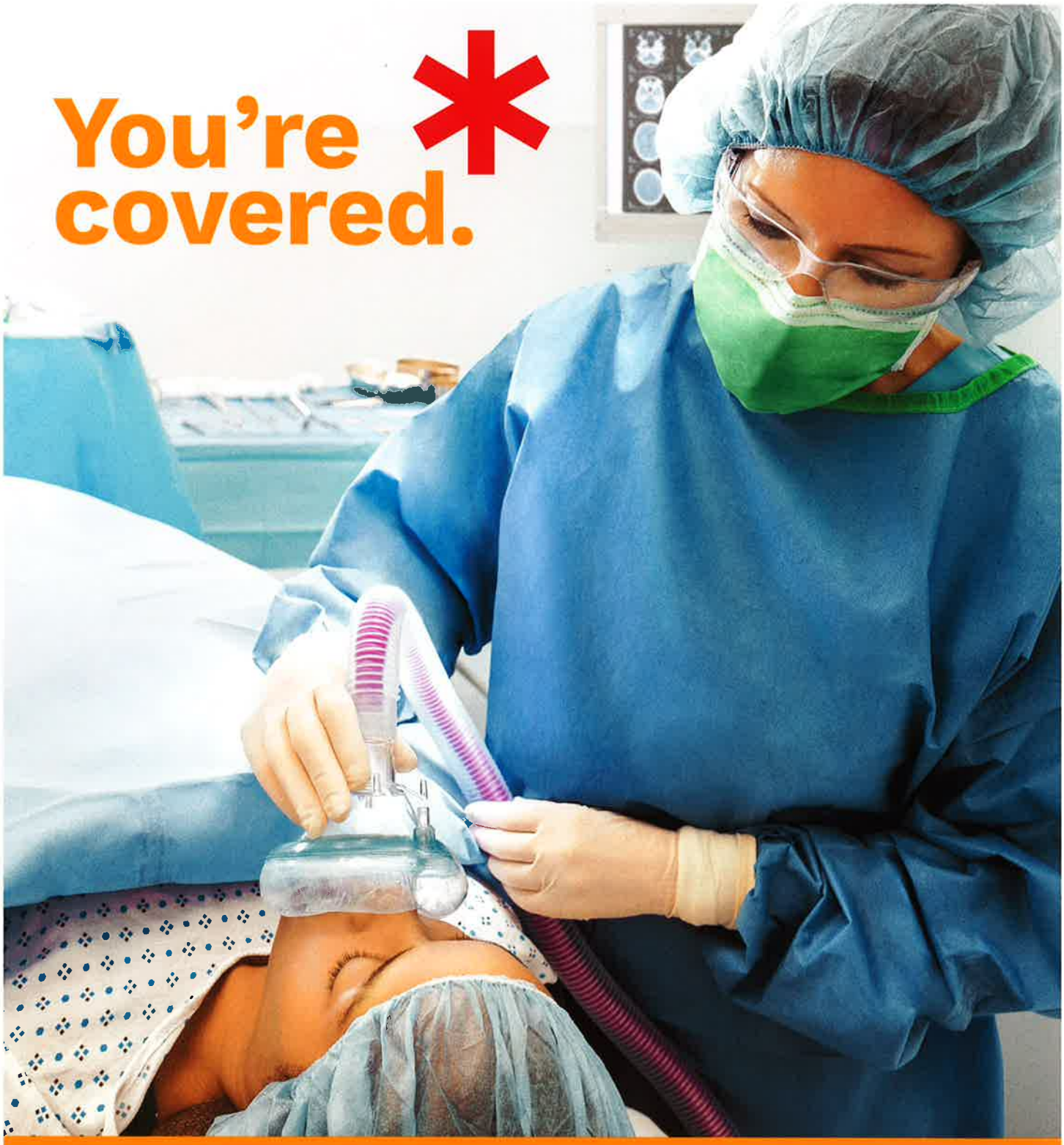
End the surprise insurance gap

Guidelines for Effective Policy Solutions to End The Surprise Insurance Gap

- The patient should be held financially harmless for unexpected Out-Of-Network (OON) care.
- Any patient deductibles and cost-sharing for unexpected OON care should be applied to in-network rates.
- When needed, mediation should occur between the physician and the insurer, taking the patient out of the middle.
- Physicians should be allowed to initiate the mediation process and bundle claims in doing so.
- An appropriate and fair standard should be created for out-of-network services that establishes a charge-based reimbursement schedule (meaning 80th percentile) connected to an independently recognized and verified database.
- Physicians would no longer submit balance bills to patients for services rendered.
- Greater transparency should be required of insurers. Specifically,
    - Network provider directories should be easily accessible for both patients and physicians, updated immediately and completely accurate, and
    - Patients should have access to information on the average charge, reimbursement rate, and expected out-of-pocket costs for any health care service or procedure in all geozips.
- Insurance carriers should be prevented from providing false, misleading and/or confusing information in regards to coverage.

You're covered.*



***Except for** her emergency physician, anesthesiologist and radiologist.

Too many patients face a rude awakening after an emergency room visit: a surprise insurance gap. Insurance companies are forcing doctors out of their networks leaving patients to foot the bill while maximizing their profits.
Learn more at EndTheInsuranceGap.org

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End the Surprise Insurance Gap: PFC Recommends FAIR Health

Physicians for Fair Coverage and the End the Surprise Insurance Gap campaign believe physician reimbursements for out-of-network care should reflect market conditions and should be based on independent and objective market information. In our view, FAIR Health constitutes an excellent and indeed unique source of data for determining such payments. FAIR Health, a data organization established to bring transparency and clarity to health care costs and health insurance information, maintains the largest collection of private insurance claims in the United States. It is **a conflict-free, independent, national not-for-profit** with a Board of Directors comprised of nationally recognized thought leaders. It uses its vast repository of almost 22 billion claims, growing by over one billion new claims annually, to create standard data products, custom analytics and consumer tools available to the entire healthcare sector.

+ FAIR Health:
  + Continually receives claims data from 60 insurers and administrators
  + Captures approximately 75% of the privately insured population
  + Organizes data by procedure codes in 493 geozips nationwide
  + Produces benchmarks for all healthcare services based on 12 months of recent claims data
  + Applies rigorous auditing and validation process to all claims data
  + Is a highly secure, robust claims database and state-of-the-art technology
  + Does not allow data to be manipulated, supplemented or pre-edited
  + Staffed by experts who conduct all operations in-house

+ It is one of only four qualified entity organizations recognized by the Centers for Medicare and Medicaid Services (CMS) and is entitled to receive all of CMS's Parts A, B and D Medicare Data.

+ FAIR Health's consumer website was ranked the "Best Health Care Cost Estimator" on Kiplinger's Personal Finance 2016 Best List.

+ In a 2014 report to CMS comparing data bases to establish payment rates for out-of-network emergency room services, NORC at the University of Chicago concluded that FAIR Health is "...the database best suited to help address CMS' concerns about establishing comprehensive and transparent out of network payment benchmarks."

+ It has broad acceptance throughout the health care industry and its data support studies and solutions for --

  + The lack of transparency regarding the cost for out-of-network services
  + Changing reimbursement models
  + Access issues arising from low number of physicians in narrow health plan networks
  + Surprise billing
  + Reimbursement for medical services including emergency care
  + Fair, practical dispute resolution process

FAIR Health was created as part of a settlement of an investigation of health insurance companies' reimbursement practices arising from consumer complaints that insurers were misrepresenting usual and customary charges for services. When it was determined that all the insurers were

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setting rates based on a database created by Ingenix (now renamed Optum), a wholly-owned subsidiary of the insurer, United Health Group, the parties agreed the arrangement created a conflict of interests. The Attorney General's Office in New York reached a settlement with the insurers to establish a new, independent nonprofit, FAIR Health, to create a fair, independent, and transparent database for use in determining out-of-network payments to providers, support public policy and academic research, and offer consumers a website providing information about healthcare costs and insurance.

State governments, private insurers, physicians and consumers use FAIR Health's data. Fair Health is:

Setting Standards

+ New consumer protection laws passed in New York and Connecticut designate FAIR Health as the official benchmarking database for determining reimbursement for out-of-network emergency services.

Growing Nationally

+ 10 more states have applied, in a variety of ways, the FAIR Health database: AK, AZ, CA, GA, KY, MS, ND, NJ, PA and WI. In addition, the GAO, HHS and CMS and academics at major universities and think tanks have used FAIR Health data for research.

Conflict-free

+ Unlike FAIR Health, two major corporations promoted as data resources for healthcare costs were created and funded by insurance companies, making them neither conflict-free, nor independent. Optum360/Ingenix is a wholly owned, for-profit subsidiary of UnitedHealth Group, while the Health Care Cost Institute (HCCI) was created and is funded by UnitedHealth Group, Aetna, Humana and Kaiser Permanente.

When physician reimbursements for emergency out-of-network care align with FAIR Health, patients' are protected and transparency and clarity to health care costs and health insurance information is ensured. Things to consider:

+ Commercial insurance payments should be sufficient to offset losses for treating uninsured and underinsured patients, as well as patients covered by governmental programs such as Medicaid and Medicare.
+ An adequate amount of reimbursements are needed to recruit hospital-based physicians and on-call specialists.
+ Insufficient payments – like those tied to a low percentage of Medicare rates -could force providers to leave the state or close their practices.
+ Inadequate payments could also lead to reduced access to care and endanger the health care safety net.
+ There is tremendous variation in payments (non-contracted or contracted) as a percentage of Medicare between specialties. The difference can be more than 4-fold. Using a percentage of Medicare may be above or below market rate depending on the specialty.
+ Medicare has not kept up with inflation. In 2012, the American Medical Association noted there was a 20% gap between what Medicare pays and what it actually costs physicians to treat patients.
+ Requiring hospital-based physicians to contract with health plans that are contracted with the hospital could lead to coercive contracting.

End the surprise insurance gap

Even if you have health insurance and go to an in-network hospital, you can still get surprise bills. Insurance companies are narrowing their networks and leaving patients to foot the bill. Join physicians around the country to close the insurance gap for emergency care.

Learn more and share your story at **EndTheInsuranceGap.org**

This campaign is led by
Physicians for Fair Coverage.
thePFC.org | **info@thepfc.org**

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You're covered*

***Sometimes.**
Is your insurance company hiding behind an asterisk? Get the full story.

Have you ever been surprised that your **health plan didn't cover all of your emergency care bills?**

Here's the full story and what it means for you

Insurance companies are forcing emergency department doctors, radiologists, anesthesiologists and other physicians from their coverage networks – leaving patients to foot the bill.

If a patient has a medical emergency and goes to an in-network hospital, they may still receive care from an out-of-network physician. Through no fault of their own or the physician's, they're getting less coverage and more bills their insurance company should be covering.

Patients and physicians are working together to end the coverage gap

End the Surprise Insurance Gap is a campaign led by Physicians for Fair Coverage (PFC) in partnership with coalitions of patients and doctors across the country. Together, they are advocating to improve patient protections, promote transparency and increase access to care by working to pass laws that stop insurance companies from shifting costs to patients and physicians, ensuring access to care when it's needed most.

Guidelines for effective policy solutions to End the Surprise Insurance Gap:

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- An appropriate and fair standard should be created for OON services that establishes a charge-based reimbursement schedule (meaning 80th percentile) connected to an independently recognized and verified database. In doing so, balance billing would be eliminated for unexpected OON care, taking the patient out of the middle.
- When needed, mediation should occur between the physician and the insurer, taking the patient out of the middle of the dispute.
- Physicians should be allowed to initiate the mediation process and bundle claims in doing so.
- Greater transparency should be required of insurers. Specifically,
  - Network provider directories should be easily accessible for both patients and physicians, updated immediately and completely accurate, and
  - Patients should be provided with information on accessing consumer engagement tools that highlight average charges, reimbursement rates, and cost sharing for health care services.
- Insurance carriers should be prevented from providing false, misleading and/or confusing information.

Join Us!

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Who We Are

Physicians for Fair Coverage (PFC) is a national multi-specialty alliance of doctors, who are advocating to improve patient protections, promote transparency and increase access to care by making sure insurance companies pay what they owe.

We are comprised of tens of thousands of emergency physicians, anesthesiologists and radiologists nationwide who annually serve tens of millions of patients.

What is the Surprise Insurance Gap?

Insurance companies are forcing emergency room doctors, radiologists and anesthesiologists out of their networks, raking in record profits and leaving patients to foot the bill.

End the Surprise Insurance Gap, a campaign led by PFC, in partnership with coalitions of patients and physicians across the country, has a legislative solution to stop insurance companies from shifting costs off their books and onto patients and their doctors.

Learn more at **EndTheInsuranceGap.org** and join us! We will only succeed at ending the surprise insurance gap if we build an active movement nationwide. Add your voice to help create fair healthcare coverage and better protections for patients and physicians everywhere.