FAIR Health®
Know Your Source

shc.exhibits@oregonlegislature.gov

February 7, 2017

Senator Laurie Monnes Anderson, Chair
Senator Jeff Kruse, Vice Chair
Oregon Senate
Committee on Health Care
Salem, Oregon

RE: Committee on Health Care – Hearing on February 9, 2017

Members of the Committee:

On behalf of FAIR Health, Inc., I am providing a slide presentation and a statement for the record for the Committee's hearing scheduled for February 9, 2017. A one-page summary of the statement also is provided.

FAIR Health is a national, independent nonprofit committed to transparency in healthcare costs and insurance and unaffiliated with any insurer or other stakeholder in the healthcare sector. Our organization owns the largest private insurance claims database in the country, a growing collection of more than 22 billion claims, including more than 134 million Oregon records. A CMS-designated Qualified Entity, FAIR Health also holds a substantial volume of Medicare claims data. As a tax-exempt charity, FAIR Health does not lobby and we are not taking a position on issues pertaining to the proposed law. However, because of our work, experience and data resources, we believe that it is consistent with our mission to provide this statement to the Committee.

FAIR Health has extensive experience dealing with healthcare data and consumer protection in healthcare and insurance. We have been consulted about many governmental and private programs involving different types of payment systems, including providers' market charges, insurers' allowed amounts and Medicare rates. Accordingly, we believe that our information and experience may help inform the Committee's deliberations on the pending legislation.

Thank you for your consideration.

Sincerely,

Michelle P. Scott
General Counsel

Enclosures

Overview of FAIR Health

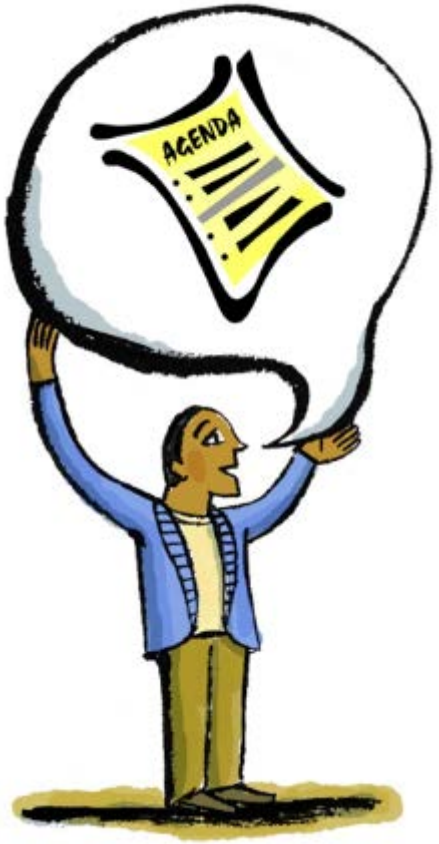
FAIR Health®
Know Your Source

February 9, 2017

530 Fifth Avenue, 18th Floor, New York, NY 10036
fairhealth.org • fairhealthconsumer.org • consumidor.fairhealth.org

Agenda

- FAIR Health Mission
- Governing Body
- Data Assets
- Role in the Marketplace
- State Applications of FAIR Health Data
- Policy Making and Research
- Consumer Engagement Tools



FAIR Health Mission

- **MISSION:** to bring clarity to healthcare costs and health insurance information
- **ACTION:** fulfills mission with robust data products, award-winning consumer tools and research platform
- **ORIGINS:** established as conflict-free, independent, national not-for-profit
- **IMPACT:** widespread impact on diverse stakeholder groups, including state leaders

FAIR Health Board of Directors

Nationally Recognized Thought Leaders

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Ropes & Gray, LLP

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Nixon & Peabody, LLP

Nancy Nielsen
State University of New York at Buffalo

Sara Rosenbaum
George Washington University

John W. Rowe
Columbia University

The FAIR Health National Data Repository Today

>22B

Procedures from 2002 to the Present from Medical and Dental Claims

>150M

Covered Lives

493

Geozip Regions Reflecting Local Billing Patterns

- **Coverage**
  - All 50 states
  - District of Columbia
  - Puerto Rico
  - Guam
  - US Virgin Islands
- **60 Contributors**
  - National and regional payors
  - Third-party administrators
- **Private insurance claims**
  - Fully-insured and self-insured/ERISA plans
  - Cover 75% of privately insured US population
- **Quality testing and control**
  - Data validated with expert-vetted tests for completeness, volume, accuracy, etc.
  - Recognized statistical “outlier” methodologies identify and exclude excessively high and low charges that would distort distribution of charges

The FAIR Health Repository: Oregon

133,513,552

Records 2002 - Present

25,940,504

Records 2015

50

Number of Contributors 2014-2016

26

Above > 10K Records

Data Auditing and Validation Tools

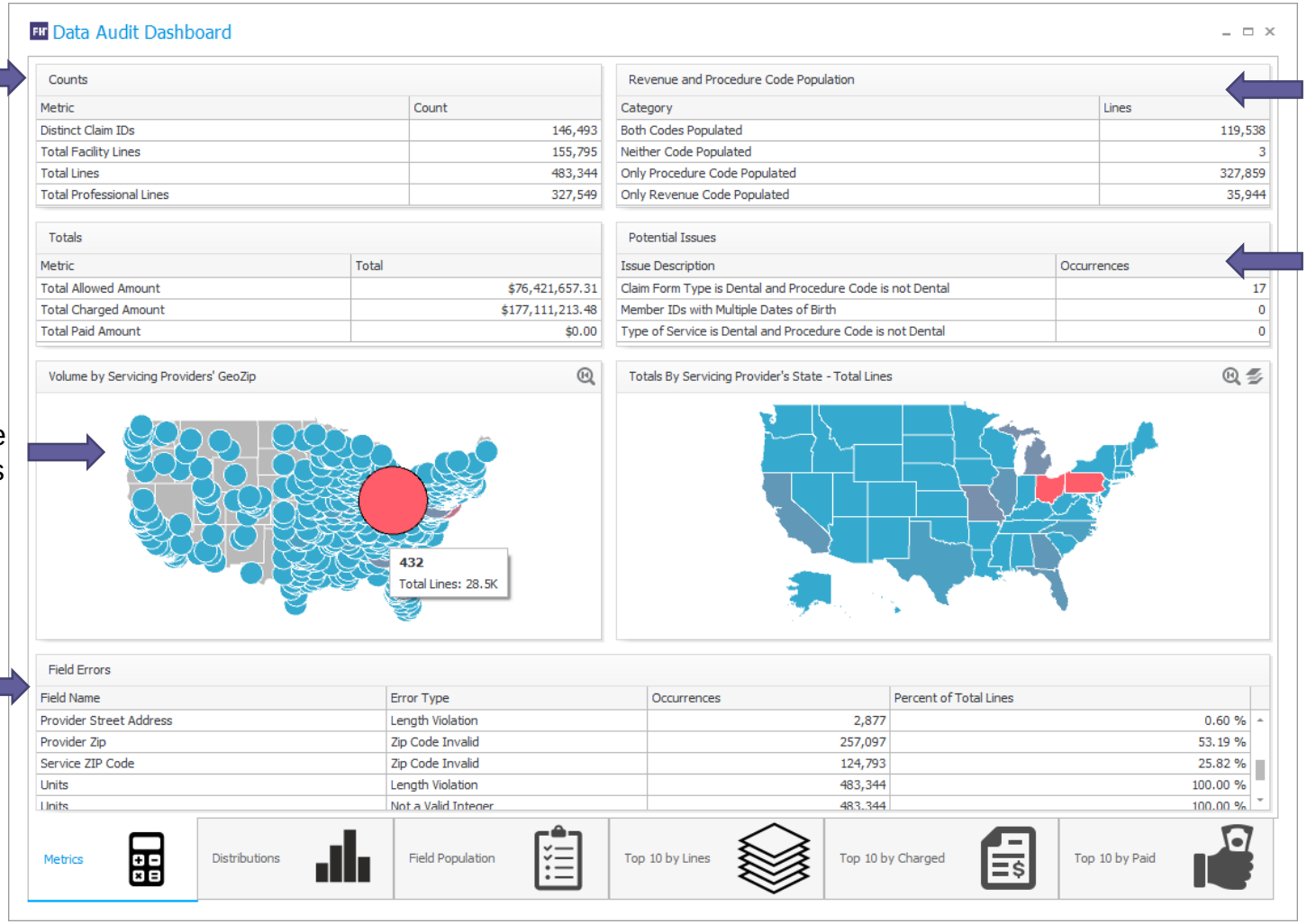
Basic Claim Metrics

Data Population Statistics

Potential Claim Issues

Geozip and State Maps of Services

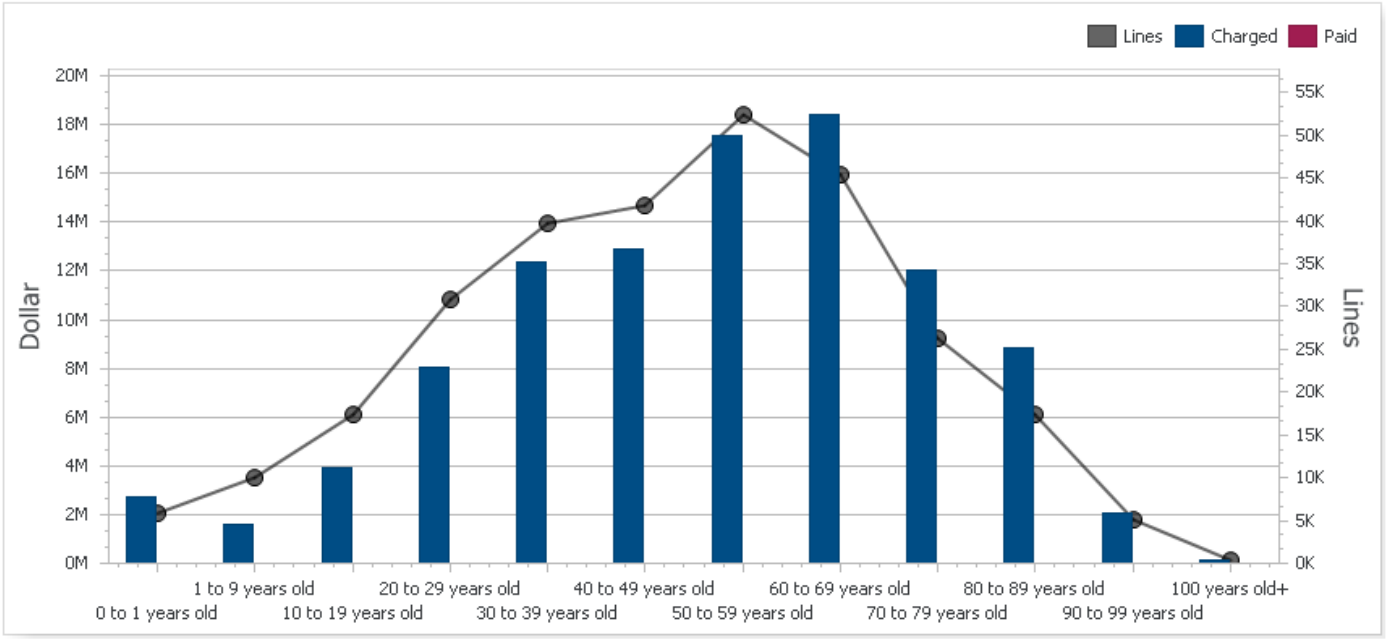
Data Error Information



Data Auditing and Validation Tools

Distribution of Data

- Bill Type
- Charged Amount
- Date of Service From
- Date of Service To
- Gender
- High Level Procedure ...
- Line Diagnosis Code 1
- Line Of Business
- **Member DOB**
- Middle Level Procedur...
- Paid Amount
- Paid Date
- Place of Service
- Procedure Code Modif...
- Procedure Code Modif...
- Provider Specialty
- Servicing Provider Loc...
- Type of Service



Value	Description	Lines	% of Total Lines	Charged	% of Total Charged	Paid	% of Total Paid
0 to 1 years old		5,868	2.00 %	$2,735,567.82	2.72 %	$0.00	0.00 %
1 to 9 years old		10,086	3.45 %	$1,575,062.97	1.57 %	$0.00	0.00 %
10 to 19 years old		17,385	5.94 %	$3,936,500.99	3.92 %	$0.00	0.00 %
20 to 29 years old		30,847	10.54 %	$8,035,436.68	7.99 %	$0.00	0.00 %
30 to 39 years old		39,694	13.56 %	$12,352,543.02	12.29 %	$0.00	0.00 %
40 to 49 years old		41,773	14.27 %	$12,879,409.08	12.81 %	$0.00	0.00 %
50 to 59 years old		52,476	17.93 %	$17,550,659.15	17.46 %	$0.00	0.00 %
60 to 69 years old		45,512	15.55 %	$18,431,522.24	18.34 %	$0.00	0.00 %
70 to 79 years old		26,355	9.00 %	$12,019,141.48	11.96 %	$0.00	0.00 %

FAIR Health: Certified CMS Qualified Entity

- One of only four organizations across the country entitled to receive Parts A, B and D Medicare Data for all 50 states
- Issue probing reports on key aspects of healthcare industry/provider performance
- Powerful synergies between our private claims data and Medicare collection of claims

Stakeholders We Serve

- Government
- Researchers/Universities
- Payors
- Employers
- Healthcare Systems/Facilities
- Healthcare Professionals
- Bill Review Companies
- Consumers
- Unions
- TPAs
- Auto Liability
- Benefits Planners
- Consultants
- Pharma
- Actuaries
- Brokers
- DME Companies
- Think Tanks
- Investment Analysts
- Litigation Support
- Medical Societies
- Trade Associations
- Workers' Compensation
- Institutes/Foundations
- Healthcare Information Technology (HIT)

Applied Uses of FAIR Health Data

Management & Operational Support

- Plan, Benefit and Provider Network Design
- HR/Benefits Administration
- Premium Rate Review
- ACO/Bundled Payment Modeling
- Support Public/Private Exchanges
- Management of CDHPs/HSAs
- Value “Add-Ons” for Plan Members
- Strategic Planning
- Market Research

Fee Schedules & Reimbursement

- Medicaid Reform
- In-/Out-of-Network Provider Fee Schedules
- Balance Billing Negotiations with Providers
- Dispute Resolution
- Reference Pricing
- Auto Liability Fee Schedules
- Workers’ Compensation Fee Schedules
- Medicare Gap Fill

Public Health & Consumer Engagement

- Consumer Transparency Tools
- Educational Materials
- Public Health/Education Campaigns
- Support Open Enrollment
- Advocacy Materials
- Syndromic Surveillance
- Design Interventions

Policy & Research

- Health Economics and Policy Research
- Evaluate Legislative and Regulatory Action
- Analyze Health and Cost Disparities
- Statutory Benchmark for State Programs
- Epidemiologic Heat Maps
- Study Treatment Protocols

State Applications

State	Purpose
Alaska	• Workers' compensation fee schedule • Out-of-network claims pricing under the state health insurance plan
Arizona	• Dental claims reimbursement for disabled pediatric patients
California	• Emergency care for low-income patients
Connecticut	• FAIR Health 80th percentile benchmark designated as UCR for emergency services
Georgia	• Worked with the state to update and distribute their workers' compensation fee schedule
Kentucky	• Data support workers' compensation fee schedule
Mississippi	• "Usual and customary" charges under workers' compensation fee schedule are based on the FAIR Health 40th percentile

State	Purpose
New Jersey	• Authorized personal injury protection (auto liability) reimbursement standard • Department of Banking Insurance recognizes FAIR Health as consumer information source
New York	• Medical indemnity fund for birth-related neurological impairments • Benchmark for consumer cost transparency and dispute resolution
North Dakota	• Data used to inform the state's workers' compensation fee schedule
Pennsylvania	• "Usual and customary" standard in the workers' compensation program is based on the FAIR Health 85th percentile
Wisconsin	• Certified for use for workers' compensation fees

New York Statute: Role of FAIR Health

Issues Addressed:

- Lack of transparency regarding out-of-network services
- Changing reimbursement models
- Adequacy of provider networks
- Surprise bills
- Reimbursement for emergency services
- Fair, practical dispute resolution process

Codified Definition: NY Usual and Customary Cost (UCC)

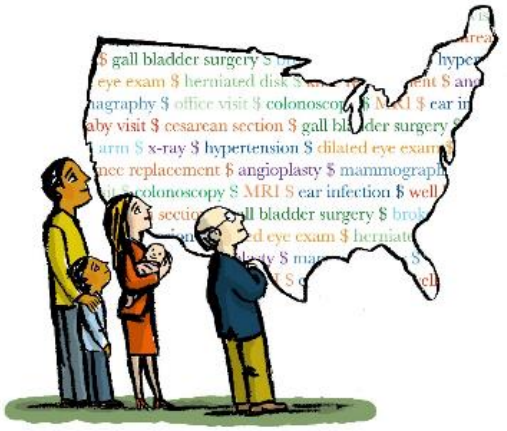
- 80th percentile of charges for a particular service in a particular geographic area
- As reported in a benchmarking database maintained by a conflict-free not-for-profit organization not affiliated with an insurer or similar organization
- Plans are not required to reimburse at 80th percentile level but must articulate how they reimburse in comparison to UCC
  - Supports “apples to apples comparisons”
  - Supports dispute resolution
- *FAIR Health is the **only** data source officially recognized as UCC*

Connecticut Consumer Protection Statute

Connecticut: FAIR Health 80th percentile is the UCR standard for payments for out-of-network emergency services.

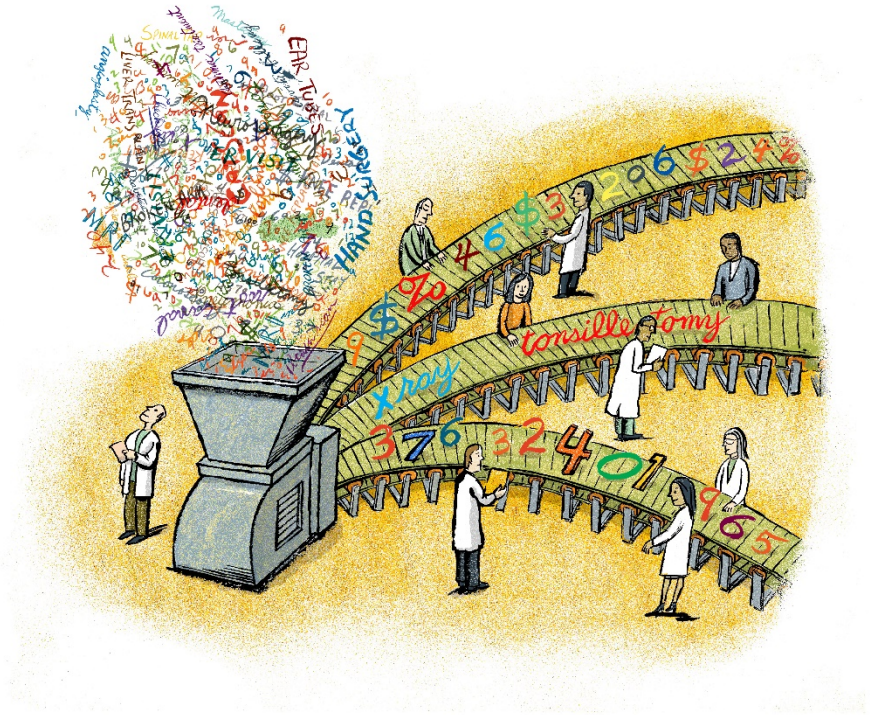
Consumer Protection Laws around the Country

- Numerous stakeholders in a variety of states considering legislation featuring FAIR Health
- FAIR Health conducts webinars and telephone conferences and presents material responsive to requests to advance analysis of legislative initiatives
  - Emphasize our:
    - Neutrality
    - Independence from all healthcare stakeholders
    - Data auditing and validation techniques
    - Breadth of data
    - Versatility of data



Suite of Data Products

FAIR Health Data Products
FH NPIC® Database
Medical/Surgical
Allowed Medical
Dental
Inpatient Facility
Outpatient Facility
Anesthesia
HCPCS *Healthcare Common Procedure Coding System*
Ambulatory Surgery Center
Medicare GapFill PLUS™
FH Fee Estimator®
Episode of Care Platform
Custom Data Analytics
Interactive Data Dashboards
Data Visualizations



Range of Benchmarks: Percentiles

- Data are arrayed by percentiles
- A percentile illustrates where a value falls in the distribution of values in the database
  - 80th percentile: represents the benchmark for charges at the point that 80% of standardized data are equal to or less than the benchmark value (and 20% are higher)
  - Standard products include percentiles from 50th to 95th
  - Percentiles from 5th to 50th also available

Description	Frequency	Mean (Avg.)	Mode	Percentiles							
				50	60	70	75	80	85	90	95
Office Outpatient Visit – 15 minutes	358,784	$96	$100	$93	$100	$103	$104	$108	$114	$120	$136

Usual, Customary and Reasonable (UCR) Charges

FAIR Health does not set UCR

- Commonly called: UCR, R&C, U&C, U&P, C&P and R&N
- In the past, these terms were applied to identify any data used to process claims
- UCR currently determined by:
  - Insurance policy language
  - Payor guidelines
  - State laws and regulations
  - Federal agencies and laws

Selected Uses for Policy and Research

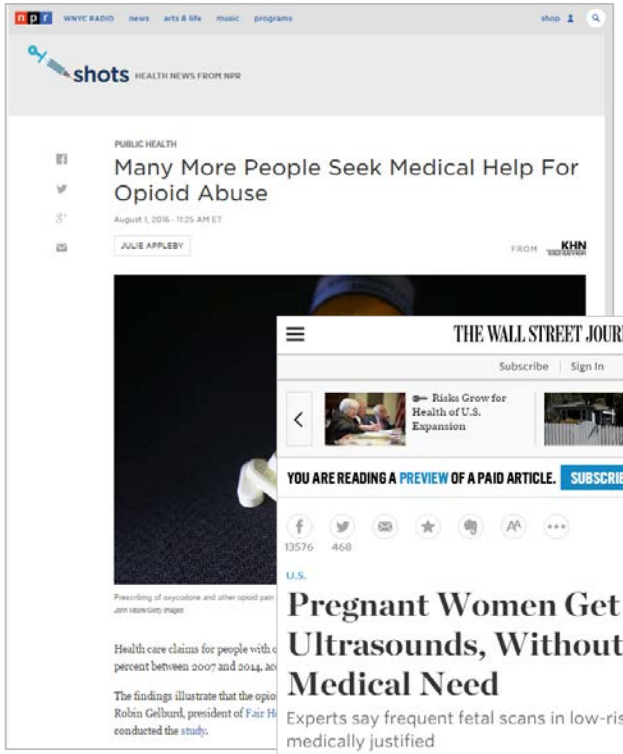
- Transparent, local market benchmarks for out-of-network or non-covered supplies and services
- Validated, robust charge and utilization data for estimating costs or savings related to legislative proposals, research hypotheses and other needs
- Evaluation of policy interventions (e.g., use of a newly covered service, pre- and post-implementation)
- Heat mapping of disease outbreaks, utilization trends and more
- Assessment of impact of the ACA
- Review of geographic variation in utilization and charges
- Development of wide variety of healthcare market indices

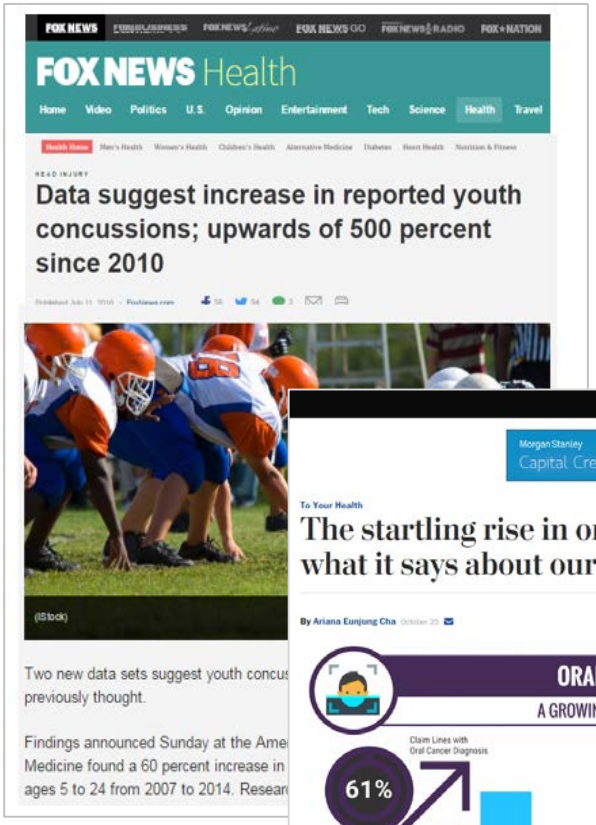
FAIR Health and CMS: A Comparison

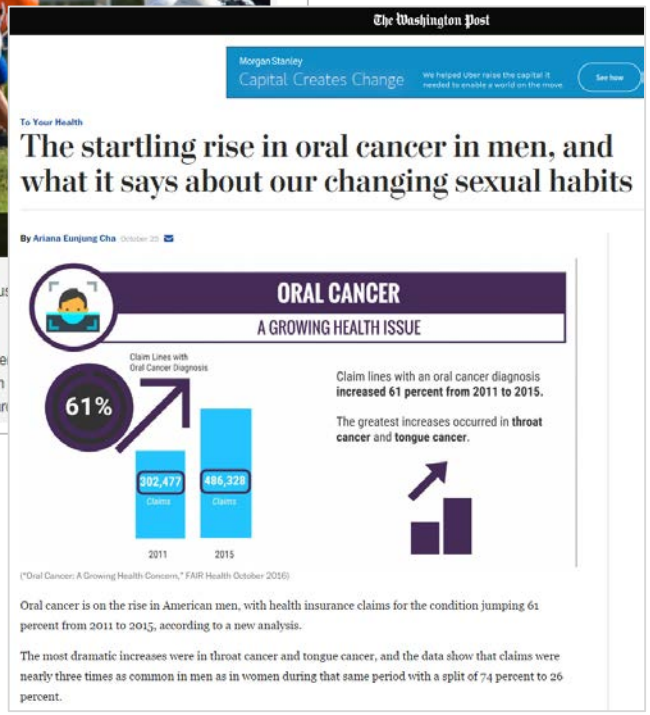
Category	FAIR Health Data	Medicare Fee Schedule
Geography	Most benchmarks are organized into 5 geozips in Oregon	2 GPCIs in Oregon
Methodology	• High frequency procedures: based on actual charges • Low frequency procedures: statistically derived based on relative values and actual charges in same market for related procedures	• Relative values and conversion factors set by committee • Geographical adjustments for GPCI areas • Some procedures omitted as not relevant to covered population
Relationship to Market	Mirrors the healthcare market	Fees adjusted to meet national budget and policy objectives

Broad Acceptance in the Industry

National Coverage







Local Coverage: Oregon

FOX 12 OREGON

Jan 13, 2017

Type 2 Diabetes, Often Referred to as Adult-Onset Diabetes, Shows Marked Increase in Pediatric Population

Private health insurance claim lines with a type 2 diabetes diagnosis more than doubled in the pediatric population (ages 0 to 22 years) from 2011 to 2015, increasing 109 percent, according to data from FAIR Health, a national, independent, nonprofit organization dedicated to bringing transparency to healthcare costs and health insurance information. This finding, reported in the new FAIR Health white paper, *Obesity and Type 2 Diabetes as Documented in Private Claims Data: Spotlight on This Growing Issue among the Nation's Youth*, runs counter to the common appellation of "adult-onset diabetes" for type 2 diabetes.

The Bulletin
Serving Central Oregon since 1903

Sep 15, 2016

Opioid treatment costs rose more than 1,300 percent over 4 years

The Fair Health study found a sharp difference in how much insurers spend on individual patients with such a diagnosis.

On average, insurers spend $3,435 a year on an individual patient, but for those with an opioid dependence or abuse diagnosis, that amount jumps to $19,333. Those numbers reflect what insurers actually paid. The report also includes data on what providers charged, amounts that are lowered by their contracts with insurers.

Aug 1, 2016

Herald and News
empowering the community

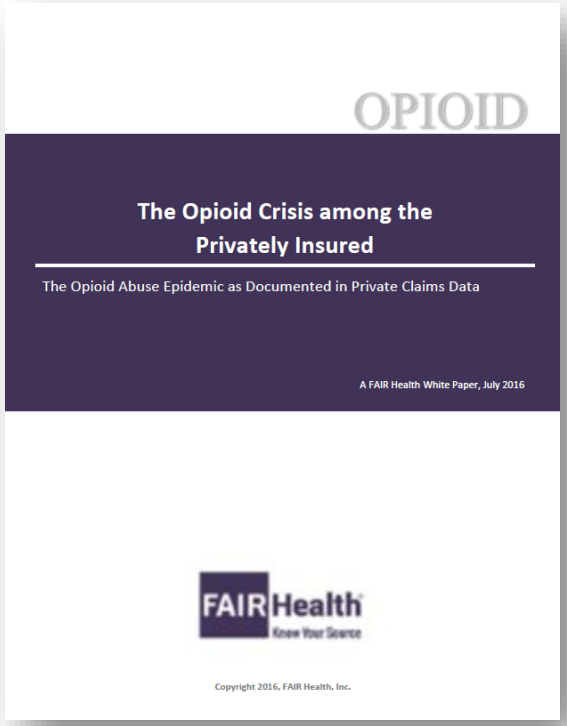
Opioid Dependence Leads To 'Tsunami' Of Medical Services, Study Finds

The scope of the increase found by Fair Health stunned even those already familiar with the problem.

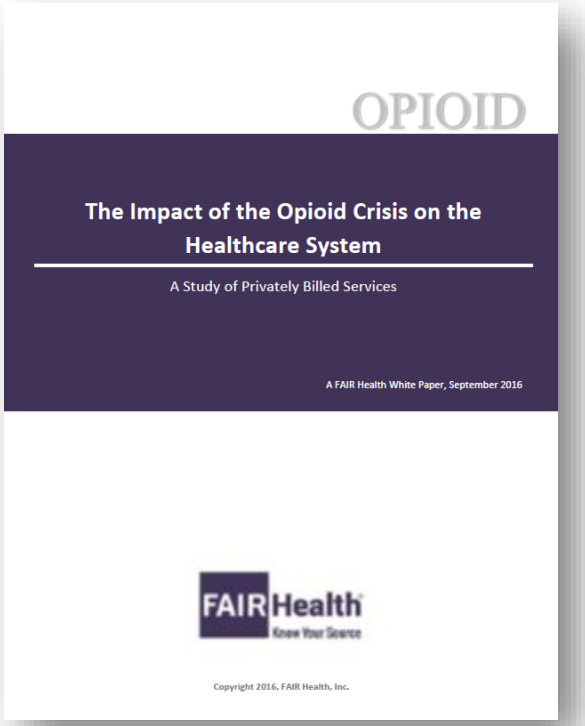
"A 3,000 percent increase is enormous," said Andrew Kolodny, senior scientist at the Heller School for Social Policy and Management at Brandeis University. He did not work on the study.

FAIR Health Analytic Reports

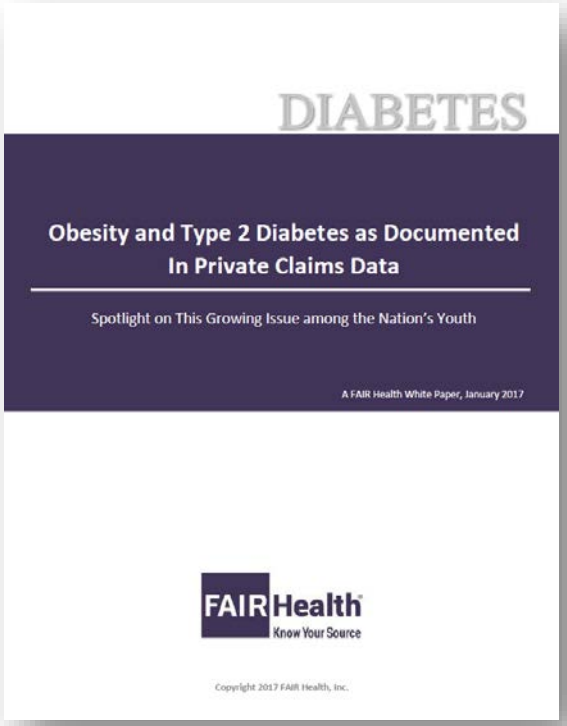
July 2016



September 2016



January 2017



Sampling of Publications

United States Government Accountability Office

GAO

Report to Congressional Requesters

September 2011

HEALTH CARE PRICE TRANSPARENCY

Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care

U.S. Government Accountability Office

GAO 90 YEARS 1921-2011

ACCOUNTABILITY • INTEGRITY • RELIABILITY

GAO-11-791

Urgent Care Facilities: Geographic Variation in Utilization and Charges for Common Lab Tests, Office Visits, and Flu Vaccines

JEFF DANG, PhD, ERIC OKUROWSKI, MBA, ROBIN GELBURD, JD, LORRAINE LIMPAHAN, BA, AND NICOLE INY, MPH

ABSTRACT — The rapid growth of urgent care facilities (UCFs) and other types of convenient care centers has largely been attributed to increasing consumer demand for more convenient and affordable healthcare. UCFs typically treat non-emergency, acute conditions and are increasingly serving as an alternative to "traditional" care settings, such as physician offices and emergency departments (EDs). A study was conducted to characterize geographic variation in both utilization and charges for common lab tests, office visits, and flu vaccines by care settings. Based on claims data from FAIR Health's National Private Insurance Claims (FHNPIC®) database, the results suggest that utilization and charge patterns for common procedures vary significantly by care setting across geographic region and over time but the variations are generally small in magnitude. For example, across geographic regions, charges for the flu vaccine are found to be higher when performed in a physician's office in contrast to being performed in a UCF.

KEYWORDS: healthcare claims data, urgent care facilities, convenient care centers

JEFF DANG, PhD, Senior Director of Statistical and Quality Analysis; ERIC OKUROWSKI, MBA, Senior Data Analyst; ROBIN GELBURD, JD, President and CEO; LORRAINE LIMPAHAN, BA, Research and Communications Associate; NICOLE INY, MPH, Director of Consumer Education and Outreach; FAIR Health, Inc., New York, NY; *Corresponding author*: JEFF DANG, PhD, jdang@fairhealth.org.

Introduction

There has been a notable increase in the number of urgent care facilities and other types of walk-in "convenient care" centers, such as retail clinics, in the United States over the past decade.[1-3] Rising healthcare costs, primary care physician (PCP) shortages, overcrowding in hospital emergency departments, and consumer demand for more convenient and affordable care, have all been attributed to the significant and rapid growth of this alternative care delivery model.[1,3] The growth of the convenient care industry seemingly addresses commonly cited issues that restrict access to care, such as long appointment wait times and limited availability outside of business hours.[1,10,11] This study examines geographic variation in utilization and charges for services in different care settings, including UCFs, which have been only marginall

Retail clinics and UCFs are
and referred to as convenient
they offer many of the same se
often provide different levels of
Association of America broadly
ED facilities that are open d
beyond standard business hours
weekends—to provide care on a
non-emergency conditions.[4,5,11]
usually located in pharmacies
treatments for minor conditio
urinary tract infections, and ea
flu tests and vaccines.[4,12] Howe
services and also treat a wider r
conditions that require prompt
tures.[2] UCFs also perform simp
suturing for lacerations.[3,5,7] The
tions, UCFs are increasingly s
to traditional care settings, i.e.,

Dispute Resolution

FAIR Health data: choice of both parties to resolve disputes

- Facilitated settlement of suit involving disputed claim reimbursements in 38 states and Washington, DC
- 80th percentile benchmark agreed upon as a standard for “usual and customary” charge for five years
- Lebanon Chiropractic Clinic v. Liberty Mutual Insurance Company, Case No. 14-L-521 in the Circuit Court of St. Clair County, Illinois. Court approved February 23, 2015. www.lebanonpipsettlement.com
- Other cases settled in Oregon, Washington

Free Educational Content

Understanding Your Medical Bill

After you visit a provider, you'll typically receive a bill telling you how much you have to pay. Providers can include healthcare professionals, hospitals and other types of healthcare facilities. The amount you owe will depend on a number of factors – whether you have insurance, your type of plan and its cost-sharing features, and whether you received services in or out of your plan's network. It's important to look at your bill carefully and understand all the items on it to make sure you're being charged the correct amount.

Before You Get Care: Know What You'll Owe

Medical bills can be complicated. It's easier to review and understand them if you have an idea of what you should owe *before* your bill shows up in the mail. Communicating clearly with your doctor up front and keeping detailed records can help you minimize billing errors and avoid surprises.

Before Your Visit: Ask your doctor which specific services you will be receiving and how much you will have to pay for each. Find out which providers will be involved in your care, and whether they are in your plan's network. Remember, even if a hospital is in your plan's network, doctors involved in your care may not be, so be sure to check.

At Your Visit: If the visit is in-network and you pay a co-pay and/or co-insurance, make sure you get a receipt. Keep this proof of payment for your records. Write down any services you receive and the dates you receive them.

When You Get Your Bill: Read, Review and Ask Questions

What Information Will I See?

Medical bills may look different, but they all include the same basic information. Your bill tells you the services you received, the dates you received them, the cost for each service and the total amount you owe.

Usually, you'll get a separate bill for each type of specialty care you receive. For example, when you visit a hospital, you'll get a bill from each provider who had a role in your care. This includes physicians who you may not have met—like the pathologist who studied a tissue sample from a biopsy or the radiologist who interpreted your x-ray. If you have any questions about any of the services on your bill, it is a good idea to contact that doctor.

In-Network vs. Out-of-Network Care

Know Before You Go

You've probably seen the terms "in-network" and "out-of-network" on your insurer's website and in your plan description. But, what do these terms mean? And how do they affect how much you have to pay for your care?

Your plan contracts with a wide range of doctors, as well as specialists, hospitals, labs, radiology facilities and pharmacies. These are the providers in your "network." Each of these providers has agreed to accept your plan's contracted rate as payment in full for services.

That contracted rate includes both your insurer's share of the cost, and your share. Your share may be in the form of a co-payment, deductible or co-insurance. For instance, your insurer's contracted rate for a primary care visit might be $120. If you have a $20 co-payment for primary care visits, you will pay $20 when you see a doctor in your network. Your insurer will pick up the remaining $100.

If you go outside your network, it's a different story. You will likely pay more if you go "out-of-network" for your care. That's because:

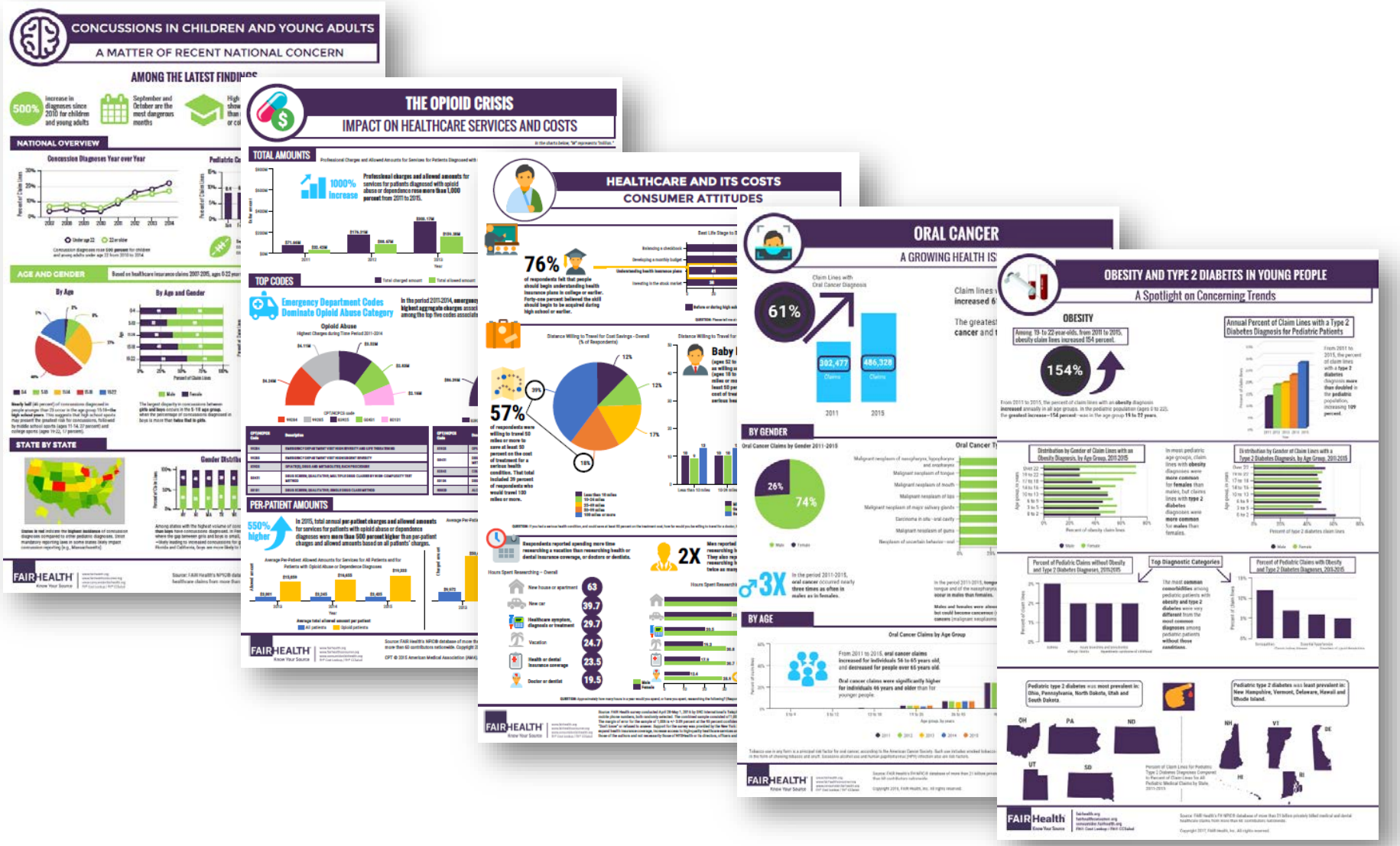
- Providers outside your network have not agreed to any set rate with your insurer, and may charge more.
- Your plan may require higher co-pays, deductibles and co-insurance for out-of-network care. So, if you normally have to pay 20% of the cost of the service in-network, you may have to pay 30% out-of-network. Often, you'll have to pay that PLUS any difference between your insurer's allowed amount and what the provider charges.
- Your plan may not cover out-of-network care at all, leaving you to pay the full cost yourself.

Your costs for out-of-network care also depend on your type of plan:

- In a Health Maintenance Organization, or HMO, or Exclusive Provider Network, or EPO, you generally have to pay the full cost of any out-of-network care, except for emergencies.
- In a Preferred Provider Organization (PPO) or Point-of-Service (POS) plan, you will usually have to pay:
  - A higher deductible than in-network and or a higher co-pay
  - PLUS a higher percentage co-insurance, which is a percentage of the "allowed amount"
  - PLUS, the full difference between the allowed amount and your provider's actual rate, which could be much higher

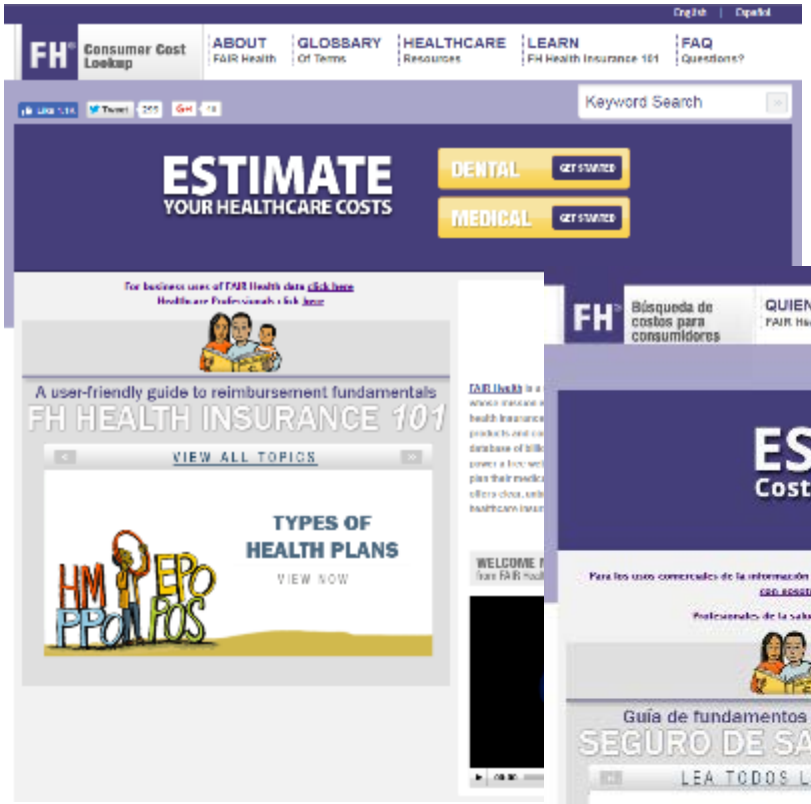
These costs can add up quickly, even for routine care. If you have a serious illness, it can mean tens of thousands of dollars more. So, when you need care, it's important to find out if all of your providers are in

Insights from the Repository



Consumer Engagement Platform

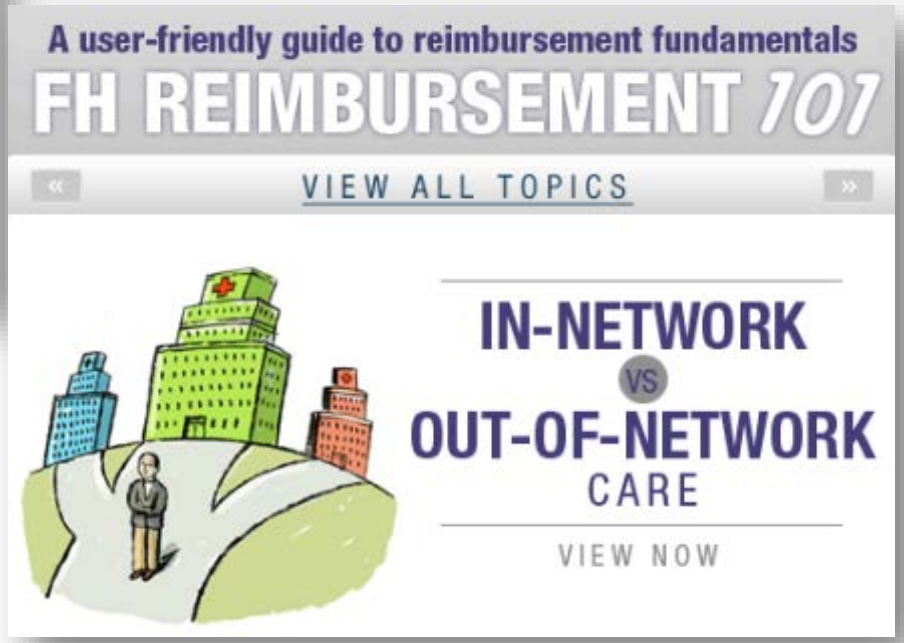
fairhealthconsumer.org



consumidor.fairhealth.org

MOBILE APP
FH ®Cost Lookup/FH®CCSalud

Educational Platform



Comparison of Relevant Reimbursement Methods

UCR - Based | Medicare - Based | Compare Both

ESTIMATED OUT-OF-POCKET COSTS: A COMPARISON

PRINT

ESTIMATED OUT-OF-POCKET COSTS: UCR-BASED

Select	Code/Facility	Consumer Description	Est. Charge	Est. Reimbur-sement	Out-of-Pocket Cost
Select all professional charges that apply					
☑	45380	Biopsy of large bowel using an endoscope (COLONOSCOPY W/BIOPSY SINGLE/MULTIPLE)	$1,400.00	$980.00	$420.00
☑	00810	Anesthesia for procedure on lower intestine using an endoscope	$700.00	$490.00	$210.00
☑	88305	Pathology examination of tissue using a microscope, intermediate complexity	$240.00	$168.00	$72.00
Select one type of facility (if applicable)					
○	Ambulatory Surgery Center	Ambulatory Surgery Center (ASC) facility estimate for procedure code 45380 (in addition to your doctor's fee)	$1,750.83	$1,225.58	$525.25
●	Hospital Outpatient	Hospital Outpatient Facility (HOSPF) estimate for procedure code 45380 (in addition to your doctor's fee)	$3,219.08	$2,253.36	$965.72

Estimated Out-of-Pocket Cost $1,667.72

GEOZIP: 972xx
This GEOZIP includes zip codes with the following prefixes: 972

In the table above, the Estimated Charge is set to the 80th percentile of charges in the FAIR Health database and the Estimated Reimbursement is set to 70% of the Estimated Charge. You may adjust these values on the UCR-based cost estimate page.

ESTIMATED OUT-OF-POCKET COSTS: Medicare - BASED

Select	Code/Facility	Consumer Description	Est. Charge	Est. Reimbur-sement	Out-of-Pocket Cost
Select all professional charges that apply					
☑	45380	Biopsy of large bowel using an endoscope (COLONOSCOPY W/BIOPSY SINGLE/MULTIPLE)	$1,400.00	$207.62	$1,192.38
☑	00810	Anesthesia for procedure on lower intestine using an endoscope	$700.00	$231.37	$468.63
☑	88305	Pathology examination of tissue using a microscope, intermediate complexity	$240.00	$70.30	$169.70
Select one type of facility (if applicable)					
○	Ambulatory Surgery Center	Ambulatory Surgery Center (ASC) facility estimate for procedure code 45380 (in addition to your doctor's fee)	$1,750.83	$465.02	$1,285.81
●	Hospital Outpatient	Hospital Outpatient Facility (HOSPF) estimate for procedure code 45380 (in addition to your doctor's fee)	$3,219.08	$859.69	$2,359.39

Estimated Out-of-Pocket Cost $4,190.10

GEOZIP: 972xx
This GEOZIP includes zip codes with the following prefixes: 972

In the table above, the Estimated Charge is based on the 80th percentile of charges in the FAIR Health database. You may adjust the percentile of charges on the UCR-based cost estimate page.

The Estimated Reimbursement is based on 70% of a percentage of the Medicare fee for each procedure. The reimbursement is set to 140% of the Medicare fee. You may adjust these percentages to match your plan provisions using the sliders on the Medicare-based cost estimate page.

Honored for Innovation and Utility

- **White House Summit on Smart Disclosure**
  - FAIR Health consumer website recognized as example of Smart Disclosure for consumers by White House; FAIR Health invited to present at National Archives before 75 federal agencies
- **Agency for Healthcare Research and Quality (AHRQ)**
  - FAIR Health Cost Lookup listed as “Quality Tool” on AHRQ Health Care Innovations Exchange
- **Utilization Review Accreditation Commission (URAC)**
  - FAIR Health received the award for Best Practices in Health Care Consumer Engagement and Protection at the 2013 Quality Summit
- **Strategic Health Care Communications**
  - FAIR Health awarded the eHealthcare Leadership Awards for five consecutive years, since 2012
- **appPicker**
  - FAIR Health mobile app selected as one of best healthcare apps in 2014
- ***Employee Benefit News (EBN)***
  - FAIR Health President Robin Gelburd recipient of 2016 Dig|Benefits Technology Innovator Award
- ***Kiplinger’s Personal Finance***
  - FAIR Health recognized as best healthcare cost estimator in 2016

EBN Innovator Award

Employee Benefit News
ebn

50 benefit technology innovators

Slide 19 of 26

Robin Gelburd

Title: President

Organization: FAIR Health

Achievements: Robin directed the launch of www.fairhealthconsumer.org, a free website dedicated to sharing information about healthcare prices and healthcare benefits so that employees and other consumers can better manage their healthcare expenses. The core of the website is the FH® Consumer Cost Lookup tool, comprising both FH Medical Cost Lookup and FH Dental Cost Lookup. Powered by the nation's largest repository of privately billed medical and dental healthcare claims, that tool allows consumers to estimate their out-of-pocket costs for medical and dental care in their geographic area, to aid them in choosing a health plan option during their employer's enrollment period, planning out-of-network expenses or negotiating with a provider.

FAIR Health Value Proposition

- Largest private claims collection in the country – a national APCD
- Independent, mission-driven nonprofit
- Conflict-free, unaffiliated with any stakeholder
- Uncompensated, diverse and expert board of directors
- Robust network of independent advisory committees
- CMS Qualified Entity
- Award-winning consumer platform
- Physical custody of the claims
- Data access to all stakeholders
- All operations performed by expert in-house staff
- Codified in statutes; cited in regulations; referenced in official policy memoranda
- Successful business plan for sustained, economic self-sufficiency

Thank You

Robin Gelburd, President
212-370-0704 | rgelburd@fairhealth.org

Michelle Scott, General Counsel
212-257-2351 | mscott@fairhealth.org

For more information, visit:

- fairhealth.org
- fairhealthconsumer.org / consumidor.fairhealth.org
- feeestimator.org
- Mobile App: FH® Cost Lookup / FH® CCSalud

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Summary of Statement Submitted by FAIR Health, Inc.

Organization and Data. An independent, national nonprofit, FAIR Health has nation's largest collection of private healthcare insurance claims, Claims contributed by over 60 national and regional insurers and claims administrators. It uses the claims data to create benchmark products licensed by insurers, providers, government agencies, policymakers and others, consulted by consumers and referenced in federal and state statutes and regulations. All data are validated prior to inclusion in production of data products. Its data include over 134 million Oregon records.

Benchmarks. Using actual claims records, FAIR Health determines benchmark dollar values for provider's non-discounted billed charges and separately for insurers' allowed amounts for thousands of healthcare procedures and services. FAIR Health employs statistical methodologies recommended and vetted by independent experts. The benchmarks correspond to the distribution of charges (and separately, allowed amounts) in five separate regions of Oregon. Customized regions can be provided. Prior to determining the percentiles, FAIR Health applies a standard statistical "outlier" methodology to the underlying data to identify and remove from the dataset any amounts that are so exceptionally high or low that they would distort the overall distribution.

Percentiles. FAIR Health can report benchmarks from the 5th to the 95th percentile. The 50th percentile represents the median charge, the point at which 50 percent of the charges in a region are equal to or lower than, and 50 percent are higher than, the stated percentile benchmark amount. Similarly, in relation to the 70th percentile benchmark, 70 percent of the charges are equal to or lower than, and 30 percent are higher than the 70th percentile benchmark value.

Benchmarks and UCR. FAIR Health reports the range of percentile values that corresponds to the market distribution of amounts, whether, charges or allowed amounts, in an area. The relevant stakeholder, e.g., plan sponsor, insurer or regulator, may choose to use a particular percentile benchmark as the usual, customary and reasonable rate, prevailing rate or other applicable standard.

Category	FAIR Health Benchmarks	Medicare Fee Schedule
Geography	5 regions in Oregon; custom regions can be provided	2 regions in Oregon
Methodology	Charge Benchmarks: Based on directly on actual charges in specific region; except for infrequent procedures, relative market value methodology applied. Allowed Amount Benchmarks: Derived on basis of actual allowed amounts in region.	Relative values and conversion factors set by committees; Geographical adjustments for some areas; Not all procedures covered because system was designed for particular populations: elderly, disabled, end-stage renal failure;
Relationship to Market	Mirror market distribution of charges and allowed amounts; also show market differentials in charges and allowed amounts for different specialists	Fees adjusted to meet national policy objectives and budgetary ceiling.

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FAIR Health Statement for Hearing

Oregon State Senate

Committee on Health Care

February 9, 2017

FAIR Health appreciates the opportunity to comment on the important legislation under consideration by this Committee. As an independent nonprofit committed to providing consumers with clear and actionable information about healthcare costs and insurance, FAIR Health has been consulted by legislators and regulators around the country as they address consumer protection and other issues in the complex healthcare sector. As a tax-exempt charity, FAIR Health does not lobby nor does it take positions on the specifics of proposed policies; however, the organization believes its charitable mission includes sharing information based on its resources and experience. Therefore, FAIR Health is providing this statement with the hope of assisting the members of the Oregon Senate who are considering legislation to address the challenging issues arising for consumers dealing with balance billing for emergency and surprise or inadvertent out-of-network services.

This statement provides information about FAIR Health, its origins, data holdings, products and work related to healthcare costs and insurance to explain the sources and bases for our comments. In particular, we present a discussion of considerations affecting the selection of standards for determining the value of services and the appropriate fees for providers that we believe are relevant to the pending legislation. Below we focus our discussion on three sources of standards—providers' charges, insurers' allowed amounts and Medicare rates—with which we have substantial experience. We hope that sharing observations made in the course of our work will be helpful to the Committee.

About FAIR Health

FAIR Health is a national, independent, nonprofit organization dedicated to bringing transparency to healthcare costs and health insurance information through data products, consumer resources and health systems research support. FAIR Health's activities involve the use of a variety of data sources, including non-discounted fees for services reported by providers in private claims records, the "allowed amounts" that insurers negotiate with providers under network contracts, Medicare fees and Workers Compensation fee schedules in many jurisdictions.

FAIR Health's own database of billions of privately billed medical and dental claims is the largest collection of private insurance claims in the country. FAIR Health uses this database—which contains both fees or "charges" in the private market and allowed amounts established by insurers and providers in their networks—to power an award-winning free consumer website and to create data products and custom analytics serving all healthcare stakeholders, including government officials, researchers, consumers, providers, insurers and other businesses.

In addition, FAIR Health's private claims data serve as the official data source for a variety of state health programs, including workers' compensation and personal injury protection (PIP) programs, as well as state consumer protection laws governing surprise out-of-network bills and emergency services. FAIR

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Health data have also been recommended to the federal government by NORC as an appropriate, comprehensive source of benchmarks for emergency services under the Affordable Care Act. FAIR Health, likewise, has been sought out and consulted by a number of jurisdictions as they consider revisions to the Medicaid and workers' compensation fee schedules with a view to ensuring access to care for individuals insured under those programs. Separately, FAIR Health also holds extensive Medicare data. FAIR Health has been certified by the Centers for Medicare & Medicaid Services (CMS) as a Qualified Entity, eligible to receive all Medicare claims data for use in nationwide transparency efforts—one of only four entities across the country with such a designation.

FAIR Health Origins

FAIR Health was created in 2009 as part of a settlement between the New York State Attorney General and healthcare insurers operating in New York State. Both the officials and insurers agreed that having insurers determine out-of-network reimbursements on the basis of a database created by the subsidiary of an insurer, Ingenix, now Optum, constituted a conflict of interest. Although the settlement pertained to New York State, it became a national remedy.

FAIR Health was created with a wholly independent, conflict-free Board of Directors, with diverse backgrounds and experience in many different parts of the healthcare sector, including law, government, consumer activism, medical practice, hospital leadership, insurance and academia. The members of the Board are recognized leaders in their respective fields and serve without compensation. The organization serves all stakeholders in the healthcare sector and operates with complete neutrality; it is not supervised or funded by any governmental agency nor is it affiliated with any insurer, healthcare system or other stakeholder group.

FAIR Health was assigned the mission of establishing a comprehensive and reliable database of healthcare claims data to provide accurate and current information to the industry; to create a free consumer website to provide cost information and educational content about insurance and healthcare to consumers; and to provide its data to government officials, policy makers and academics for research.

FAIR Health Data Resources: Private Insurance Claims

Currently, the FAIR Health data repository contains over 22 billion records from both fully insured and self-insured (i.e., ERISA) private insurance plans; it is adding claims at a rate of 1.7 billion per year. The claims in the database represent the records of over 150 million individuals, approximately 75 percent of the privately insured population of the country, including those covered by self-insured plans. Claims are contributed by approximately 60 insurers and claims administrators nationwide and undergo rigorous data quality and validation processes upon receipt, as discussed more fully below.

For the state of Oregon specifically, the FAIR Health repository contains approximately 140 million records from 2002 to the present, including approximately 26 million claims added by 50 contributors for 2015. FAIR Health organizes the Oregon claims data into, and reports benchmarks for, five geographic regions throughout the state; by comparison, Medicare divides Oregon into two regions in determining its fee schedules. Accordingly, FAIR Health benchmarks reflect with granularity the economics of very specific, local markets.

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FAIR Health Charge and Allowed Amount Benchmarks

FAIR Health collects claims data from insurers and claims administrators throughout the country. From that data, FAIR Health produces two lines of percentile benchmark products: (i) charge benchmarks based on actual, non-discounted fees for services and (ii) allowed amount benchmarks that are imputed based on the actual amounts that insurers use as appropriate fees for services. Both product lines are based on the claims in the FAIR Health database and have been subjected to FAIR Health's extensive validation testing.

FAIR Health developed proprietary algorithms and methodologies for validating the data and determining benchmarks in consultation with academic experts in statistics, economics, public health and clinical care at major US universities. FAIR Health's processes include numerous quality tests to establish the accuracy and comprehensiveness of the data (e.g., tests that confirm that payors have provided all their data and have not preselected or omitted any claims). In addition, claims are checked to confirm, for example, that they contain accurate zip codes, use proper procedure coding and report an appropriate number of units for each procedure, service, item or dosage.

In addition, in determining its charge benchmarks, FAIR Health applies to the charge data an outlier methodology vetted by experts in statistics and economics that identifies, and excludes from the data used in calculating benchmarks, those charges that are so extremely low or so extremely high that their inclusion would distort the distribution of charges represented by percentiles. FAIR Health bases its benchmarks on 12 consecutive months of data, for a period ending usually no more than 3 months before the release date of its modules. Each module is updated every six months with more recent data replacing earlier data.

FAIR Health reports benchmarks for 493 geographic areas, called "geozips," nationwide that tend to track with the first three digits of a zip code. All benchmarks are determined and, in the case of charge benchmarks outlier rules are applied, exclusively on the basis of claims for services rendered in the particular geozip. FAIR Health does not determine, prescribe or recommend any specific benchmark as a usual and customary rate (UCR). Rather, it reports benchmarks from the 5th to the 95th percentile, based on the distribution of charges or allowed amounts, depending on the product line, reported on claims for services in each geozip. However, it should be noted that upon specific request, data can also be customized to state and regional levels or configured to reflect urban/rural communities.

FAIR Health conducts all operations in-house with its own statistical, clinical, technology, policy, service and security experts. FAIR Health's capability to produce all of its products and analytics with its own staff facilitates consistency, accuracy and efficiency in its work. It has become a wholly self-sustaining enterprise.

FAIR Health Products: Benchmarks and Episodes of Care

FAIR Health produces data products, usually called modules, which offer benchmarks for distinctive clinical fields, including separate modules reporting charge benchmarks for medical/surgical services, dental services, anesthesiology services, HCPCS categories, ambulatory service centers and inpatient and outpatient facilities. The modules report the charges by official codes—CPT, CDT, ASA, DRG—as appropriate and as required by federal regulation. The standard modules licensed by most payors with

national or multistate operations contain benchmarks for all 50 states and are used in adjudicating claims covering approximately 190 million individuals nationwide. FAIR Health also offers smaller modules focusing on the charges of particular clinical specialties that providers license for the markets pertaining to their own practices.

FAIR Health data products enjoy wide acceptance by stakeholders in the healthcare sector. Thousands of licensees, including payors, employers, professional and institutional providers, researchers, consultants, consumer advocates and policy makers rely on FAIR Health modules, custom datasets, analytics and tools. The broad acceptance of FAIR Health benchmarks is evidenced by their use as a remedy in settling lawsuits involving payors and providers; for example, the parties in the *Lebanon PIP* litigation,[1] a class action covering claims in 38 states and the District of Columbia (which did not involve FAIR Health as a party), agreed to use FAIR Health benchmarks for claims administration for five years as part of their settlement.

In addition, FAIR Health creates custom datasets, based on its benchmarks or on the underlying data in its repository, depending on the needs of its licensees. FAIR Health benchmarks are used widely by payors complying with certain legal requirements. Some state laws, regulations and programs require payors to reimburse at UCR or local "market" rates. Others require or authorize payors to use specific percentile benchmarks directly in reimbursing medical expenses in workers' compensation, automobile personal liability (PIP) and other programs. The benchmarks also are consulted by government policy makers, to evaluate and update fee schedules for a variety of programs (e.g., programs serving disabled children in Arizona, medically impaired newborns in New York, state governmental employees in Alaska, workers compensation in Kentucky), often to reflect rates closer to market to facilitate access to services. The state of Georgia has engaged FAIR Health for three consecutive years to create its official Workers' Compensation fee schedule. A list of laws, regulations and governmental programs using FAIR Health data is attached to this statement.

FAIR Health also can provide information about the costs and pricing for episodes of care, i.e., risk-adjusted bundles of services that constitute a course of treatment for specific illnesses or injuries and chronic conditions. Such episodes are taking on more widespread relevance as payors and providers explore value-based payment systems. Beyond economic information, FAIR Health can construct custom datasets that reflect other factors, such as the concentration of disease, variations in treatment protocols or trends in conditions or treatments over time.

Medicare Data and Related FAIR Health Products

As noted above, since its beginning, FAIR Health has held extensive Medicare data which is kept separately from its private claims data. Also as noted above, in 2016, FAIR Health was certified by CMS as a Qualified Entity, entitled to receive and hold Medicare Parts A, B and D (prescription) claims data for use in nationwide transparency efforts. For several years, FAIR Health has created and licensed a "Medicare GapFill" product which provides the Medicare fee schedule for the entire nation and also provides values for fees for the "gaps" in the Medicare schedule, i.e., for 1500 services and procedures

[1] Lebanon Chiropractic Clinic, P.C. v. Liberty Mutual Insurance Company, et al., Case No. 14.-O-521. Circuit Court of Illinois, St. Clair County, www.LebanonPipSettlement.com.

not included in the official Medicare schedule. The "GapFill" values are determined by employing a methodology that determines their rates in relation to the rates in the official schedule. Effectively, FAIR Health's database is the effective equivalent of a national All Payer Claims Database (APCD) of private claims. FAIR Health's similarity to an APCD was enhanced with FAIR Health's designation by CMS as a Qualified Entity.

FAIR Health Consumer Tools

In keeping with its commitment to transparency and its mission to provide consumers information about healthcare costs and insurance, FAIR Health has created a free website and free consumer apps for mobile devices where they can obtain fee estimates for specific healthcare services and procedures in their neighborhoods as well as educational materials in consumer-friendly language on healthcare insurance. A consumer can simply enter his zip code in the lookup tool, pick out a service or procedure from a list and obtain an estimate of the typical market charge in his area. If a consumer knows the terms of his own healthcare policy, he also can get an estimate of his out-of-pocket amount for the procedure. Both the website and apps are available in English and Spanish. The consumer website also provides educational materials and lists of resources, including state resources, to help consumers with healthcare insurance.

A number of insurers, healthcare insurance exchanges, employers and agencies have licensed the tool for their members, employees or constituents. FAIR Health can create "white label" versions of the site that bear the sponsor's logo and trademark and provide direct access to the site and choose statewide, regional or national cost information appropriate to their users. The FAIR Health consumer website has been widely honored; a selection of its awards appears in the outline accompanying this letter.

Consumer Protection and Standards for Provider Payments

In evaluating appropriate reimbursements for providers for out-of-network services, legislators and regulators with whom FAIR Health has consulted generally have considered three different standards as the bases for such payments:

1. Providers' charges (non-discounted fees) for a service in the relevant market, sometimes characterized as the usual, customary and reasonable rate or UCR;
2. Allowed amounts, which are the in-network fees paid under a plan to a provider for a service; or
3. Medicare fee schedule rates.

Providers' Charges

In a number of jurisdictions, the payments standards for provider services in a variety of programs are set according to charge benchmarks determined by FAIR Health on the basis of the recent, actual billed charges of providers in the particular geographic area where the service was rendered. FAIR Health benchmarks reflect the distribution of charges for a particular service from the 5th to the 95th percentile in a specific geographic area. Depending on the program, a percentile benchmark may be the prescribed payment or one of several standards; and different laws adopt different percentiles. For example, Connecticut prescribes payment for out-of-network emergency services at the highest of three values: (1) the in-network rate (allowed amount) under the member's plan; (2) UCR for out-of-network emergency services, with UCR set at the FAIR Health 80th percentile charge benchmark; or (3) the

Medicare reimbursement for the service. On the other hand, California law caps the fees that low-income individuals can be charged for emergency services at the FAIR Health 50th percentile charge benchmark.

Because FAIR Health charge benchmarks are independent, based on 12 recent months of claims for actual charges in 493 local areas, they closely reflect the healthcare market economy in a particular area and time. In addition, because they are based on market information, the relationship between and among the percentile benchmarks for different procedures, as well as different medical specialties, corresponds to the relationships in the specific market. Accordingly, using percentile benchmarks facilitates flexibility in the level of a payment while still tying the overall system of payments to local market factors.

Allowed Amounts

FAIR Health also creates benchmarks for insurers' allowed amounts, their in-network rates of payment for specific services in 493 specific geographic areas. FAIR Health provides a range of percentile values for imputed allowed amounts, which, similar to the charge benchmarks, are based on 12 recent months of validated claims data. The benchmarks for allowed amounts, although almost always lower than the non-discounted charge benchmarks for the same services, nonetheless also reflect actual market dynamics. They indicate the range of payments negotiated between payors and providers in a specific area for specific services, and the differences in the benchmarks for the various specialists also correspond to the relationship of the payments made to different specialists for their services in the area.

Medicare Rates

In some programs, the Medicare rate schedule has been adopted as the standard for payment, using either the actual Medicare payment amounts in a particular region or a percentage of the Medicare rate, usually an amount higher than 100 percent of the Medicare rate.

Although Medicare rates, which are fixed by the federal government, are accessible and easily adjustable by some percentage, they can present serious challenges when being deployed in the general healthcare market. As is widely known, Medicare was established to pertain certain distinct populations: the elderly, disabled and end-stage renal disease patients. Accordingly, Medicare is not designed to support the full range of medical services that necessarily include pregnancy, childbirth and pediatric care. Moreover, the Medicare fee schedule does not cover the full range of services as coded in the official AMA CPT codes that federal regulation requires be used in billing and record-keeping. Even if the official Medicare schedule is adopted, the gaps in that schedule must be filled by other means. (In some programs, laws and regulations have filled these gaps by mandating payments based on FAIR Health benchmarks.)

Another complication is that Medicare rates are adjusted and readjusted, often annually, to promote specific federal policy goals and budget limitations. For example, the Medicare fee schedule has been adjusted to encourage primary care rather than certain specialized services. In addition, Medicare fees are subject to a ceiling—i.e., the amount of funds appropriated for the program—which is not related to the market. Indeed, in some cases, Medicare may even pay less than costs. Accordingly, because of the special, non-market factors that affect Medicare rates, their use as standards in the general healthcare

market may require complex adjustments if different professionals are to be compensated fairly and providers' expenses in some high-cost markets are to be covered.

Policy Approaches: Mandates, Guidelines, Transparency

As the number of states focusing on protecting consumers faced with enormous healthcare costs for out-of-network emergency services grows, FAIR Health has been increasingly consulted by government officials about the use of its data, particularly its benchmarks, for a variety of approaches. The principal goal of most legislatures has been to protect consumers from the burden of substantial, unexpected balance bills for unavoidable out-of-network services, particularly emergency care.

Some states, such as Connecticut, have adopted laws that mandate a particular payment or require that the insurer pay the highest of specified standards. In New York, the state eschewed a mandatory payment schedule or formula, but instead emphasized transparency by stressing disclosure and the creation of a standard basis for comparison of plans and evaluation of billed charges and reimbursements.

When the New York consumer protection legislation enacted a non-prescriptive "Usual and Customary Cost" (UCC) formulation, the state designated FAIR Health's 80th percentile charge benchmark as the only official database that meets that standard. The New York approach emphasizes a prohibition on balance billing, more comprehensive disclosure by insurers and providers alike about networks and financial terms, and substantive guidelines for independent dispute resolution (IDR) for cases that providers and insurers fail to resolve through direct negotiation. The New York law requires that plans include in their documents clear examples of their reimbursement calculations with comparisons of the plans' allowed amounts to reimbursements calculated using UCC. In addition, UCC is a factor, one among many, for consideration in IDR.

The selection of FAIR Health benchmarks to support these policies has been based on the organization's independence, the breadth of its data, the objectivity of its methodology, the transparency of its processes and results and its lack of an agenda other than reliably representing the distribution of its benchmarks using recognized scientific statistical methodologies.

Thank you for your interest and consideration. We will be happy to respond to any questions.

Submitted by:

Michelle P. Scott
General Counsel
FAIR Health, Inc.

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Government: Laws, Regulations and Studies Referencing FAIR Health Data

Alaska

1. FAIR Health data inform the fee schedule for the workers' compensation program of the Department of Labor and Workforce Development, Division of Workers' Compensation of the State of Alaska.
2. State Health Insurance Plan (http://doa.alaska.gov/drb/ghlb/employee/info/faqs/healthPlan.html#.U_fAMfldV1Y)

Arizona

FAIR Health data are licensed by the State to support the reimbursement of dental claims for disabled pediatric patients.

California

Statute: Emergency Care Charges

California expressly provides by statute that the payments for emergency physicians for services to low-income patients shall be no more than the median or average rates paid by commercial insurers for the same or similar services in the same or similar geographic areas as reported by FAIR Health. California Health and Safety Code, Chapter 2.5 of Division 107, Article 2. Emergency Physician Fair Pricing Policies. Section 127452(b):

"An emergency physician shall limited expected payment for services provided to a patient at or below 350 percent of the federal poverty level ...When FAIR Health , Inc. makes available the rate of payment received by physicians and surgeons from commercial insurers for the same services in the same or similar geographic region, the amount of expected payment under this section shall be no greater than the median or average of rates paid by commercial insurers for the same or similar services in the same of similar geographic region."

Connecticut

Pursuant to a state law protecting consumers from high surprise bills for out-of-network emergency services, the Connecticut Insurance Commissioner designated only FAIR Health's 80th percentile charge benchmarks for health care services as the "usual, customary and reasonable rate" to be used in determining insurance reimbursements for health care providers. Public Act 15-146.

Georgia

FAIR Health provided development assistance and data consultation for the 2015 and 2016 editions of the Georgia Workers' Compensation Fee Schedule, and continues to manage distribution of both schedules.

Kentucky

Pursuant to RFP processes, FAIR Health was awarded contracts to advise the **Commonwealth of Kentucky** and its **Department of Workers' Claims** and to prepare data studies and analyses for the

purpose of updating the 2013 and 2016 editions of the Kentucky Workers' Compensation Fee Schedule for Physicians.

Mississippi

Mississippi Workers' Compensation Fee Schedule (http://www.sos.ms.gov/ACProposed/00019998b.pdf at page 178) Usual and customary means that when a payment is designated herein as "usual and customary," the amount of the payment equates to the charge value reported by FAIR Health, Inc. in its FH RV Benchmarks products at the 40th percentile for the applicable geographic area in Mississippi.

New Jersey

1. **New Jersey Automobile Insurance/PIP Regulations**
   N.J.A.C. 11:3-29.4 (e) 1. Amendment adopted October 18, 2012, effective January 4, 2013. PIP. FAIR Health database listed as one of "(N)ational databases of fees, such as those published by .... FAIR Health ... are evidence of the reasonableness of fees for the provider's geographic region or zip code."
2. **New Jersey Department of Banking & Insurance – Consumer Assistance**
   NJ DOBI Website at http://www.state.nj.us/dobi/lifehealthactuarial/rateinfo/index.html lists FAIR Health as an "additional resource" and provides information about the organization and a link to the FAIR Health consumer website.

New York

1. **2013 Budget Act - Definition of "UCC" – Usual and Customary Cost**
   Effective March 31, 2014, insurers must provide examples comparing benefits provided by their plans with benefits using a percentage of "UCC" as allowed amount. Ins. Law §§ 3217-a(a)(19)(B) and 4324(a)(20)(B) and Public Health Law § 4408(1)(t)(ii). UCC means "the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the Superintendent. The nonprofit organization shall not be affiliated with an insurer...." The FAIR Health is the only database designated to provide UCC. See NY State Department of Financial Services, Out-of-Network (OON) Law Guidance, (http://www.dfs.ny.gov/insurance/health/OON_guidance.htm)
2. **New York Medical Indemnity Fund**
   New York State regulations for its Medical Indemnity Fund for birth-related neurological injuries prescribe the use of FAIR Health data for physicians' fees. New York Codes, Rules and Regulations. Title 10. Ch.II. Subch. H, Part 69-10.20 Rates of Payment. "(a) Physicians shall be paid at the 80th percentile of the usual and customary charges for services provided in private physician practices, as reported by FAIR Health, Inc. in its Usual, Customary and Reasonable (UCR) database at the time of billing. Payment of these charges shall constitute payment in full for any such services provided to an enrollee of the fund. (b) Services, supplies, equipment and medications for which there is a Medicaid fee or rate will be paid at that fee or rate. (c) Any other service will be paid in an amount established by the prior approval process.

3. **New York Workers' Compensation**
   FAIR Health data support analysis for the New York Workers' Compensation fee schedule.
4. **New York Health Insurance Exchange**
   Use of FAIR Health data to provide consumers with cost information was treated as fulfilling Affordable Care Act requirements for cost transparency; several insurers provide FAIR Health data on their exchange information sites.

North Dakota
FAIR Health data products were used to support the development of the fee schedule for the workers' compensation program of North Dakota Workforce Safety and Insurance.

Pennsylvania
Effective 11/01/10 when resolving applications for fee review under 34 Pa. Code § 127.256, the department will utilize the 85th percentile of the database published by FAIR Health to determine "the usual and customary charge" as defined in 34 Pa. Code § 127.3.

(http://www.dli.pa.gov/Businesses/Compensation/WC/Pages/Statement-of-Purpose-of-Adoption-of-Usual-and-Customary-Charge-Reference.aspx#.V0X4BPkrKUk)

Wisconsin
The Wisconsin Department of Workforce Development (DWD) has certified the FAIR Health database for use for workers' compensation fees. For the standards for certification, see the regulation at http://dwd.wisconsin.gov/wc/insurance/radiology/radiology_database.htm
"DWD 80.72 Health service fee dispute resolution process."

United States Government
The United States Government Accountability Office, *Dental Services: Information on Coverage, Payments, and Fee Variation,* GAO-13-754, September 2013,
http://www.gao.gov/assets/660/657454.pdf