New Yorkers Speak Out About

Surprise Medical Bills

Consumer Stories About Medical Bill Shock
March 24, 2014
Organizations supporting Gov. Cuomo’s Proposed Consumer Protections Against Surprise Medical Bills (TED Article VII Section U)

AARP
Action Toward Independence
AIM Independent Living Center
American Cancer Society
ARISE, Inc.
Callen-Lorde Community Health Center
Center for Independence of the Disabled, NY
Central New York Citizens in Action, Inc.
Children’s Defense Fund - New York
Citizen Action of New York
Coalition for Asian American Children & Families
Coalition for the Homeless
Communication Workers of America, District One
Community Service Society of New York
Consumers Union
Empire Justice Center
Empire State Economic Security Campaign
Empire State Pride Agenda
Finger Lakes Independence Center
Fund for the Advancement of Social Services
Greater NYC for Change, Inc.
Health & Welfare Council of Long Island
Health Care for All New York
Hunger Action Network of New York State
Independent Living Center of the Hudson Valley Inc.
Independent Living, Inc.
Lesbian, Gay, Bisexual & Transgender Community Center
Lupus Foundation of Mid & Northern NY
Make the Road NY
Medicare Rights Center
Metro New York Health Care for All Campaign
Mothers & Babies Perinatal Network
NARAL Pro-Choice New York
National Multiple Sclerosis Society, New York City-Southern New York Chapter
New York Association on Independent Living
New York Immigration Coalition
New York Public Interest Research Group
New York State Council for Community Behavioral Health Care
New York State Multiple Sclerosis Coalition Action Network
New York Statewide Senior Action Council
New Yorkers for Accessible Health Coverage
Project CHARGE
Raising Women’s Voices for the Health Care We Need
Rekindling Reform
Resource Center for Accessible Living, Inc.
S.L.E. Lupus Foundation
Schuyler Center for Analysis and Advocacy
United Neighborhood Houses
Urban Justice Center
WCLA – Choice Matters
Westchester Disabled On the Move, Inc.
Westchester Independent Living Center
Women’s City Club of New York

Report prepared by:
Charles Bell, Programs Director
Consumers Union
(914) 378-2507
(914) 830-0639
cbell@consumer.org
New Yorkers for Accessible Health Coverage, Health Care for All New York, and Consumers Union invited New Yorkers who have experienced surprise medical bills to share their stories with us. Below are a sampling of stories received so far.

The first two stories recount in detail how two patients experienced surprise charges for surgery and hospitalization, even though they strived to stay in-network and avoid out-of-network care.

Claudia Knafo

My name is Claudia Knafo and I currently reside on the Upper West Side of Manhattan. I am a professional concert pianist and I can certainly tell you that I never imagined how my life would change so dramatically almost two years ago by entering a world I knew very little about.....Out-of Network Medical Surprises.

On April 24, 2012, after undergoing cervical spine surgery, I had every reason to believe this surgery was an in-network service. Instead, it subjected me to claims for payment from both provider and insurance totaling nearly $100,000. The situation arose out of:

1. Misrepresentation that the surgeon was in my plan’s network
2. My health plan retroactively applying a new reimbursement method for what it determined to be an out-of-network service.

I received recommendations for neurosurgeons at 3 different hospitals in Manhattan. The one highest recommended was out of network. I knew that was not an option, so I couldn’t go to him. After three different consultations, I opted for the hospital I’ve used in the past, where most of my in-network doctors work. The referring neurologist, who was in my health plan, had raved about a particular neurosurgeon at my hospital. This surgeon is listed as a clinical professor and was allegedly under my plan as well. My initial consultation was booked for April 5, 2012.

I did my due diligence. I researched this physician and read reviews on the web. I made sure he was in-network by checking the hospital’s website, using the telephone physician referral system, and contacting the hospital’s patient coordinator in the neurosurgery department. All three confirmed he was in-network.

On April 5th, I met the surgeon and signed consent forms. I gave my insurance card to the office manager who made the usual photocopy. When I asked about my copayment, she replied that they would bill the insurance company directly. This seemed a bit unusual, but I didn’t think to question it because of my prior research. Nobody quoted a price for the surgery, and I didn’t
expect they would because I believed it was in-network.

On May 18th, nearly one month after surgery, I received from my insurance company a check for $66,891.78 made out to me. I immediately called my insurance company to find out why the check was in my name. I was told that the physician had dropped my plan in 1997. I was also told to endorse the check over to the doctor, as did the doctor’s office when I contacted them.

I did just that. I also asked the office manager why they hadn’t told me they no longer accepted my insurance. I was told “not to worry, and that they would work with my insurance.” Two weeks later, on June 5th I received the full bill for the surgery, $101,000! This was the first time I was told the procedure’s cost. Since the check only covered part of this cost, I was left with a balance of $34,433.22.

A note followed urging me to appeal to my insurance for the remaining $34,433.22. It stated: “It has been the experience of this office if an insured aggressively requests a review of benefits provided, additional benefits will be forthcoming.” They had prepared a letter for me to sign, which argued that the reimbursement was too low for the complexity of the surgery. Of course I signed it, because I was terrified that the doctor would come after me for the balance if insurance wouldn’t cover it.

3 weeks later, on July 24, I got an answer from the appeal. The claim had been processed incorrectly. My group policy apparently reimburses at 140% of the established Medicare rate, rather than at 70% UCR.

This means that, after non-network coinsurance was applied, the insurance’s coverage amounted to $3,510.19. They demanded a return of the $66K before they would reprocess the new reimbursement. Since I had signed the check over to the doctor, there was no way for me to return anything.

I called the doctor’s office to urge them to return the check and get involved directly in this dispute. They did not help. My blood pressure hit the roof as I saw my exposure go up to $97,489.81. On July 24, 2012, I received the first of many collections notices from the insurance company. This lasted through November 2012, once things were resolved.

I filed a complaint with the Department of Financial Services and the Office of the Attorney General. In reply to these inquiries, the insurance company stated that the problem stemmed from the surgeon’s misrepresentation of his status, not with them. Further, I was scolded for picking an out-of-network physician. Never mind the research I had done prior, and, at the time, a screenshot of the hospital’s webpage still listed him as accepting several plans, including Medicare.

On Sept 18th, my doctor received a letter from the Office of the Attorney General, asking him to accept a negotiated fee. The letter also reminded him that he listed my insurance on the
hospital’s webpage. The next day, the page no longer listed my insurance. However, one other insurance company was still erroneously listed, and remained so until I brought that to the attention of the Attorney General.

On October 3, 2012, I received an apology from the hospital for the “undue stress” caused by the inaccuracy of its website. Though it promised to review its website information more frequently, the hospital took no responsibility over my doctor or his information, and that the situation was a “complex one.” To this day, I have yet to get a straight answer as to who the responsible party is for accurate information on those websites.

The spring into fall were immensely stressful, as anyone can imagine. I was concerned that, to get through this, I was going to have to declare bankruptcy. My husband and I even talked about divorcing to separate and protect our assets. It felt like my family and I were used as pawns in a chess game between insurance and doctor. It was also infuriating that neither wanted to address each other directly, and that all liability rested on my shoulders.

Because I could no longer take this stress, I hired a lawyer in August. Ironically, my post-operative instructions had been to cancel all concerts, and to keep my neck in a neutral position for 2 months. I never had a chance, as I had to spend hours a day at the computer writing letters of appeals.

My lawyer initiated further appeals, but the matter was not resolved before the end of November, when in desperation, I wrote directly to Superintendent Ben Lawsky, and other high officials at DFS. Their response was immediate. Within 24 hours, my insurance company called me to say that I would be taken out of collections and my debt forgiven.

Looking back, I am one of the lucky ones. I was not facing a life-threatening illness. After many stress-filled months, I was able to protect my family from a potential medical bankruptcy. Friends and friends of friends, strangers, started to call me and share their horrific stories with surprise Out-of-network medical bills. One person had a $20,000 plastic surgery bill from a visit to the E.R for sewing up his finger because the on call plastic surgeon was not in his network. Another person had knee surgery performed in a surgical center and she was never informed that this facility was considered out of network, despite the physician being in network.

New Yorkers deserve a system in which patients get accurate, up-to-date information about the network status of their doctors, and about what they will have to pay for medical care. We deserve to be safe from huge financial liability when we do end up getting surprised by out-of-network bills. The insurers and the doctors should have to resolve disputes over the amounts directly with each other, without involving the patients. There should be some independent state agency we can turn to, to resolve these disputes. I understand the governor’s proposed bill would provide all these protections that I did not have, and I passionately support it.
My name is Jocyn Krevat, and I am 36 years old. About four years ago, I became very sick. I was working as an occupational therapist, at a nursing home. I felt like I had the flu, and that feeling of having the flu turned into, I thought I had pneumonia.

As it turned out, I had a very rare auto-immune condition called Giant Cell Myocarditis, which causes end-stage heart failure. I was rushed via ambulance from my doctor’s office to New York Presbyterian Hospital, where I was worked up in the emergency room, and I was transferred to the Cardiac Intensive Care Unit, where I stayed for seven weeks.

I was hooked up to pumps that did the work of my heart for me, because my heart wasn’t working. I was told I would die without a heart transplant. I was put on the heart transplant list, and about seven weeks later, a heart became available at Columbia Presbyterian Hospital, where I was rushed, via ambulance, and brought into their ICU. A few hours later, I had the heart transplant surgery. I recovered there for a couple weeks, and then I went home.

A couple weeks after that, I started receiving bills. As it turns out, the insurance situation wasn’t what we thought it was. We went into this thinking that that was an aspect of this terrible ordeal that we wouldn’t have to think about. My husband had just changed careers, and he was a first year New York City teacher. New York City teachers supposedly have fantastic insurance – Empire Blue Cross for hospitals, and GHI, for what I thought was outpatient doctors.

As it turns out, the doctors at Columbia Presbyterian Hospital don’t work for Columbia Presbyterian Hospital. They have formed their own company, called Columbia Doctors LLC, and they don’t accept what Blue Cross paid as payment for their services. They bill separately, and they bill as though I selected them, that I looked a book, and said, “I want to go to that doctor!” and I walked into his office, and I willfully ignored the insurance participation.

So none of those doctors take GHI. And as it turns out, no heart transplant surgeon in the United States takes GHI. So I received a bill for the surgeon and for the assistant surgeon, totaling $70,000. And that $70,000 quickly went into collection. I found myself at home, recovering from a heart transplant, and now faced with the full-time job – this full-time nightmare – of dealing with these medical bills that were coming every day. I was getting letters from lawyers, and I would call – it seemed like it was mistake. Nobody even believed us. We would tell our friends, and they would say, “No, no,no -- teachers have great insurance, the bills will stop.”

But they didn’t stop. Every time I called GHI to see what the deal was, I would get a different person on the phone. The same thing, if I called the billing department [at the hospital]. I
would get a different person, no one ever made any record that I had been calling, and I would have to start the whole story from scratch, like I’m doing now. And GHI’s helpful advice was, you should have picked in-network doctors. And the hospital billing department said, “Well, sometimes our doctors don’t take your insurance.”

Now, when we went into the hospital, our insurance card was photocopied. No one said anything about, “Well, we’re going to put a sign on your door, so you don’t get screwed. Non-participating doctors, don’t come in.” I still don’t really understand how that happened, because I was in a participating hospital.

So something needs to change. I have a masters degree, and I had the luxury of being able to stay at home to recover, rather than having to go back to work right away. I don’t know what somebody would do who didn’t have that luxury. I would sit with Microsoft Excel every day, and try to figure out how to deal with this. And I would make my calls. GHI, when you see a non-participating provider, mails the payment for that doctor visit to the subscriber, so I had all these checks from GHI, made out to me, or made out to my husband, and I would have to sit and figure out which doctor it would get mailed to. And of course the amount from GHI never matched the billed amount.

And it was just horrible, and I think that it seems very shady, and I think this needs to be regulated somehow. Something needs to change, so no one else has to worry about losing everything and going bankrupt. As somebody with health insurance, we sort of figured we would have been better off, if we didn’t have insurance, because this was an absolute nightmare.
In March, 2014, Consumers Union invited consumers from across New York state to send e-mails to members of the New York State Legislature, in support of stronger consumer protections against surprise medical bills. More than 4,000 people took this action, indicating strong support for comprehensive reform. We also invited consumers to share brief stories about surprise medical bills that they received, and more than 125 people responded. Here are some of the stories that patients and family members shared with us about their experiences.

**Mercedes**

New York, NY

My husband and I went on vacation to visit my mom. The same night, my husband became ill and had to go to the ER. He never was told that the doctor was out-of-network, until we received the bill. We are devastated with the amount! Something has to get resolved with this issue. We are both retired and can't afford to pay!

**Roger**

Holtsville, NY

We had our first child in Long Island Jewish Hospital. The hospital knew very well what insurance we have. My wife had an epidural. We were charged over $2,000 for the procedure for out of network services that we didn't know we would incur.

**Sungmi**

Flushing, NY

I recently had my baby at the age of 37. Due to my age, my blood screening result said I had a risk of having a child with Down’s Syndrome. I was offered a genetic counseling session to decide whether to have an amnio test. So I went to the counseling session, which I had to miss work for.

A few months later, I received a bill for the session which was $800. Had I known my insurance wasn't going to cover the cost, I wouldn't have agreed to go through with the session! On top of that, I'm hit with more bills from the blood lab and the hospital for things that apparently are not being covered through my insurance. What is the point of having to give my insurance information all the time and yet I'm not being informed of what is covered or not covered under the insurance?

Now on top of having to find childcare for my baby, and going back to work early because I basically don't have maternity leave, and having to pay back my job for borrowing days, I need to dish out more money for medical bills.
Dana
Yonkers, NY

I was billed for an out of network anesthesiologist for a surgery that was authorized by my insurance and was pre-planned. [I] was never made aware the anesthesiologist was out of network and that I would have to pay until a week after my surgery when I received bill. I called my insurance carrier and they stated they do not cover out of network providers.

Melissa
Red Hook, NY

My new $1700/month BCBS plan doesn't have an in-network allergist or immunologist within 20 miles. There are at least 6 hospitals within 20 miles. I'm not in the boondocks. So do we wait for the allergic asthma to send my child to the ER for lack of a specialist? When we asked which plan offered an in-network specialist we were told there were NONE that we could join.

C_____
New York, NY

My brother has been in the hospital for almost 7 months. I am still waiting to find out what total of out-of-network doctors used will charge, that his insurance company didn't cover to some degree. And how much we will be responsible for.

I asked the hospital doctors and physician assistants to use in-network doctors when treating him. What amazes me is that an out-of-network nurse got more money for a 2 min. checkup than an in-network attending physician did for considerable time spent.

And the collection agents don't seem to know what's been paid and what hasn't been....we are constantly getting reissued bills for the full amount, even though it has been partially paid. This is very frustrating.

Michelle
Horseheads, NY

I suspected I had an ovarian cyst. The doctor ordered blood work and an ultra sound. I received a $700 bill after insurance for the 15 minute ultra sound I received. Nothing was found in the ultra sound. I don't know how necessary it was, however for $700 after insurance I would have chosen to wait and see if the condition worsened or improved. I haven't returned to an MD since. I have found acupuncture and chiropractic care to be affordable and effective. I haven't seen an OBGYN in 5 years. I'm really hesitant to go.

Curtis
Lido Beach, NY

I experienced the symptoms of a stroke and went to the emergency room. I informed them of my GHI insurance and was admitted. Turns out I hadn't had a stroke, but did get a bill for over $1000 from the doctor who admitted me and who didn't take GHI.
Lisa
Oriskany, NY

I was given permission by BCBS to go out of network for a neurologist that prescribed my specific medication, Tysabri. I just needed to call and notify them before each visit. I did call and notify. I then got a denial and $120.00 bill. I filed an appeal stating I had made the required call. They then agreed to cover the bill.

Jack
Merrick, NY

I had a colonoscopy performed by my gastroenterologist who I chose partly because he was covered under my insurance plan. After the procedure I received a bill from the anesthesiologist he used for over $1000. There were other anesthesiologists covered on my plan.

Dollene
Brooklyn, NY

I have on different occasions been told that my co-pay was huge, due to someone not being in network.

Marion
Brooklyn, NY

I have good coverage (I thought) through the City, with Empire and GHI. Two years ago, while visiting my cousin on Maui, my husband was hospitalized with catastrophic internal bleeding. A correct diagnosis was made only after a third trip (second admission within a week) to the hospital, the third trip being by ambulance at a point when he had lost more than half the blood in his body from upper GI bleeding. He was told by one of the attending doctors that he would likely have died had another 15 minutes to ½ an hour elapsed before he received medical care and that there was no doubt that he would bleed again. This time, had the hospital discharged him before identifying and treating him it would very likely have been fatal.

I certainly had no way to bring him back to New York to an in-network provider for any of the procedures that saved his life. The cause was a very rare condition (Meckel’s diverticulum). I asked, and was assured by the hospital, that all the costs were covered - that they "would make sure of that."

Not until months after we returned home did the the bills show up. To their credit, Empire BC/BS paid the hospital bills - i.e., as it was explained to me, "room and board." But that excluded thousands in "medical" expenses - doctors, radiology, anesthesia etc which we were not told about and over which we had no choice. What GHI eventually paid to the providers was a shock, and more so was the balance then billed to me. Eventually, the providers turned their bills over to the debt collectors, even as I waited for responses from both the providers and GHI to my calls and letters of appeal. In the end, I paid the bills, rather than have my credit
ruined.

Here's a quote from the hospital brochure: "We will help you verify your insurance coverage and benefits, and obtain authorizations if required."

They did nothing of the sort, and GHI had the temerity to deem certain diagnostic procedures "medically unnecessary." I could not even get the providers to respond to my repeated requests that they contact GHI and clarify the necessity of the services they performed.

I spent months trying to understand this, writing letters, making phone calls, all in an effort to find someone to deal with me straightforwardly. Even appeal letters sent by certified mail went unanswered...and the bills just kept pouring in.

I shudder to think what it's like for people with less in the way of resources than I have. I have savings, a job, good health, and a law license. I can cope with this. If I were ill, or my husband were, I'd think about throwing myself off the roof. The system is inscrutable, wasteful and heartless. It is an embarrassment to the country.

Gloria
Bronx, NY

I was billed $25.00 co-pay for my Wellness Exam at Montefiore. I sent a letter of Appeal to my insurance company (after numerous calls to both the clinic where I had the exam and my insurance company). They rectified the overcharge and I was reimbursed the $25.00 by the hospital. It seems they may have been charging me for a specialist visit/or clinic fee. Many people will let it go, but every dollar counts when you are retired. It was an error on the part of Empire Mediblue.

Edmund
Schenectady, NY

I called 911 because I was having a heart attack. My local fire department sent their paramedics to assist me. Minutes later an ambulance also showed up. I was taken to the local hospital by the ambulance as one of the crew treated me as the other drove.

Some time later I got a bill for this ambulance service. It was stated that this ambulance company is not under my insurance company’s coverage, and I must pay $394 out of pocket.

When someone calls 911 you are not given a choice of which ambulance co. is sent, it just comes to save you and that’s all you are caring about. I can't believe we should have to ask if the ambulance service being sent is under my insurance coverage before I get it sent to me.
Does this make ANY sense at all ! I did go over all this with both the insurance co. and ambulance co. They didn't seem to care or get it.

Rand
Utica, NY

My medical care at the Bassett Hospital in Cooperstown, NY, is normally covered by my insurance. Last spring I was required to have a bone marrow sample taken from my spine by an oncologist/hematologist at Bassett.

I assumed that the lab work would be done 'in house. But later I received a bill for several thousand dollars from a laboratory in New York City which I discovered was 'out of the network' for the insurance I then had, MVP.

Fortunately, the patient relations staff at Bassett came to my aid and worked with the lab and the insurance company to reduce the bill, but it took several months to resolve the issue, during which time I received numerous threats from the NYC lab. The Bassett staff told me that they were working to resolve similar problems with dozens of Bassett patients.

Jordan
Hartsdale, NY

My experiences and those of my clients are replete with unknown items.

[There are many unknown doctors] whose names appear on bills -- but even worse, sometimes the bills don't come for more than a year, which makes submission to an insurance company impossible.

Steve
New York, NY

My 11 year old son was on a school trip to a local ice-skating facility in a large park. He fell, and his own blade sliced into his leg, creating a small but bloody injury.

The school administrators and rink staff acted admirably and did the right thing -- they treated his wound as best they could and called an ambulance, as no other vehicle would be allowed to drive into the park. They called me and told me which hospital the ambulance would take my son to, and I was able to leave work and meet him there.

The ambulance staff were wonderful, as was the hospital staff -- my son received excellent care all around -- and received 5 stitches from a highly skilled and gentle medical doctor. We were grateful, even if the wound would normally not have required an ambulance...

A few weeks later, the bill from the ambulance company arrived (AFTER my Oxford insurance paid the paltry amount they are obligated to pay), and it was stunning -- and far beyond the bill amount I received from the Hospital ER itself. It required borrowing money via a bank loan to
pay it... and we pay $1200 a month for Oxford insurance!!!! Surprise surprise. And this is NOTHING compared to someone who requires emergency surgery!!!! I fear if that ever happens, it would drive me and my family into bankruptcy... The insurance companies, even under the ACA, will bankrupt the fabric of America at every chance they get -- we must have single payer.

Steve  
Astoria, NY

As a result of a recent trip to an Emergency Room at the hospital next door to my workplace -- my first in decades -- I received a large bill for a routine blood test from my insurance company.

When I spoke to them, I was told that the hospital had sent my blood to "the wrong testing facility", one that was not part of my plan's network, and that I had to pay the bill.

I had no idea that I am the one who needs to tell the hospital which testing facility to send any of my samples to to be covered.

I find this situation ridiculous for obvious reasons, should a patient be incapacitated or otherwise too busy with treatment, or too distraught to take this initiative.

Roland  
Merrick, NY

My mother recently died from cancer. During one of her trips to the emergency room, the doctors were not covered under our network. So my father had to pay out of his pocket for numerous doctors that she or my father did not even know about.

I thought it was a real crime. [My parents] worked all of their lives. And they paid heavily into the insurance plan, only to have to pay thousands more for crooks like this. At the end, it was very sad.

Michael  
Springville, NY

I underwent cataract surgery at an eye clinic. The surgeon was in network, and no problem. [But] I had no idea who the anesthesiologist was, until after I had actually arrived for surgery and had signed a consent form. It was kind of late to back out then, if I had even thought to ask. (Under the circumstances, I hadn't. Wouldn't you assume?)

I got an explanation of payment two weeks later from the insurance company, advising they would pay nothing for this service. Zero. Fortunately, they accepted the explanation that I had no knowledge and no choice, and worked out a payment ( I think) with the anesthesiologist. Who knows? Maybe the anesthesiologist won't accept what they finally chose to pay, and I'll get a bill. The surgery was in late January, so I may not have heard the last of this.
Jean
Brooklyn, NY

Last year I was excited to learn about a doctor who not only treats my medical condition, but also specializes in it and does research on it as well. However before agreeing to see him, I called his office to make sure they would accept my insurance which is under the Blue Cross/Blue Shield network. I have been using this insurance, Freelancers Insurance for over five years now and have always done this without any problems. I do not see any medical provider that isn't under the Blue Cross/Blue Shield umbrella.

Since this doctor was under the Blue Cross/Blue Shield umbrella, I went in for a consultation. Afterward Freelancers denied my claim because they said he was not in the Anthem Blue Cross/Blue Shield network. I had never been informed of this change. Now I am liable for a huge bill. Shouldn't insurance companies, like all other companies, inform their clients of a change, before making them liable for it?

Lester
New York, NY

I had lung cancer surgery by a in network surgeon in an in network hospital. But I was billed by the anesthesiologist who was not in network. I had no choice.

As I wrote in my appeal, "Was I supposed to ask when introduced to him in the operating room, 'Do you accept Atlantis...? No? Cancel the surgery,' and get up and leave." It took almost a year of writing letters, but it was finally covered.

Lawrence
Brooklyn, NY

My employer switched from an ungated policy to a gated one (where referrals are required to see a specialist). It took a month for Oxford to process the change. When either I or my doctor called, they would not give a referral, saying it was not needed.

A few months later the claims all came back because they had no referral. Oxford has records of our attempts to get a referral and still they won't pay. In the end the doctors took most of the hit because they belonged to a PPO.

Donna
Binghamton, NY

On 2 separate occasions I have used the emergency department of a local, participating, hospital. On both of these occasions I received very substantial bills from the emergency room physician. While the hospital was a participating provider, the physician was not. I have recently learned that my health insurance provider suggests that we always question the physician as to whether he or she participates in our insurance.
This is absolutely ridiculous. What am I supposed to do if the physician does not accept my insurance? Leave the hospital and NOT be treated? Hospital emergency departments do not have a list of physicians to choose from... they usually have one physician on call. All of the staff at a participating hospital should be required to accept any insurance plan that the hospital accepts.

Mary Massapequa Park, NY

I had a routine colonoscopy. However, the anesthesiologist was not in network.

The doctor’s office informed me that in the slew of paperwork they gave me, I unwittingly signed an approval form that said I would be responsible for the anesthesiologist’s bill.

Sonia New York, NY

I went to my primary doctor's office for my annual physical examination. At that time, along with the routine tests, he recommended that I get the shingles vaccine because of my age. I answered, yes, and I received the vaccination.

Not long after, I received a bill from the doctor totaling $410.00 ($365.00 for the vaccine and $45.00 for administering the vaccine). The insurance company did not pay the bill because the vaccine was administered at the doctor's office instead of at a pharmacy.

I had to pay the bill with a credit card because I did not have the funds with which to pay it. Currently, I am appealing the insurance company's decision not to pay and I am in a "fight" with them trying to get all or some of the $410.00 I paid. They won't accept any of the paperwork I have mailed to them and insist that I get a load of information before they will even consider my case. It is an uphill battle that I hope I will live long enough to win.

Rose New Hyde Park, NY

I was in Pennsylvania on vacation with my family. I became ill and an ambulance was called. The ambulance brought me to one hospital (I not sure what the name of this hospital was) and they refused me. They sent me to another hospital that was over an hour away. Because I needed immediate medical attention, I was transported via helicopter to the second hospital where I was treated.

A few weeks later I received a bill for almost $25,000 for the helicopter transport. I assumed my insurance company would take care of this matter. Initially, however, they refused to make any payments for it. Their argument was that they do not cover air transport.

I argued with them because at the time I was unconscious and unable to make any decisions
about my care. I still don’t know why the first hospital turned refused to treat me.

After going back and forth with my insurance company several times, they paid a portion of it (about $18,000). I am left to pay the balance. I have tried to negotiate the balance with the air transport company, but they will only reduce the bill if I pay it off in one payment. I am unable to do this, so I have an agreement with them, and am making monthly payments to them.

I’m still not sure about the events that transpired around my illness and have wondered sometimes if this is a racket that Pennsylvania has going to increase income from out-of-towners...

Kathy

Lancaster, NY

My son is a diabetic and needs constant monitoring. The doctor's office is out of network. Not only is the office out of network, he has to be seen by an actual doctor, not the physician’s assistant that he has been seeing.

This was a surprise to him, and he was hit with a bill that was much more than the co-pay he was expecting. I feel he should have been told this, before he made appointments. The doctor's office was also surprised at the requirements of the insurance company.

Jeff

White Plains, NY

My story is only half a surprise. I have what is considered to be good insurance, but they have year by year been adding more deductibles and copays to the in-network coverage portion of the plan.

I recently had some diagnostic testing, that required a week as a hospital inpatient. After the coverage was applied, I had bills that were due totaling about $3000.00 for covered services by in-network providers.

Sproule

New York, NY

My wife gave birth to our second child, a girl, last November at a hospital that was in United Healthcare’s network, using a OB-GYN practice that was also in-network. The birth happened after our in-network deductible and our in-network out-of-pocket maximum had been met for the year.

Lo and behold, we get a confusing bill from the hospital that does not match up well the claims submitted to United Healthcare, saying that we owe $800. I know this is a small portion of the
total cost of delivering a baby, but in this case, I don't understand why we owe anything. It seems "out-of-pocket" is a fluid term.

Roberta
Ronkonkoma, NY

I received a surprise bill for an out of network anesthesiologist, because the one I confirmed in advance as in-network was switched without my knowledge on the day of the procedure. I disputed it with the insurance company. What was I supposed to do, ask everyone in the operating room if they were in-network? And if they weren't, cancel the operation?

The insurance company did pay. I don't know what the new insurance company I just switched to will do [if this happens again].

David
Chester, NY

I got burnt by Helen Hayes Hospital, who charged me twice the customary rate for cognitive testing related to temporal lobe epilepsy. I disputed this, and filed a hardship document.

They sued me, and hold a judgment against me. I could not afford a lawyer, which they knew.

Renee
Brooklyn, NY

The Point of Service doctor called me in for the "yearly physical" requested by the Blue Cross/Blue Shield. After taking the exams, Blue Cross/Blue Shield did not cover $1,000.00 portion of the exam. I am living on a fixed income.

Virginia
East Setauket, NY

The situation that this bill would correct actually happened to me about 5-6 years ago. I went to the hospital not feeling right with what was later diagnosed as a pulmonary embolism and I was admitted. I went to that hospital because I had been there in the past and knew that they took my insurance.

The hospital took all of my insurance information when I was processed in the ER. After a couple of days and the immediate danger of the embolism had passed, the doctor in charge of my case suggested that I have a type of screen implanted that would "catch" any future blood clots before they reached my lungs. This obviously sounded like a good idea, so I approved this.

A doctor then appeared whom I knew nothing about personally, and indicated that he had been the doctor selected for this. He did the procedure, and I thought no more about it, until his bills arrived and I found out that he did not accept my insurance.

I sent letters to the hospital protesting his selection, since he didn't take my insurance. I got NO
satisfaction from them -- just defensive stuff. The first reply was that it was an emergency. I wrote back indicating that the emergency had passed by the time this procedure was proposed, and he was selected.

The second reply was just nonsense. I had to do at least two appeals to my insurance, and luckily I have a decent policy and it was all eventually covered. However, I was (and am still) mad as heck about the whole thing! Either another doctor should have been selected, or at the VERY least I should have been told that he didn't take my insurance so that I could have better evaluated my options!

Inez Nassau, NY

Ultimately, I did NOT have to pay for custom orthotics ordered from a podiatrist, but..... At an in-network doctor's office, I was forced to sign a statement saying that I would pay whatever my insurance did not cover, while the nurse assured me that my insurance would pay in full.

My insurance company later paid what would be owed to an out-of-network provider because, even though I initially was seen by an in-network doctor, my care was transferred to a doctor newly brought into the practice, who had not been added to the insurance company's in-network list. What a Fiasco!

I had no idea that by seeing the new doctor I had gone out of the network. The doctor's office also was taken by surprise by the insurance company's treatment of my claim. More than a year later, the doctor's office wrote off the amount due, and I breathed a sigh of relief.

Vicki Coram, NY

Many times my family members and I have gone to in-network physicians, who ordered tests by an in-network doctors that were read and interpreted by non-network practitioners. Then we received surprise bills that were not covered by insurance. Sometimes the tests in the doctor's office have not been covered even if the physician is in-network.

It happened again in January when my husband had an out patient surgical procedure in an in-network hospital with an in-network doctor. Several tests, scans, etc. associated with the procedure were done by out of network providers, even though the hospital records had the name of his insurance. The insurance denials and the bills are filling our mailbox.
Christopher
New York, NY

I received a referral from my in-network doctor for a CAT scan of my sinuses. At Beth Israel I just found the technician by wandering around. There was no desk to check in with, and no one to ask questions. The technician took my scan, and that was the extent of the interaction.

Much later I received a bill from my insurance company saying they would not cover the whole amount, and I had to pay the difference, though no one had told me this beforehand. I found it outrageous, but refusing to pay only gets you referred to a collection agency, and that is very hard to fight.

I had the same thing happen when the doctor said he wanted to test my hearing. [I had the test] and TWO MONTHS LATER Oxford sent me a letter saying they did not think that test was warranted. They refused to cover it, even though my doctor thought it was necessary! AGAIN, AFTER THE FACT!

It's is utterly outrageous. Nobody can make plans for that. No one should be able to change the price of what we have to pay after the fact. We may as well be slaves and just give them everything we own.

Bernice
Brooklyn, NY

My husband was diagnosed with skin cancer on his nose. Rather than have surgery, his doctor recommended he have radiation treatment, which he did have done.

Weeks later, he received a bill for over $1,600 that he was told was his responsibility, after the health insurance payments were made to the doctor.

We are senior citizens who rely on our Social Security benefits each month, and so we aren't able to pay this money. We were able to get $500 from Cancer Care, which was sent directly to the doctor. But the new bill we just received from them is for $1176.51. I don't know how we will be able to pay this amount of money.

Glen
Macedon, NY

Several years ago, I had a recurring severe bleeding nose issue. I went to an ER in Dunkirk, NY where I was at the time.

After the fourth visit to the ER the doctor decided that I needed to be seen by a specialist. He called around first to ECMC in Buffalo, NY and found one person who was just finishing a 24 hour stint. He seemed not to be thrilled at the prospect of seeing me. Following that, the doctor called Hammet Medical in Erie, PA. They had no problem with me being transported.
there.

Seeing how I had been covered (by a copay) for the hospital (Dunkirk) I presumed I'd be covered for anything beyond that, since the doctor ordered it. Several thousand dollars later, I found out that my coverage [wouldn't pay] for a lot of the physicians attending me at Hammet. It was a shock for sure.

Hedy

I needed a MRI and lumbar spinal tap, which were both done in a hospital (Columbia Presbyterian). I did not know because the procedures were done in the hospital, as an out-patient , I was responsible for the entire bill.

My hospital deductible at the time was $5,000. I did not know that deductible was for any hospital procedure, even if I were an out-patient. All of my previous MRI's were done at MRI facilities of NY Presbyterian, but were not located at the hospital, and were part of my co-payment for my doctor’s visit.

My total bill for my ignorance of health insurance billing cost me almost $7,000. My insurance company at the time was HIP. Because of the Affordable Care Act I now have a better insurance plan with Aetna. I cannot go out-of-network, but in an emergency I would be covered for out-of-network doctors, and in NYC most doctors seem to accept Aetna. But if insurance companies can opt out of insuring individuals and Aetna decides to opt out, I will not be able to obtain the insurance plan that I need.

Amy

I had my gall bladder removed in 2010. The doctor chose the anesthesiologist, and didn't make me aware of the fact before or after surgery the he wasn't a participating provider, as the surgeon was. It took a year of haggling back and forth between the provider and insurance company. Neither would work with the other or me. In the end, I ended up owing about $3,200 for the cost of the service and late fees.

Here is something else to consider please: In addition to surprise costs from out of network bills, the legislation should also be expanded to include some kind of reform in regards to making patients aware of ALL costs prior to procedures/visits, etc..

For example: a friend of mine went in for ACL (anterior cruciate ligament) surgery and wanted to know the total costs up front so she could budget for them, i.e.: the cost of child care assistance and other ancillary costs from being out of work.
Not only is it bad enough to force the populace to buy insurance, it is not true that is AFFORDABLE for all Americans... some people make just dollars above the 'poverty' or subsidies threshold and are now having to make medical payments instead of putting food on the table, or managing to pay the rent.

The insurance companies and doctors argue sometimes "unforeseeable things" happen that don't allow for providing an exact dollar amount to the patient...hogwash... What happens during the billing process??? Do they decide to 'tack on' or make up the cost as they go along?? Of course they don't, they are accountable to the state concerning their rates, so why shouldn't they have to account to the patient as well ? My humble opinion believes we could keep people a hell of a lot healthier if they weren't stressing over how and what they are going to pay, just to stay healthy!

Judith Bronx, NY

I received a surprise bill because the biller for my doctor at NYU Langone forgot to include a procedure performed. When I called, no apology was given, but at least the biller has said that they would re-submit the bill to Medicare. Shame on them for asking me for more than $600.00 without checking, before sending out the bill to me, and not to Medicare and United Health Care!

Hubert New York, NY

Over a year ago, I lost sight in my right eye and was diagnosed with a hemorrhage in the back of a detached retina, and macular degeneration. I was sent to a retina specialist, who began a series of injections into the eye.

After the second injection, I was confronted with a $800 bill for the medication, that was not covered by Medicare. I was never advised that I would be held responsible for the medication costs, and felt compelled to discontinue the treatment. Over $500 had already paid in out of pocket expenses, eye examinations, and tests. I continue to receive bills from the retina specialist for the administered medication injections for the $800 bill, that he says has been turned over to a collection agency.

So now for over a year, I suppose thousands of dollars have been billed for the treatment, and I continue to be without focal vision in my right eye without a prospect of a cure. Incidentally, I'm a photographer and cannot use my right eye for that activity any more.
Abby
Ossining, NY

In 2012, I shattered my right femur and was taken by ambulance to the local hospital where I had surgery. I was fully covered through a major insurance company, I thought, and the hospital was in-network. I subsequently broke my left femur while in hospital, had surgery again, this time with a different surgeon, and remained in the hospital for 5 weeks.

During the course of my stay, I was seen by a dizzying number of different doctors, including cardiologists for pre-surgical clearance, hospital-based hospitalists who only practiced in that particular hospital, and surgeons. But only one of the surgeons was in network, leaving me with numerous bills to pay.

Despite the fact that both surgeries were done on an emergency basis, I could not walk out, had no choice in who walked into my room. The hospitalists were "part" of the hospital staff, and the hospital was fully aware of my insurance status, while I was privy to no information on what plans were accepted by whom.

The insurance company denied every one of my appeals. Their reasoning was that insurance was not meant to cover every cost. Simple as that. They did not have to pay for anyone who was out-of-network, and they did not.

So I was left to pay for hospitalists, cardiologists and surgeon (who later accepted assignment after I filed 3 appeals), amongst others. It had never occurred to me that I would ever be in this position since I was fully insured and even now, I fail to see how I could have better protected myself, nor how I could avoid this in the future if such a thing were ever to happen again.

Robert
Brooklyn, NY

My six-year-old granddaughter, who suffers with Cerebral Palsy, hydrocephalus and epilepsy, has been hospitalized on multiple occasions with shunt failure and status seizures. Her neurologist accepts my daughter's medical insurance.

On one emergency admission two years ago, another member of the same neurology practice was on call and visited her in the hospital on several occasions. Believing he was representing/filling in for my granddaughter's physician, who was not available, we failed to ask whether he accepted the same coverage, nor did he volunteer the information.

My daughter afterward received bills for nearly $7,000. Since she works in the health insurance industry and was knowledgeable about its practices, she was able to negotiate the charges with some success. I don't believe that this would be the case for a majority of families in these circumstances.
Linda 
New York, NY

1) I received a bill regarding my bone density test from the radiology company. They said my insurance company hadn't paid. It was [supposed to be covered] by my secondary insurance company. It took about half a year to straighten it out. The staff was very unpleasant and unhelpful. I finally reached the manager. He helped to straighten problem out.

2) I had blood tests my doctor had ordered. Quest sent me a bill for one test ($600.00) stating that the test wasn't covered and that I had knowingly signed that I would be responsible. This WAS NOT pointed out to me---I just signed several papers to have test. My doctor finally straightened out the problem, but it took several months.

William 
Brewster, NY

I had a hernia operation. A few days before the operation, I was required to register with the administration of the hospital. I provided all my insurance information to the hospital, and specifically asked if the anesthesiologist would be from my plan. I was assured all doctors and procedures were within my plan.

As a new employee within my company, I was being paid the entry level rate for new employees, which was not much. A few weeks later, I received a bill from the anesthesiologist for $800.00 for a 45 minute surgery.

I called the hospital and the doctor to complain, stating I specifically asked if all [providers] were going to be in my plan! To no avail, I was told I would be responsible for the bill! The doctor stated we will bill you in installments. Thank God, it was a simple surgery, or I would still be paying the bill with interest!

Richard 
West Nyack, NY

My wife was hospitalized in January with a serious condition. In two weeks, the bills exceeded $85,000. While the hospital was a member in the health plan, some of the doctors who walked into her room were not. Many of them provided no value at all, and billed her $750 just for entering the room. She finally had to tell them to leave and not to come back, because their sole purpose for coming was to generate revenue, not to care for her health.

I'm unemployed, and paying over $1,500 per month for a high deductible insurance plan. This is not an acceptable way to care for patients who are ill, and can't afford unnecessary charges. These practices need to change.
William  New York, NY

Under the new Affordable Care Act, there is still a great deal of confusion about which doctors are participating in the plans. Often doctors initially listed under the roster of participating physicians have subsequently opted out at the last minute, without any prior warning.

The insurance companies should be required to provide an immediate update when any physician or group drops out. Primary Care Physicians should be sure that any referrals are for IN PLAN services.

Marlene  Farmingville, NY

My husband was diagnosed with an aortic valve birth defect in 1980. His blood pressure was reaching unbelievable 'highs.' Immediate surgery was recommended by the best heart doctor at the best hospital. When it was done, we learned that we were not covered, because we didn't get a second opinion!!! We were billed for $27,000.00 which was a fortune in those days.

Our first opinion was from the "Heart Doctor of the Year" and the Heart Hospital was St. Francis on Long Island -- also one of the top heart hospitals!

Amy  Brooklyn, NY

My OB-GYN referred me to someone in her same office to have a colonoscopy. No one informed me that the doctor I was referred to was out-of-network, and I was stuck with a bill for $500.

Laura  White Plains, NY

A neighborhood dog bit my daughter right about the lip. I rushed her to the emergency hospital. The hospital is one of the participating hospitals on our plan. They called for a plastic surgeon who arrived about an hour and a half later. He spent about 10 minutes (at best) on my daughter. She received about 6 stitches.

I had no idea the hospital called someone out of plan, and the doctor said nothing. We got a bill for almost $4,000. After numerous phone calls and arguments with billing, we finally got them to reduce it, but it was a nightmare.

I never would have let my daughter be seen by this doctor if I had a clue what his bill would be. This was a very terrible experience for us, and one that we never should have had to go through.
George  Brooklyn, NY

I underwent a colonoscopy on two occasions, where the anesthesiologist that was assigned to me by Brooklyn Hospital was not in my insurance network, although both the internist and hospital were.

After being hit for several thousand dollars for the first time, I raised the issue with both my internist and the hospital. But they said there was nothing I could do about it and that I had to take the next anesthesiologist on the list. The second guy wasn't so bad -- only about $500 as I remember.

Michael  Andes, NY

In February 2013, I went for a test at the Albany Medical Center. I checked in advance that all the practitioners I saw were part of my plan. MVP (10 months after a procedure that they cleared in advance) “REVERSED” their coverage of that procedure. I received a bill sent on 11/19/13 from the Albany Medical Center Hospital, who want me to pay $734.58 of the $1849.18 The insurance company said that though this was in-network I had to pay a deductible—even though I spoke with them beforehand, and they since it is in-network, Albany Medical would accept MVP payment as payment in full.

Nancy  New York, NY

I'm waiting to see how many thousands I will owe, but I expect the bills to come in now that my hip replacement surgery has ended. I purchase my own health care [coverage] and have an out of pocket max of $6,000, a $1,500 deductible, plus I pay a $603 a month premium. These are the costs I knew about.

What I didn't know [is that] "out of pocket maximum" is a misnomer. It seems co-pays, some co-insurance and diagnostic testing don't count toward the out of pocket maximum; plus anything else the insurance company decides it wants to add to your bill. So what good is it? You can't estimate your costs, ever.

Stacey  Brooklyn, NY

My credit was ruined for years due to unpaid medical bills, acquired during a time when I believed I was covered by insurance. It started out with temporary insurance I signed up for during my semester off from college. After a series of emergency visits, due to extreme, sudden urinary tract infections, I began receiving bills from the hospitals. My insurance company had not covered the charges, because I couldn't prove that it wasn't a pre-existing condition.
I then acquired further hospital bills when I went in for a cystoscopy while on my student plan, and I failed to prove that I did not have other insurance coverage. For years, I was haunted by debt collectors, too poor as a student to pay. I also received surprise bills after seeing an out-of-network gynecological specialist, who assured me the insurance company would cover part of my visits. The insurance company did not have such a specialist in-network, so I was forced to go out-of-network. No part of my claim was covered.

Christine  
Brooklyn, NY

My husband had a colonoscopy on May 31, 2013, and paid a $30 fee before the procedure. A few weeks later we began to receive the usual insurance company statements, itemizing lists of fees covered, not covered, etc. Some of the fees listed were laughable, as if someone made them up. Subsequent statements showed gradually lowered fees.

Six months after the procedure, we started receiving monthly bills for $30 from the hospital network that has jurisdiction over the surgi-center where my husband actually had the procedure. The surgi-center/doctor's office advised us to disregard any bills. Now the bill is in collections!

My point is that the initial statements always show absurd amounts billed to insurance, and final statements show comparatively reasonable amounts supposedly negotiated between provider and insurance. I could tell you where I think they pulled the numbers from, but I'm trying to be polite.

Once in a while there is an outstanding mystery bill like the $30. My opinion is that people get charged and pay relatively nominal fees that they really don't owe, just to make the invoices go away. Multiply this tactic by hundreds or thousands, and you have a nice revenue stream. (I’ll be sure to contact you from Debtor's Prison, since we have no intention of paying this $30 bill we do not owe.)

Edward  
New York, NY

I had lumbar fusion [surgery] that got infected, and when they went back in, they left me with a huge herniated stomach, and an artificial urinary sphincter I had had implanted, embedded in my bladder where both were disintegrating.

I've needed 20+ surgeries and/or procedures that continue till today. It cost me my job, my career, etc. and was not considered malpractice, as things can happen during surgery. I constantly get infections from the mesh, 1/2 of which was removed. I needed a heavy duty antibiotic delivered intravenously 2x a day for 5 weeks. The cost was $2,500 with my caretaker giving me the intravenous medication.
I had Medicare and Mutual of Omaha as my supplemental insurance. I checked that it would be covered, however, what they covered was the medicine and not the intravenous bags or tubes to deliver it at a cost of $55 a day. They covered a total of $500 leaving me to pay $2,000 out of pocket.

**Amy**
**Flushing, NY**

The anesthesiologist on duty the day of my operation was out-of-network. I'd done my pre-authorization approval for the operation with the insurance company, but the hospital didn't assign a doctor as they should have. So I had a $3000 bill.

I called the Patient Advocate at the hospital and complained, and they accepted the amount the insurance company would pay and waived the rest. They knew that was wrong.

**M.J.**
**Corinth, NY**

I have not (yet) been left with shocking bills. But at 64, retired, and doing OK, I am terrified that an unexpected illness or injury will leave me with bills that could ruin my life. I have insurance, but I hear horror stories of people having to use all their savings, lose their homes, etc. This seems so ridiculously unfair, after someone works for a lifetime to be independent.

**Karen**
**Valley Stream, NY**

Seven years ago I was diagnosed with a condition that needed to be taken care of very quickly. It wasn't an emergency, but it was unusual. My internist told me there was only one doctor in Manhattan that could perform this surgery, and had experience with the procedure.

The doctor gave me his first surgical appointment, which was two weeks later. Prior to the surgery he sent me for other tests, ensuring these doctors were covered by my insurance. The hospital took my insurance, and so did all the other doctors who assisted in the surgical procedure. But no one in his office told me that the surgeon didn't take the insurance.

That was seven years ago. The insurance company paid a top NYC cardio-thoracic surgeon less than $2500 on an $18,000 bill. I am still paying this off. The surgeon has passed away and I am still paying this off!

**Claire**
**Yonkers, NY**

I have encountered the problem of surprise medical bills. It was at a time when I was unemployed and had little savings. I had a procedure done that required anesthesia.
I had made sure that the hospital and the doctor performing the procedure were in network and I had budgeted accordingly. I didn't think to ask about the anesthesiologist, who I only met moments before she put me under. It turns out that she was not in network, and I didn't find out until a huge bill came, one that I had a great deal of trouble paying.

Rose

Endicott, NY

A few years ago, I had foot surgery, and my insurance company said it would be covered. Little did I know that -- yes -- the surgery was covered, but not the assistant my doctor had in to assist him in the surgery. They did not cover one penny of the assistant’s services, and I got stuck with a $3500.00 bill, which I did not know about.

Glenn

New York, NY

My wife had a terrible infection last year. The doctor we visited recommended we go to the ER. We chose a nearby hospital, Lenox Hill, which had a good reputation. She was given IV antibiotics and admitted overnight. She was ultimately diagnosed with Lyme, given additional antibiotics, and discharged the following afternoon.

Despite being insured through my company, we received bills of close to $3000. The hospital had charged $10,000 for one night's stay, and that didn't even include the infectious disease specialist that visited her in the hospital.

T.J.

Amherst, NY

You go to your doctor for a simple thing such as recurring nosebleeds; he checks you and tells you you need to have it cauterized but he doesn't do that procedure, so he sends you to a specialist! That means two co-pays and whatever else the specialist does.

If the specialist is in your 'network', fine; but if not, you get screwed by additional costs. This stinks! Insurance companies are the worst businesses on earth! We must have them but they run the show and WE pay for it.

Nadiera

Rosedale, NY

My son was attacked by a gang on the street, and he was referred to a surgeon by the Emergency Room. He saw us, even though he knew he was out-of-network. (I asked to be referred to someone else, he said he will try, let us see what will happen.)

The insurance did not pay, and the doctor took it to court. I was out of the country caring for my dying mother when the case came up, and a judgment was placed against me. I am
unemployed and have no money to pay this bill. I receive collection calls every day.

Ivan

My wife suffers from Diabetes, and she went to the Putham Medical Center in Carmel, NY on an emergency. Several doctors came to see her. They asked her a few questions and were gone.

Several weeks later, she received an outrageous bill from a doctor. It turns out this doctor just shook my wife’s hand in the ER, asked a few questions, and now we have a bill. We called GHI about the bill and were told we had to pay, because he was not in-network. We were outraged and had to pay. This has happen several times to us, and it must STOP.

Bryan

I have experienced this 'surprise' first-hand, when my daughter had to go to the emergency room. The hospital was in-network, and the emergency room visit was supposed to be covered by my insurance.

However, without notice to me or my consent, out-of-network physicians were used in the emergency room. The multiple out-of-network doctors bills then came, amounting to over a thousand dollars.

That type of “gotcha” billing should not have happened, and should not be allowed to happen. In my mind, it's criminal.

Kathy

In January of 2011 I slipped on ice on my driveway and broke my right ankle so badly my foot was turned to the right. I was taken to a hospital in Newburgh, and then was transferred to the Westchester Medical Center because they had the only orthopedic trauma surgeon locally. I had two surgeries, a week in the hospital, and three months recovery. I showed my health insurance card to everyone.

I received a bill from the hospital for over $86,000.00 which my health insurance paid a little over $19,000.00 on, and that hospital had been 'in network' in the recent past, but a dispute had caused them to be out of network at the time of my accident. They were soon back in that network, which had no impact whatsoever on my problem.

My surgeon’s bill was over $73,000.00, which my insurance paid $7,000.00 for. I resolved my debt by appealing to charity. It was a nightmare, and I had health insurance at the time...
Barbara West Sayville, NY

I am currently on Medicare and switched my health insurance from Blue Cross to United Healthcare. Before doing so, I checked with my primary care doctor's office to see if they were a participating doctor, since the United Health website did not list them. They assured me they were. Then I went for an office visit, and I am still getting the same run around. They say they are a participating doctor, and the insurance company says they have no record.

God forbid I end up hospitalized for some reason! Are they or not? Who do you believe?

Deborah Brooklyn, NY

I recently had hip replacement surgery. Even though the hospital and surgeon "accepted" my insurance, my final bills AFTER insurance were over $15,000. Even though I was able to renegotiate the hospital bill down, I was still stuck with over $6,000 worth of medical bills. I paid them by withdrawing money from my IRA.

Jacqueline Ronkonkoma, NY

I'm a nurse and I still get surprised by some bills... This is especially true if you go to the ER... You get seen by a doctor, only to find out he isn't in my health insurance network... this is just so frustrating!! I usually go to the hospital I work at, and this even happens to us (their employees). It truly is UNACCEPTABLE!!!

Janie New York, NY

An in-network doctor used a lab that was NOT in network. I asked the insurance company how to avoid this problem in future, and the rep told me which lab to use. I asked the doctor's staff member to send my tests to that lab, and I was told "it doesn't work that way."