

Patients increasingly are facing higher premiums for health insurance but getting less coverage. They are paying more out-of-pocket costs and have higher deductibles and co-insurance. Health insurance companies are offering plans with low premiums, and people are not aware of how little coverage they actually have. Nearly all emergency physicians across the country responding to a recent poll (96 percent) said that patients don't understand what their policies cover. What's more, 8 in 10 emergency physicians said they are seeing patients with health insurance who had delayed medical care because of high out-of-pocket expenses, deductibles and co-insurance. (This is more than a 10-percent increase over 6 months ago when emergency physicians were asked the same question.) To learn more about how insurance companies are squeezing emergency patients, go to www.FairCoverage.org.

- **Health insurance companies are misleading patients by offering “affordable” premiums for policies that cover very little.**

- No insurance plan is affordable if it abandons you in an emergency.
 - *Nine in 10 emergency physicians polled say health insurance companies mislead patients by offering “affordable” premiums for policies that cover very little.¹*
- Insurance companies shift the costs of medical care onto patients and medical providers, while enriching themselves.
 - *Nearly 80 percent of emergency physicians polled with knowledge of reimbursement issues said that insurance companies have reduced the amount they reimburse for emergency care.*

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

- Insurance companies 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).
- In a medical emergency, many insurance companies do better jobs of protecting themselves than protecting you.

- **Each day, emergency physicians see patients who have paid significant co-pays, up to \$400 or more, for emergency care.**

- For many, it's too much of a financial burden and we'll deter them from seeking emergency care.
 - *Nearly two-thirds (61 percent) say most health insurance companies provide less than adequate coverage for emergency care visits to their customers.*

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

- Insurance companies are creating narrow networks to save money, making it more likely that patients will see out-of-network doctors and be responsible for additional costs.
- 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.”
 - *More than 60 percent of emergency physicians polled had difficulty in the past year finding in-network specialists to care for patients with a quarter of them saying it happens daily.*

- **Health insurance companies have created this situation. Balance billing would not exist if insurance companies paid what is considered reasonable in the insurance industry and what's known to everyone as “fair” payment.**

- When insurance companies do not pay fairly, physicians must choose between billing patients for the difference or going unpaid for their services (similar to how a dentist bills). The solution is to return responsibility for those bills back to insurance companies where they belong.
- When insurance reimbursements do not cover the costs of providing services, physicians drop out of networks.
- **Insurance companies must be transparent about how they calculate payments and provide FAIR coverage for emergency patients.**
 - Payments for emergency visits must be based on a reasonable portion/percentage of charges, rather than arbitrary rates that don't even cover costs of care.
 - Health plans have a long history of not paying for emergency care. United Healthcare was successfully sued by the State of New York for fraudulently calculating and significantly underpaying doctors for out-of-network medical services (using Ingenix database — NOTE: the former CEO of Ingenix is the current, acting head of CMS — Andy Slavitt). The formula they used 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.
 - *79 percent of emergency physicians say the Fair Health database is the best mechanism available to ensure transparency and to make sure insurance companies don't miscalculate payments. (www.fairhealth.org)*
- **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 your state legislators.)
- **A federal regulation by CMS does not require health insurance companies to use a fair and transparent database, such as Fair Health to calculate in out-of-network payments, opening the door to reimbursements that do not even cover the costs of care.**
 - This regulation represents a failure to implement the “patient protections” 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.
 - *91 percent of emergency physicians polled say this new CMS rule will make finding specialists and follow up care for patients more difficult.*

ⁱ An emergency physician survey was conducted online in the United States by Marketing General Incorporated on behalf of the American College of Emergency Physicians between April 4-11, 2016, among 1,924 emergency physicians, providing a response rate of 7 percent and a margin of error of 2.2 percent.