American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

FAIR COVERAGE TALKING POINTS

PR Recommendation: Use the term "health insurance company" instead of "health plan" — to convey a less-positive, corporate image.

- **Health insurance companies mislead patients by offering "affordable" premiums for policies that actually cover very little.**

  —They shift costs onto patients and medical providers, while enriching themselves.

  —They exploit federal law to reduce payments for emergency care. They know that hospital emergency departments have a federal mandate to care for all patients, regardless of ability to pay (EMTALA).

  —Too often what patients perceive as "surprise" bills are simply the high deductibles that come along with low-priced premiums.

- **Patients can't choose where and when they will need emergency care and should not be punished financially for having emergencies.**

  —Cost shifting harms patients. Seven in 10 emergency physicians saw patients with health insurance who had delayed medical care because of high out-of-pocket expenses, deductibles and co-insurance. [i]

  —Insurance companies are creating narrow networks to save money, making it more likely that patients will be out-of-network.

  —Insurance companies are forcing physicians out of network by reducing reimbursements to the point they do not cover costs. The vast majority of emergency physicians and their groups prefer to be "in network."

- **Health insurance companies have created this situation and are not acting in good faith.**

  —Balance billing would not exist if health insurance companies paid what is known as "usual and customary" in the insurance industry and what's known as "fair" payment to everyone.

  —When insurance companies do not pay fairly, physicians are forced to bill patients for the unpaid "balances" (similar to how a dentist bills). The solution is to require fair payment from health plans.

  —Physicians are forced to drop out of health plan networks when plan reimbursements do not cover the costs of providing services.

- **Insurance companies must provide FAIR coverage for emergency patients.**

  —Payments for emergency visits must be based on reasonable charges (usual and customary), rather than setting arbitrary rates that don't even cover costs of care.

  —Health plans have a history of data manipulation and not paying for emergency care. United Healthcare fraudulently calculated and significantly underpaid doctors for out-of-network medical services (using Ingenix database — *is it a coincidence that the CEO of Ingenix is the current, acting head of CMS Andy Slavitt?*). New York sued for "rigged" reimbursement rates that forced patients to overpay up to 30 percent for out-of-network doctors. The company paid the largest settlement to the state of New York and the American Medical Association. Part of the settlement created the Fair Health database.

  —The Fair Health database is the best mechanism available to ensure transparency and to make sure insurance companies don't miscalculate payments.[ii]

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- **Just because you have health insurance coverage does not mean you have access to medical care.**

  —When health insurance companies shrink the number of doctors available in plans, patients are forced into out-of-network situations.

  —By reimbursing at ridiculously low rates, health insurance companies are driving doctors out-of-network and raising costs for patients without providing adequate coverage for their customers (a/k/a the patients).

  —More than 80 percent of emergency physicians responding to a poll[iii] said they treated patients who couldn't find medical specialists to care for them, because health plans had limited the number of medical providers available to them.

- **State and federal policymakers need to ensure that health plans provide fair payment for emergency services or emergency patients will suffer.**

  —States that seek to ban balance billing without ensuring fair coverage of emergency care will create huge benefits for health insurance companies while endangering patients and the medical safety net.

- **Patients and physicians must work together to combat these harmful practices by health insurance companies.** (contact Congress)

- **The last straw: A federal regulation by CMS now allows health insurance companies to pay doctors in emergency departments essentially whatever they want in out-of-network situations, opening the door to reimbursements that do not even cover the costs of care.**

  — This regulation represents a total failure to implement the "patient protections" that were promised in the Patient Protection and Affordable Care Act. It is a clear victory for health insurers at the expense of patients and physicians.

  — The health insurance industry no longer has any incentive to negotiate fairly.

  —This regulation benefits insurance companies at the expense of patients.

  —ACEP advocated for an objective standard in which benefits would be transparently determined, enforceable, reasonable, and market driven.

  —ACEP submitted claims evidence, showing how insurers were shifting hundreds of millions of dollars in out-of-pocket expenses onto patients. The evidence shows how insurance companies would use their own proprietary data to reduce payments to physicians and to shift financial liability to beneficiaries.

  —ACEP was astonished at the ruling, given the organization had been working with CMS for 5 years to resolve out-of-network issues and had no indication this would happen.

  —ACEP is considering legal action, because the regulation represents the greatest threat to the financial viability of the emergency care safety net and patient access to qualified emergency care that has EVER been proposed by federal regulations.

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[i] ACEP poll, 2015.
[ii] http://www.fairhealth.org/
[iii] ACEP poll. 2015.