PFC
PHYSICIANS FOR FAIR COVERAGE

TALKING POINTS
On
FAIR Health

- FAIR Health is a National Data Repository established to bring clarity to healthcare costs and health insurance information.
- It is **a conflict-free, independent, national not-for-profit** with a Board of Directors comprised of nationally recognized thought leaders, including Charles Bell of Consumers Union.
- FAIR Health:
  - ✓ Continually receives data from 60 payors
  - ✓ Undergoes rigorous auditing and validation
  - ✓ Is a highly secure, robust claims database
  - ✓ Organizes data by procedure code and geozip
  - ✓ Captures approximately 75% of the privately insured population
- As one of only 4 Qualified Entity organizations eligible for nationwide data, FAIR Health is entitled to receive all of CMS's Parts A, B and D Medicare Data.
- Data cannot be manipulated, supplemented or pre-edited.
- Kiplinger's Personal Finance ranked FAIR Health as the "Best Health Care Cost Estimator" on its' 2016 Best List.
- It has broad acceptance in the industry and addresses:
  1. The lack of transparency regarding out-of-network services
  2. Changing reimbursement models
  3. Adequacy of provider networks
  4. Surprise bills
  5. Reimbursement for emergency services
  6. Fair, practical dispute resolution process
- A new **consumer protection law** recently passed in Connecticut designated FAIR Health as the official benchmarking database for determining reimbursement for out-of-network emergency services.
- 11 more states have applied the FAIR Health database in a variety of ways: AK, AZ, CA, GA, KY, MS, ND, NJ, NY, PA, WI
- Both major alternative databases/research corporations were created and funded *by insurance companies*, making them neither conflict-free, nor independent. Optum360/Ingenix is a platform of UnitedHealth Group, while

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the Health Care Cost Institute (HCCI) was created and funded by UnitedHealth Group, Aetna, Humana, and Kaiser Permanente.

Additional Considerations When Advocating for FAIR Health:

- Commercial insurance payments should be sufficient to offset losses for treating uninsured and underinsured patients.
- Adequate reimbursements are needed to recruit and staff hospital-based physicians and on-call specialties.
- 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 healthcare 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. In a 2007 report to Congress, the General Accounting Office found that Medicare payments for a set of seven anesthesia services were 67 percent lower than average private insurance payments in 41 geographic areas. This disparity has only grown over the years.
- When factoring in the amount of time spent on call, as well as the expense to train a physician, per hour physicians are paid less than teachers: http://www.bestmedicaldegrees.com/salary-of-doctors/
- Requiring hospital-based physicians to contract with health plans that are contracted with the hospital could lead to coercive contracting.