated with stitches, staples, EKGs, a CT scan, and lab work, and discharged with instructions to follow up with my primary care doctor. I had multiple interactions with ER office and admin staff, **when I walked in the door and presented my insurance card, and again when I was discharged and paid my \$150 co-pay. At no point did anyone with the front office mention that Cigna was not in-network with this particular facility.**

Approximately 6 weeks later we received a bill from UC Health for \$4,585.41. We were told that the facility I had gone to was out-of-network for our insurance, despite the fact that all of the other UC Health providers we had seen in the past and continue to see are in-network.

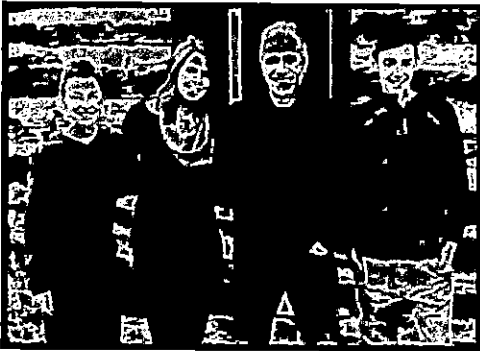
Upon investigating this charge, we discovered that the total cost of the visit was \$10,995.77. Cigna had already placed discounts on the various charges applied during my visit to the emergency room amounting to \$6,966.50 and had written a check to UC Health for \$3,103.42, which UC Health cashed. Under patient responsibility, an amount of \$925.85 was listed (which included the \$150 copay).

My husband and I are savvy enough to understand our insurance coverage and are able to navigate our insurance company's website in order to understand that we were being balance billed. **We wonder how many patients that do not have this capability are overcharged in violation of implied or actual agreements made with insurance companies.**

At this time, UC Health has sent several billing statements and has made several calls to our home phone number to pressure us in paying the amount they seemingly randomly determined to be our responsibility. We have interacted with Cigna several times to discuss the situation with UC Health but there does not seem to be much progress or cooperation from UC Health. We recently received our "final bill" where UC Health is now threatening to send us to collections. I am now "stuck between a rock and a hard place". UC Health is putting us in the position where we either have to pay their inflated and incorrect charges or risk having our credit score be affected (and potentially other legal issues in dealing with a collections agency). **Balance billing is a huge problem for families like ours. Please support HB19-1174 to stop this from happening to other consumers.**

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Jennifer R., House District 27, Senate District 20—



When the health of my child is on the line, the last thing I need to worry about is whether I'll be hit with a surprise medical bill down the line. I have health insurance to protect my family's health and finances. So when I seek care, I should feel confident it will not be at the expense of my financial security. What happened to me on January 10, 2016, made me feel otherwise.

My son Gavin complained of a sore throat and difficulty swallowing. I checked his throat and noticed some white ulcers on his tonsils, which I've seen in the past when he had strep throat. Assuming it was strep again, I wanted to take him in to the doctor as soon as possible. Since it was a Sunday, our regular pediatrician's office was closed. I logged into my Aetna account to see what in-network urgent care facilities were close by, and **I took Gavin to the new Centura Health ER/Urgent care facility right down the street from me, which was in my network.**

Once we got into an exam room, we were first met by a nurse who examined Gavin's throat and agreed that a strep test was necessary. A good while later Dr. Luis Bui entered the room, looked in Gavin's throat, said he could tell it was not strep, but a viral infection commonly known as hand, foot, and mouth disease. He wrote a prescription for a throat spray to help with the pain, told Gavin to get some rest and drink plenty of water, and we were on our way. **That interaction with the doctor lasted five minutes.**

A month later I received a bill from Centura for an Urgent Care Center fee of \$450, of which my responsibility was a \$40 co-pay. The doctor also billed me, charging me \$841.15 of which Aetna would only cover \$252.34.

Aetna explained that while the facility was in network, the doctor who saw us was not. After re-processing the bill, disputing the bill with Centura, and calling the urgent care center, I was pointed to the doctor's billing company, Endeavor Medical. **The bill had been sent on to IQMS for collections.**

By this time it was August. I was so frustrated I complained on Centura Health's Facebook page. They replied back fairly quickly and gave me contact information for Kelly Larkin, the Founder and CEO of the Larkin Group, the company that establishes these free-standing Centura centers. She told me that the facility was new, there were some delays in getting doctors in-network, and they were still working the kinks out. They took care of the bill, the collection agency stopped sending me notices, and I never received another bill in regards to this matter.

Although my situation eventually resulted in my favor, **it took 8 months and countless hours on the phone to come to a close.** Complaints about this kind of balance billing are too common. In reading about the prices other people have been charged, mine sounds almost insignificant in comparison. I could have afforded to just pay the bill, and I'm sure that's what many people do, because it's just easier to pay and not spend the time to fight it.

If facilities are considered in an insurer's network, all providers who work at that facility should be in-network. If that's just not feasible, then **patients should have the right to know up-front what they will be expected to pay for visits to these facilities.** Consumers deserve to be in control of their health care and their finances. Surprise out-of-network bills leave us feeling out of control of both. **Please support HB19-1174.**

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Consumer Profiles

Zoë Williams—



Three days after their third birthday, my child Aster fell in a park and suffered a severe spiral femur fracture. It was one of the most harrowing experiences I've had as a parent. I will never forget watching my sweet silly toddler crying in agony and fear. We were transferred from urgent care by ambulance to an emergency department, and then to an operating room for a half body cast. I remember thinking how fortunate we were, in the midst of this nightmare, to have insurance and not have to worry about money. After six long weeks of healing, I thought we would be able to move one.

Fast forward nearly two years. I was startled out of sleep at 6:30 am to someone pounding on the door. It was a process server. The ambulance company, unbeknownst to me, still hadn't been paid, and they were taking us to court. In shock, I started researching and realized that our insurance carrier hadn't paid any of our bills. We had over \$15,000 in unpaid medical bills sitting in collections, though I had never been notified. I panicked. A judgment against us would set our family back right as we were finding some financial stability. I was about to start law school and needed a decent credit score to receive student loans.

Over the next six months, we went through a tangled process of finding out why each bill was unpaid. Our insurance denied most claims because the hospital was out-of-network, despite the fact the care was an emergency. The ambulance company wouldn't submit bills to the insurance because there was a birth date error, and the hospital used incorrect billing codes for some charges.

Fortunately I had the Colorado Division of Insurance, a consumer advocate from Colorado Consumer Health Initiative, and a generous attorney, because I couldn't make sense of most of the information I was sent. If I didn't have help, I'm sure we wouldn't have resolved these issues.

My family fulfilled all of our responsibilities. We enrolled in health insurance through the marketplace and paid our insurance premiums. We trusted that our insurance would protect our family in an emergency.

This legislative session, I am looking to our local representatives to make changes to protect consumers from surprise bills like the ones I received. We need to ensure that Coloradans can access their health care while being confident that their health insurance will protect their financial security. **Now is our chance, with HB19-1174.**

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Kelly W., House District 56, Senate District 29—



In September of 2015, I was scheduled for a pre-planned surgery. Having heard the horror stories about unexpected bills, **I believed I asked all the right questions about billing and payment and felt assured that everything was covered properly.** I kept a spreadsheet of all my out-of-pocket expenses to ensure I was not paying more than my deductible. My plan covered 100% of the health care costs after reaching the deductible.

Several months after my surgery, I received a bill for \$417 from a doctor who I did not recognize. I inquired about the bill and was told it was for the surgical assistant. They said he was not in-network and my insurance rejected the claim. I told them that I never authorized his services and asked to be provided with documentation showing I agreed to pay his fees. They never did provide that. They suggested I

resubmit the claim to my insurance company with a letter of explanation, which I did and received a rejection. The surgical assistant's office explained to me that **95% of surgical assistants are out-of-network** and the fees are the patient's responsibility.

This was a shock to me. If this is true in the medical industry, **shouldn't those professionals seek to have their fees authorized ahead of procedures instead of blindsiding patients later?** Why should the average consumer be on the hook for something that is apparently not a secret in the medical world? I would have liked the opportunity to discuss this with my surgeon ahead of time, but at no point was there any mention of this issue from anyone involved. I had no control over who attended my surgery and billed me afterwards.

Still not convinced that I should really owe this bill, I didn't send the payment – I was outraged that this is a common practice. What if the bill were for thousands instead of hundreds?

In December, I received a notice from a collections company. I called them and told them I was disputing the charge. I again asked for documentation proving I authorized this service. It was not provided. I then received a summons to court from the collections company. I consulted an attorney because I was willing to fight it in court. He spoke with the owner of the collections company and also asked for documentation, which was never provided. After reviewing the situation, the attorney advised me to settle. He said that even without any documentation, the court very likely would find in favor of the collections company. **I ended up settling for \$600** (\$417 + interest + court costs).

Is there any other industry where a person can be billed for work not authorized or approved? **How can patients protect themselves** from this practice or at the very least, know what to expect prior to a medical procedure? Surprise billing is a huge problem and is unfair to consumers.

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Ilse W., Broomfield—



In early 2017, after seeing several specialists regarding increasing shoulder and back pain, it was recommended that I have a reductive mammoplasty surgery. After getting the procedure approved by Humana as a medical necessity in mid-2017, I tried for four months to find a surgeon who was in my insurance network.

As a mom raising two kids with autism on a tight budget, I wanted to make sure I was doing everything I could to prevent getting a surprise medical bill, but I found it considerably difficult to know what consumer protections existed for me in the event that something

went wrong. On my insurance company's advice, I was told that as long as my surgeon and the facility where I had the surgery were in-network, the entire surgical team would be covered as in-network. They warned me that sometimes third party providers engage in "balance billing", but my surgeon assured me his surgical assistant would not do so and that she always accepts in-network compensation. Not entirely trusting my surgeon's verbal statement, I decided to keep looking for an in-network surgical assistant, but was unable to find even a single provider in the Denver-Boulder area. After four months of diligently gathering as much information that I could, I went into surgery, confident that I could financially afford to get my health restored.

On October 26th, 2018, my insurance denied a claim for \$3,900 and a balance bill for over \$625 dollars from the surgical assistant who my insurance stated was out-of-network. I was so upset since I had tried to do everything right. In the ensuing back and forth, Humana customer service mentioned, for the first time, that my plan was not subject to insurance network protections. I had never heard anything about this at all. **It's a labyrinth of misinformation, and patients like me pay.**

I had tried all that I could to ensure my providers were in-network, and was given incorrect information about the protections I had. Unable to appeal my claim denial because of how much time passed between the procedure and this balance bill, I am now waiting in legal limbo with the bill on hold, hoping the surgical assistant and surgeon will negotiate with my insurance.

This situation is far too common in Colorado. As a diligent, responsible consumer, I tried to make sure I was financially protected from surprise billing, and yet here I am. **Consumers like me need to be protected from surprise bills like this so that we can get the care we need without ending up in financial uncertainty. Please support HB19-1174 to make sure Coloradans can safely and responsibly access their health care without fearing a surprise bill might end up in their mailbox.**