Testimony on S.31 to Senate Health & Welfare – February 14, 2019

My name is Gini Milkey, and I am testifying as an individual member of COVE, the Community of Vermont Elders. Thank you for taking up S.31, and for giving us the opportunity to share the difficulties we have experienced while trying to get accurate information on the costs of health care services.

For about two decades, my primary care physician has been a naturopath, and for most of that time, my insurance covered the services I received. When I went onto Medicare, suddenly those services were not covered, so I had to find a second primary care physician in order to have the insurance for which I now pay actually cover my health care costs.

I was fortunate to find a practice that was taking on new patients and was open-minded about complementary and alternative health care, since I continue to work with a naturopath at my own expense. It turned out to be unfortunate that the practice is owned by the local hospital. While everyone I have dealt with has been extremely nice, it has been a constant battle to get accurate information on costs until the bills arrive, and to get some services billed properly to Medicare.

The individual health care professionals who provide the services often have very little, if any information about what Medicare covers. They send their reports to a person who enters the codes, who then sends it to a person who bills Medicare. Here's what my experience has been over the past several months:

Last summer I opted to get the two new shingles shots from my primary care provider's office. The lovely nurse who administered the shots had no idea whether Medicare covered them, but I had heard in a conversation at a local pharmacy that Medicare did, so I went ahead and got them. When the bills and statements began arriving, there were two $48 charges (per shot). It turned out that one was for the administration of the shot, the other for some kind of facility fee. The former was covered by Medicare, but not the latter, which I then paid. Next I received a bill $286.43 for the first shot itself.

I sat down with a customer service person at Blue Cross (my Medigap provider, which denies if Medicare denies) to find out why Medicare wasn't covering the shot, as well as an unrelated PT charge. We called Medicare and found out that the hospital had billed Part B for the shot, but it was covered by Part D, not Part B. Yea!

I got the number for the billing department at the hospital, and called them. The very nice person who handles Medicare billing told me, when I asked why they billed Part B when it was covered by Part D, that the hospital didn't bill Part D. Upon my asking why not, the only answer I could get was that it was hospital policy, and I could bill Part D myself and get reimbursed. (My best guess is that, because they accept Medicare, they couldn't bill me until Medicare denied the charge, so maybe that's why they bothered to bill Part B?)

So, I wondered, if I pay the hospital the full amount and Medicare reimburses me less than that, does the hospital reimburse me the difference, since they accept Medicare, or do I have to eat that cost? I called the Health Care Advocate for help.

It took a few weeks to get this issue resolved, but because I had not been asked to sign off that if Medicare didn't pay, I would, the hospital ultimately had to write off the $286.43 charge for each of the two shots I received. I still don't know why they wouldn't bill Part D and get the shots paid for; or, if there is some reason why they can't, why they don't tell patients that up front, or refer patients to a pharmacy, where the bill is sent in right away, you pay any copay due on the spot, there is no facility fee, and everything is simple and clear. I will most definitely get any shots I can at a pharmacy in the future. I suspect that doing so might save Medicare a little money, too, since, when I told this story to the pharmacist who later on gave me a flu shot, she said that their cost for the serum was significantly lower than what the hospital had charged.

I have had two other experiences beginning last summer with services being billed using the wrong codes. One (the PT visit mentioned above) was denied and resulted in more work to get it corrected. The other was caught by a very alert registration person at the hospital before I got a prescribed test, and we both worked for several days to get the specialist's office who prescribed the test to use a code that would be covered. Otherwise, I would have had to sign the form that I would pay for it before I could get the test.

I am only 69, have many years of experience with health insurance issues and advocacy, and still have plenty of energy to fight back when I am asked to pay for services I shouldn't have to pay for. What about older Vermonters who are frail, ill, or just plain worn out? Would they just pay these bills because they don't have the energy to fight them?

We need to know what we will be charged for our health care services up front, and what our options are, rather than getting surprises when the bills arrive. My costs would only have been several hundred dollars, but others get bigger surprises when their bills arrive.

Please vote out a bill that addresses this issue in a meaningful way. Please listen to your constituents, and avoid just deferring to the medical providers because they are telling you it's too hard for them to give us the information we need. Yes, I do understand that we have a health care non-system that is complicated, but if we can't get a rational system, we at least need price information so that we can make informed, rational decisions about our own health care.

Again, thank you for the opportunity to testify on this very important issue.

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