

An \$80,000 tab for newborns lays out a loophole in the new law to curb surprise bills

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When Greg and Sugar Bull were ready to start a family, health challenges necessitated that they work with a gestational surrogate. The woman who carried and gave birth to their twins lived two states away.

The pregnancy went well until the surrogate experienced high blood

pressure and other symptoms of preeclampsia, which could have harmed her and the babies. Doctors ordered an emergency delivery at 34 weeks' gestation. Both infants had to spend more than a week in the [neonatal intensive care unit](#).

It was April 2020, early in the pandemic. Unable to take a plane, the Bulls drove from their home in Huntington Beach, California, to the [hospital](#) in Provo, Utah. They had to quarantine in Utah before they could see the children in the hospital.

A couple of weeks later, after the babies could eat and breathe on their own, the Bulls took them home to California.

Then the bills came.

The Patients: Scarlett and Redford Bull, newborn twins covered by a Cigna policy sponsored by Greg Bull's employer. The gestational surrogate had her own insurance, which covered her care.

Medical Service: Neonatal intensive care when the babies were born prematurely after emergency induced labor. Scarlett spent 16 days in the NICU; Redford, 10.

Total Bill: \$117,084. The hospital was out of network for the infants. Cigna paid for some of Scarlett's care, for reasons the Bulls couldn't figure out. The Bulls were left on the hook for about \$80,000, for both babies. Their account was ultimately sent to collections.

Service Provider: Utah Valley Hospital in Provo, Utah, one of 24 hospitals run by Intermountain Healthcare, a nonprofit with about \$8 billion in revenue.

What Gives: The Bulls' ordeal points up a loophole in coverage for

emergency care—even under the No Surprises Act, which took effect Jan. 1 and outlaws many kinds of surprise medical bills.

Patients who need prompt, lifesaving treatment often don't have time to find an in-network hospital. In the past, health plans sometimes have said they would pay for emergency care even if it's out of network. The No Surprises Act now makes this a legal requirement in every state. The provider and insurer are supposed to negotiate a reasonable payment, leaving the patient out of the equation.

But what if the insurance company denies that the care is for an emergency? Or the hospital doesn't supply the paperwork to prove it?

That's what happened to the Bulls. Cigna said it lacked documentation that the NICU care for the twins qualified as an emergency.

So the Bulls began receiving insurance explanations showing huge balances owed to Utah Valley. The family had expected to owe its out-of-network, out-of-pocket maximum of \$10,000 for the twins' care. They assumed most of the bills would be paid by Cigna soon. They weren't.

"I was, like, there is no way this can be real," said Sugar Bull, an interior designer.

"Dear Scarlett Bull," began one of Cigna's letters, addressed to a 6-month-old baby. "We found the service requested is not medically necessary."

How could NICU care not qualify? The gestational surrogate was admitted to obstetrics by her doctor without going through the emergency department, which prompted Cigna to initially conclude there was no emergency, said Dylan Kirksey of Resolve Medical Bills, a consultancy that eventually worked with the Bulls to resolve the claims.

To establish that there was, Cigna asked for daily progress notes and other medical records on the infants. The Bulls tried to get the hospital to comply. Cigna kept saying it hadn't received the necessary documentation.

The Bulls appealed. Sugar spent hours with insurance paperwork and hold music. But almost a year later, about \$80,000 in bills remained. Utah Valley sent the accounts to collections, Sugar Bull said. It was the last thing she had time for.

"I own a company, and I am super busy, and we had twins," she said. "Every two weeks or so, I would feel a panic and righteous anger about it. And I would keep pushing and calling, and it would take like five hours every time."

Though they disputed what they were being charged, the Bulls agreed to pay the hospital \$500 a month for five years to settle just one of the babies' bills, in an attempt to keep their good credit.

Resolution: With seemingly nowhere else to turn, the family hired Resolve, which beats a path through the claims jungle in return for a portion of the money it saves clients.

"It was a lot of prodding" to get Utah Valley to give Cigna the information it needed to pay the hospital, said Kirksey, a senior advocate with Resolve, which was founded in 2019 and has 16 employees. He said he had to give the hospital a detailed list of steps to take and then follow up with multiple calls and emails per week.

In the end, most of the errors causing the Bulls' nightmare were on the hospital's side, Kirksey said. But instead of supplying what Cigna needed, Utah Valley went after the Bulls.

"The hospital repeatedly failed to provide a detailed list of services and important clinical information, despite our continuous efforts to secure the information," said Cigna spokesperson Meaghan MacDonald.

"There were no errors on the hospital's part," said Utah Valley spokesperson Daron Cowley. "Utah Valley Hospital properly billed for services provided to the twins and provided the requested information to Cigna in a timely manner."

The hospital didn't bill the Bulls for outstanding balances until nine months after the twins were born and didn't send the accounts to collections until six months after that, "after the family did not return the legally required paperwork to set up a payment plan," he said.

Finally, in fall 2021, the bills were settled. The twins were 1½ years old. To compensate Resolve for curing the balance, the Bulls paid the company about 10%—\$8,000.

The fee, though substantial and unrelated to medical care, was worth it to avoid the much larger debt, said Greg Bull, who works in finance. "At the end of the day, it was such a relief for it to be a smaller amount," he said. Still, many families could not have afforded it.

The Takeaway: About 1 in 5 emergency room visits are at facilities that are out of network for the patient's insurance, research has shown. The No Surprises Act requires insurers to cover non-network emergency treatment with the same patient cost sharing as in-network care. It also prohibits hospitals from billing patients extra.

But if the insurer denies that the care was for an emergency or doesn't obtain documentation to prove it, the claim can still be rejected and the patient left on the hook.

"That's a coding issue we see a lot," said Kirksey, especially "if the person didn't literally check in through the emergency room."

If this happens, insurance experts urge patients to immediately appeal the decision to the [insurance company](#), a process the law requires to be available. Unfortunately, that usually requires more phone calls, paperwork, and waiting. (If the appeal with the insurer fails, patients can then turn to an independent reviewer, like their state insurance board, state attorney general's office, or the No Surprises Help Desk.)

"It would be a critical step for the consumer to leverage their appeal rights ... and get the determination that it was an emergency service from the get-go," said Kevin Lucia, co-director of the Center on Health Insurance Reforms at Georgetown University.

Once it's established that the visit was for an emergency, he said, protections from the No Surprises Act clearly apply.

The No Surprises Act is a step in the right direction. But it is clear that loopholes and minefields remain.

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