Speaker 1: Last year, I experienced one of the scariest moments of my life. I was a student in the Masters of Public Health Program at Brown University. After taking a break to watch a Sunday afternoon football game alone in my apartment, I sat down at my desk in an attempt to finish writing a paper. I suddenly noticed little flashes of light in my vision. I drank some water, thinking that I might be dehydrated, and then my lips and fingers started to tingle. I continued typing, but when I looked up, all of the words that I had just typed were spelled wrong. I tried unsuccessfully to send a text message, then called my mom, who thankfully, only lives 30 minutes away and could barely get the words out. I sat on the floor, my heart racing, waiting for help to arrive, and panicking that I might be suffering a stroke.

I spent several anxious hours in the Rhode Island Hospital emergency room, eventually being seen by the attending physician, a third-year medical student, and a neurologist consultant. They all suspected that I had experienced a silent migraine, but the neurologist suggested that I get an MRI to make sure. Since I was dealing with the U.S. healthcare system, I first had to go to my primary care physician, who would then make a referral, so that the MRI would be covered by my health insurance. After meeting with my primary care doctor, I received the referral. The next step was to find a testing center that was part of my preferred provider network. Luckily, there was an Imaging Center at my local hospital, which was part of the preferred network. Later, I got the MRI results back from my primary doctor, who said that everything looked okay, and that it must have been only a migraine. Ironically, that's when the real headache started.

Several months after the migraine incident, I got a bill for close to $2000. The bill was for the MRI that I received at the hospital. I called the hospital to see what was going on, and they told me that I needed to call my health insurance company. When I called the claims agency for my insurance, the agent told me that I had been charged for using an out of network provider, that is, I owed 70% of the total cost of the procedure. I was advised to call the hospital billing department to ask them to re-submit the claim, so that they could check to see if my visit was covered within the provider network. I called the hospital, and the agent said that he would pass the information on to the billing department. Thinking that everything was taking care of, I went about my normal life until I received the exact same bill in the mail.

I spent the next several months on a rollercoaster of communications with the hospital, insurance provider, and the insurer's claims department. Generally, I would call the hospital, and be advised to call the insurance company, who would then tell me to call elsewhere. This pattern would repeat itself over, and over again. There are times now, when I'm hopeful that the issue has been resolved, and then I receive another bill for the original balance. As of this writing, the issue has still not been officially resolved, and I continue to waste time and energy placing phone calls in a roundabout fashion, due to the complex cost and reimbursement model between providers and insurance companies.

This experience has not only tested my patience and caused me stress and anxiety about paying an outrageous bill for something that should've been covered, but it has also given me perspective. I have a better understanding of how confusing and complex the costs reimbursement system in the U.S. can be, and I feel a great deal empathy for anyone who suffers as a consequence of the bewildering morass that exists. I can see how many patients get lost in this system. I will be extremely wary when seeking medical care in the future, and will keep this incident in mind when advising my future patients.