Testimony in SUPPORT of HB 1337 - House Health and Government Operations Committee - March 5, 2024

Dear Honorable Chair Peña-Melnyk, Vice Chair Cullison, and Members of the Committee,

I own a cleaning company called Well-Paid Maids with about 30 employees, most of whom are Marylanders. As part of their compensation package, I offer health, dental, and vision insurance. While the cost of health insurance goes up every year, I find that what my staff actually get, even with "good insurance" is worse and worse.

A major problem they bump up against again and again is how hard it is to get reimbursed for claims. Another is accessing care in the first place, which is often tied up in the tedious "prior authorization" process.

Regarding claim reimbursement, this is a major issue not only due to the potentially high out-of-pocket costs a person must bear, but also due to the nature of employer-sponsored health insurance. When an employee signs up for a new policy, delays in policy activation are frequent. This is even worse during open enrollment, when carriers blame delays on the high volume of applications, as if this is unforeseen instead of a regular, yearly occurrence.

Often, the period between enrolling in health insurance and receiving crucial information such as your policy & group number, let alone your card, can be as long as one month. During this time, employees "have insurance" but are unable to use it normally. They must go out of pocket for whatever care they incur, and trust that the claims system will reimburse them.

As we all know, no one in any part of the healthcare system will ever confirm insurance reimbursement – insurance companies' provider directories have information on which doctors take what plan, but this is almost always paired with a disclaimer that you must call the doctor. Doctors' offices will tell you to confirm with your insurance. The circularity here means that receiving care with the expectation to be reimbursed via the claims process is a financially risky move. Obviously, this prevents people from seeking the care they need during these periods which can be damaging to their health. It also gives insurers a free month of premiums wherein they can count on being paid but not having to pay anything out, constraining the practical, payable policy year to 11 months of service for 12 months of pay.

Once an employee has active coverage with a valid card and number, the problems do not end. Care is denied for arcane reasons and employees are tied up in bureaucracy that is designed to make them give up. I know because staff come to me and my managers for help navigating these issues. When you simply purchase healthcare for yourself, you can sometimes assume that maybe not everyone is mired in whatever bureaucratic problem you find yourself in, like a ridiculous prior authorization requirement. But when you buy it for an entire staff, you see that the problems are systemic.

One employee of mine was attempting to use health insurance for cataract care for a dependent family member. After ping-ponging between the doctor and the insurance company, he was denied. It was considered an elective procedure despite the family member not being able to see. He ended up going completely out of pocket, despite having insurance, and is currently enrolled in a monthly payment plan for the $5,000 surgery.

Please take a stand for patients and policyholders around our state and pass this legislation. Let's make sure that insurance works for us when we need it. And let's make sure that employers and employees are actually getting what they pay for.

Please support HB 1337 and encourage your House colleagues to do the same.

Sincerely,

Aaron Seyedian

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