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INSURANCE REFORMS**

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# New York's 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study

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## Introduction

In March 2014, the New York legislature passed the Emergency Services and Balance Billing Law (“Surprise Billing” law), which went into effect in March 2015.<sup>1</sup> The law protects consumers from charges for out-of-network (OON) services not paid by an insurance plan, in cases of emergency or circumstances in which the patient did not have a reasonable choice between an in-network and out-of-network provider. New York’s law has been touted as a model for other states as

well as potential federal legislation because of its unique “baseball-style” arbitration approach to settling payment disputes, which generated broad buy-in among a set of stakeholders that typically have strongly opposing views.<sup>2</sup> Five years post-enactment, this study assesses the implementation of New York’s law and how it is working for consumers, providers, and insurance company stakeholders today.

## Background

### **What is a surprise balance bill?**

Surprise bills can arise from both emergency and planned health care services, and can lead to significant financial liability for patients, even though they have health insurance. For many consumers, a “surprise bill” is any bill they receive from a medical provider that is larger than expected. A “balance bill” is a bill the patient receives from a medical provider that charges the balance remaining after the insurer makes a payment and any plan cost-sharing or deductible is applied; it may or may not be larger than expected. Insured patients may receive *surprise* balance bills in the case of an emergency when they unknowingly receive services from an out-of-network provider, in the case of a scheduled procedure when they make a good faith effort to ensure that the facility and treating physician are in-network but receive services from a non-participating provider, or when they are misinformed about a provider’s network status

by their health plan or provider (New York’s law defines a surprise balance bill somewhat more narrowly; see Glossary).

Insurers and providers participate in negotiations to determine the rate the insurer will pay for the provider’s services. Typically, in-network providers agree to accept rates that are lower than what they would otherwise charge (often called the “allowed amount”; see Glossary) in return for the guarantee of patient volume among the insurer’s members. Some physicians, such as anesthesiologists, emergency room physicians, radiologists, and pathologists, gain patients by practicing within a particular facility, and do not have the same incentive to participate in a plan’s network. They can often earn more revenue by charging a higher, out-of-network price for their services. For example, out-of-network emergency department physicians charge, on average, 2.4 times more than the in-network rate for their services.<sup>3</sup>

## Glossary of Key Terms

**Allowed amount:** The maximum amount a health plan will pay for a covered health care service. In-network providers typically agree to accept this amount as payment (plus any patient cost-sharing) and not to balance bill the patient.

**Baseball-style arbitration:** Also referred to as “final offer” arbitration. Each party to the dispute (the payer and the physician) must submit to the arbiter their best offer. The arbiter must choose one of the two offers without compromising between the two sides. This encourages the parties to submit reasonable bids.

**Emergency services bills (as defined by New York law):** Bills that arise from a medical screening examination conducted within the emergency department of a hospital, including ancillary services routinely available within the emergency department needed to evaluate and, if needed, stabilize the patient with an emergency condition.

**Health Maintenance Organization (HMO):** An HMO is a network-based health insurance product. Enrollees generally need to receive a referral from a primary care provider for specialty services and HMOs typically do not cover the cost of care delivered by an out-of-network provider.

**Participating hospital or physician:** A provider who has a contract with a health insurer to provide services to their members. These providers typically agree to accept the insurer's allowed amount as payment (plus any patient cost-sharing) and not to balance bill the patient.

**Preferred Provider Organization (PPO):** A PPO is a network-based health insurance product. Unlike an HMO, enrollees are typically allowed to see the providers of their choice without a referral from a primary care provider. Additionally, the plan may cover a portion of the cost of care received from an out-of-network provider.

**Self-funded health plan:** A plan in which the sponsor (typically a large employer) takes on the risk of paying its members' health care claims. State laws that relate to such plans are generally preempted by the federal Employee Retirement Income Security Act (ERISA).

**Surprise bills (as defined by New York law):** Bills that arise from non-emergency services (1) in a participating hospital or ambulatory surgical center when an in-network physician is unavailable, or an out-of-network physician renders services without the patient's knowledge; (2) when a participating physician refers a consumer to an out-of-network provider without the consumer's consent; or (3) for uninsured or self-insured patients when disclosure is not made.

**Usual and Customary Rate (UCR) (as defined by New York Law):** The 80th percentile of all (non-discounted) charges for a particular health care service performed by a provider in the same or similar specialty within the same geographic area. New York law requires these charges to be reported by a benchmarking database maintained by an independent nonprofit organization.

Surprise medical bills are a top concern for consumers. Thirty percent of privately insured Americans received a surprise bill between 2013 and 2015, with 76 percent left unresolved or unsatisfactorily resolved.<sup>4</sup> Between 2008 and 2011, the New York Department of Financial Services (DFS, which houses New York's insurance department) received 8,339 consumer complaints related to reimbursement for health care services. The DFS investigation found systemic challenges for consumers, including the inability to compare out-of-network benefits

across competing insurers, a lack of disclosure of providers' network participation, excessive billed charges for emergency services, inadequate provider networks and coverage of out-of-network services, and administrative complexity in submitting out-of-network claims.<sup>5</sup>

### New York's Surprise Bills Law

Various states have implemented policies designed to curb surprise bills, but most states lack comprehensive consumer protections. New

York is one of just 9 states with laws that extend protections to both emergency and in-network hospital services, apply protections across all types of state-regulated insurance, hold

consumers harmless from extra provider charges, and adopt either an adequate payment standard or establish a dispute resolution process.<sup>6</sup> See Text Box.

## New York Surprise Billing Law: New Requirements for Insurers and Providers

### Consumer Protections

- Requires insurers to protect consumers from all out-of-network emergency room (ER) bills.
- Requires both insurers and physicians to protect consumers from non-ER out-of-network claims:
  - > In a participating hospital or ambulatory surgery center when a participating physician is unavailable, or an out-of-network physician renders services without the consumer's knowledge, or unforeseen medical services arise at the time the health care services are rendered; or
  - > Whenever a participating physician refers the consumer to an out-of-network provider without the consumer's consent; or
  - > For uninsured or consumers in self-funded plans, unless certain disclosures are made.

### Dispute Resolution

- Establishes an independent dispute resolution (IDR) process for out-of-network ER services and surprise bills for non-ER services.
  - > IDR chooses either the provider bill or the insurer's payment as reimbursement for services.
  - > IDR must consider (1) whether there is a gross disparity between the provider charge and (a) fees paid to the involved physician for the same services rendered by the physician to other patients in health care plans in which the physician is not participating; and (b) fees paid by the health care plan to reimburse similarly qualified physicians for the same services in the same region who are not participating with the health care plan; (2) the provider's training, education, experience, usual charge, the complexity of the case, individual patient characteristics, and UCR as reported by a benchmarking database.
  - > The loser pays for the cost of the IDR process.

### Consumer Disclosures

- Requires insurers to disclose their reimbursement methodology for out-of-network services and provide examples of out-of-pocket costs for frequently billed out-of-network services.
- Requires insurers to keep provider directories up to date (web updates within 15 days)
  - > When a service is scheduled in advance:
    - > Requires insurers to inform the consumer which of their providers are out-of-network and the reasonably anticipated out-of-pocket costs;
    - > Requires hospitals to make public the health plans in which the hospital is a participating provider and disclose the physician groups that the hospital has contracted with to provider services. Hospitals must also inform consumers how to determine the health plans in which these physicians participate.
    - > Requires physicians to inform the consumer whether they participate in their health plan. Physicians who are arranging a scheduled hospital service must inform the patient which other physicians will be providing services.

### Network Adequacy

- Extends state network adequacy requirements to non-HMO plans (i.e., PPOs).
- Requires insurers to hold consumers harmless for out-of-network cost-sharing if the insurer does not have an appropriate in-network provider.

Importantly, the requirements of New York's law do not extend to self-funded health plans, as the state is preempted from regulating such plans. In addition, while insurers and out-of-network physicians are subject to the IDR process described above, other out-of-network providers, including hospitals, ambulances, and dialysis facilities are not. In the case of out-of-network emergency services, insurers must protect

enrollees from out-of-network charges, but only the physician fees are subject to the IDR process; hospital charges are not. The law also does not protect consumers who are misinformed about their provider's network status, either because they relied on an out-of-date provider directory or were given inaccurate information by their physician's office staff.

## Case Study Approach

This brief evaluates the implementation and operation of New York's Surprise Billing law, 5 years post-enactment. The findings herein are based on a review of New York's law and implementing regulations and published reports and analyses about New York's experience to

date. In addition, we conducted ten structured interviews with state regulators, consumer advocates, insurance company representatives, physician and hospital representatives, and expert observers. The interviews took place between January 16 and March 20, 2019.

## Findings

Insurer, provider, and consumer stakeholders generally agree that the implementation of New York's Surprise Billing law went smoothly, was relatively fair to all parties, and is working as intended to protect consumers from a significant source of financial hardship. However, several stakeholders noted continued gaps in consumer protections, as well as the potential that the IDR process could lead some physicians to inflate their charges.

### Implementation eased by front-loaded legislative process

Negotiating and drafting New York's law was, by all accounts, a "pretty intense process." Stakeholders gave extra credit to DFS and the Governor for their commitment to the issue, beginning with the publication of a 2012 DFS report quantifying the level of consumer complaints associated with surprise balance billing.<sup>7</sup> That report was "a really important first step," said one stakeholder. "We have this law because [the regulator] gives a damn...and embraced the idea of putting the consumer first." At the same time, the report put provider

advocates on the defensive, prompting media coverage of high provider charges and raising public awareness.

DFS' efforts to subsequently draft a bill that all parties could support – or at least agree not to oppose – were lauded by all sides. Stakeholders credit the agency for listening to their feedback and making changes to the bill in response. "It was a collaborative process," shared one industry stakeholder. Indeed, key to the bill's success were the administration's efforts to bring all the relevant interest groups together. As one observer put it: "The message [from the administration] was: 'This is going to happen, so you better be here.'"

The emergence of baseball-style arbitration as a mechanism to solve provider-payer disputes was critical to the bill's passage. "It was easier for these interest groups to agree to [IDR] because it's not forcing them to adopt a religious position with which they violently disagree," said one observer. "IDR allows both sides to come to the middle." Ultimately, the bill was enacted thanks to support from "elated" consumer groups, provider groups who were "mostly ok," and insurer groups

who were “concerned,” but did not actively oppose it.

That front-end negotiation, while “intense,” generated stakeholder buy-in and ultimately eased the path from enactment to implementation. The bill that was passed is quite detailed and “got into the weeds,” leaving few post-enactment battles to be fought. “All the hard work, hard decisions – it was front-loaded,” commented one insurance expert.

### **Stakeholder consensus: New York regulatory agencies managed implementation well**

Recognizing that implementing the broad and complicated Surprise Billing law would be no small lift, New York lawmakers provided a year of lead time for the agencies – DFS and the Department of Health (DOH) – to draft regulations, prepare and publish templates for provider and plan disclosure notices, and educate the public about their rights and obligations under the new law.

#### ***Engaging stakeholders***

State officials worked hard to reach out to provider, payer, and consumer stakeholders and incorporate their feedback and concerns during implementation. For example, many health plans were concerned that the IDR process would lead automatically to provider reimbursements set at the 80th percentile of UCR, an amount typically much higher than negotiated in-network rates. This, in turn, would create a disincentive for affected physicians to join the health plans’ networks and incentives for physicians to increase their billed charges. Insurers pushed DFS to ensure that IDR reviewers could consider other factors, including negotiated (allowed) rates as well as Medicare rates, in rendering a decision. DFS was able to help alleviate payers’ concerns by clarifying their ability to submit alternative fees for the IDR reviewer to consider.<sup>8</sup>

Consumer advocacy organizations had words of praise for DFS’ efforts to engage them in the review of draft regulations and disclosure forms. “They consulted us on the mechanics,” said one advocate, particularly with respect to how consumers interact with providers and payers in both emergency and elective health care scenarios, and whether and how they would

likely respond to the language of the required disclosure notices.

Provider representatives also reported “lots of meetings and discussions” with the implementing agencies and applauded their willingness to listen and modify certain requirements. For example, hospital representatives reported working closely with the agencies to design a monitoring and audit program to assess hospitals’ compliance with the law.

#### ***Leveraging existing resources***

Proactive efforts to generate stakeholder buy-in paid off, as the agencies were able to leverage the infrastructure and dissemination capabilities of the state’s provider and payer associations and consumer advocacy organizations to educate stakeholders and the public about the new law. DFS also tapped an existing help line for consumers with insurance problems – run by the Community Service Society of New York – to help consumers with balance billing issues. Their phone number, along with information about how to protest a surprise balance bill, now appears on the “Explanation of Benefits” form that patients receive after claims are submitted on their behalf.<sup>9</sup>

New York was also able to streamline implementation by taking advantage of relationships it had in place with external appeal organizations. These are independent, third-party entities that make determinations on consumers’ plan appeals regarding utilization review issues. As such, they had many of the same personnel and policies needed to step in as IDR review entities, making it easy for the state to implement the IDR process. Unfortunately, not all states have a similar external review infrastructure in place.<sup>10</sup>

### **Stakeholder consensus: Law has achieved its primary goal; views are mixed about impact**

Virtually all stakeholders we interviewed reported that New York’s law has successfully helped protect consumers from a major source of surprise balance bills. “[The law] is working great...it works really well for consumers,” said one consumer advocate. An analysis of calls to the Community Service Society’s consumer help line related to surprise balance billing found that 57 percent were resolved thanks to the law’s protections.<sup>11</sup>



State officials report a “dramatic” decline in consumer complaints about balance billing: “It’s downgraded the issue from one of the biggest [consumer concerns our call center receives] to barely an issue,” said one regulator. Insurance company representatives also reported a decline, although they were unable to quantify it. Further, several stakeholders reported that the accuracy of insurers’ provider directories had improved since the law was enacted (although there are still problems); others suggested that many consumers have become savvier about the risks of out-of-network billing and are asking more questions about providers’ network status prior to scheduled procedures.

In general, respondents viewed the IDR process as fair, although providers were more bullish on it than insurers. As of October 2018, IDR decisions have been roughly evenly split between providers and payers, with 618 disputes decided in favor of the health plan and 561 decided in favor of the provider (see Table 1). However, insurers have tended to win the majority of out-of-network emergency services disputes (534-289), while providers have won the majority of surprise bill disputes (272-84). Additionally, insurers and

physicians appear to be making “a real concerted effort” to work out their payment disputes before filing with IDR; experts on the IDR process assert that filed complaints represent just “a tip of the iceberg” of the number of relevant payment disputes that occur.

Physician representatives appear largely satisfied with the process and its results. One specialist representative reported “the law worked better than we ever anticipated.” Physician-members of his association who had used the IDR process had “no complaints.... They appreciate the fairness of it,” he said. He also observed that the law may have prompted insurers to “be a little looser” during network negotiations, offering his members higher reimbursements to be in-network than they had prior to the law. Insurers too told us that the incentives are for their networks to be as “expansive as possible.” This observation is consistent with a recent analysis of claims data, which found a 34 percent drop in out-of-network billing in New York since the law was in effect.<sup>12</sup> State officials reported receiving some complaints from providers, but that they tend to be from physicians who have traditionally charged very high rates.

Table 1. Independent Dispute Resolution Results: Emergency Services and Surprise Bills (as of October 25, 2018)

IDR Results for Bills for Emergency Services							
Total Received	Not Eligible	Still in Process	Decision Rendered	Decided in Favor of Health Plan	Decided in Favor of Provider	Split Decision*	Settlement Reached
2,104	534	150	1,431	534	289	364	244
IDR Results for Surprise Bills**							
Total Received	Not Eligible	Still in Process	Decision Rendered	Decided in Favor of Health Plan	Decided in Favor of Provider	Split Decision**	Settlement Reached
1,294	399	186	709	84	272	211	142
IDR Results, Total							
Total Received	Not Eligible	Still in Process	Decision Rendered	Decided in Favor of Health Plan	Decided in Favor of Provider	Split Decision**	Settlement Reached
3,398	933	336	2,104	618	561	575	386

Source: Oechsner T. “New York’s Out-of-Network Legislation.” (Presentation to the NYS Health Foundation, October 29, 2018). On file with authors.

\*A split decision occurs when more than one CPT code is submitted in a dispute and the IDR entity finds in favor of different parties for different codes.

\*\*See Glossary for definition of “surprise bill.”



Insurers and other observers raised concerns that IDR reviewers' use of the 80th percentile of UCR as a benchmark for settling payment disputes could open the door for "the provider community to...just drive up the UCR." Further, they noted that certain specialty groups (neurosurgeons and emergency doctors in particular) now have "no real incentive" to join plan networks because they can gain higher reimbursement through IDR. However, insurer respondents acknowledged that the ability to submit alternative data, such as in-network or Medicare rates, to the IDR reviewer enables them to make the best possible case for a reasonable rate. "We're creating ways to present [rate] information to the IDR that's outside the 80 percent UCR...to create a willingness to change the pricing," said one insurer representative.

It may be too soon to know whether New York's approach to settling billing disputes will lead providers to inflate their out-of-network charges. Indeed, one study found a 13 percent average *reduction* in physician payments since the law was enacted.<sup>13</sup> State regulators report that there has not been, as yet, an indication of an inflationary effect in insurers' annual premium rate filings. Observers further noted that, prior to the law, New York HMOs were required to pay out-of-network doctors' full billed charges for emergency services if the provider would not agree to a negotiated rate; the IDR process has likely reduced those payers' costs.

In short, IDR is not perceived as "a slam dunk for either side." But observers do believe the legislation has sent a signal to insurers and providers alike to "just be reasonable and work it out amongst yourselves if you can."

#### **Stakeholders identify needed improvements, continued challenges for consumers**

Although it helped solve two types of surprise billing problems for consumers, the New York law has left them exposed to others. First, stakeholders across the spectrum noted with

regret that self-funded plans are not subject to requirements to hold the consumer harmless, as state regulation of those plans is preempted under ERISA.

Second, advocates identified network "misinformation" as the biggest remaining problem for consumers receiving surprise bills. "It's enraging," one said. When a consumer gets a balance bill after they've relied in good faith on information that the provider is in-network, "that's a surprise bill." In some cases, consumers may rely on inaccurate, out-of-date plan provider directories (although New York has created its own provider look-up tool, which consumer advocates report has been helpful).<sup>14</sup> In others, they are misinformed by physicians' office staff, who represent that they participate in the patient's network when in fact they do not. The representative of a consumer help line has reported that complaints about inaccurate network information represent 35 percent of calls about surprise bills, with the source of the problem roughly evenly split between plan directories and providers' office staff.<sup>15</sup> Although regulators report that they require insurers to hold consumers harmless if the consumer files a complaint showing they relied on an inaccurate plan provider directory, they are as yet unable to hold providers similarly accountable.

Advocates – and insurers – have also called for the legislature to amend the law to subject out-of-network hospital facilities to the IDR process. In an emergency, if a patient is taken to an out-of-network hospital by an out-of-network ambulance, health insurers must limit the patient's out-of-pocket costs to the in-network cost-sharing. If there is a balance bill, the insurer must pay it. However, several observers noted that these providers often submit "excessive charges," knowing the insurer is on the hook to pay them. Further, advocates noted that these hospitals often initially send the bill directly to the patient, "which is completely confusing." Many patients pay it without realizing they don't need to.

## Conclusion

Health care is complicated. Determining how providers set prices for their services, how insurers determine what to pay for those services, or ultimately what those services should actually cost is “three-dimensional chess.” New York’s Surprise Billing law doesn’t attempt to answer any of those questions. It simply says that patients should not be the ones expected to figure it out. On that score, the law has been a success. Consumer complaints have declined dramatically. For the most part, insurers and providers appear to be working out their differences without resorting to arbitration. Further, there is not yet clear evidence that the law’s use of UCR as a benchmark price has had broadly inflationary

effects. However, it can take time for a policy change to change behavior, including the billing practices of a diverse array of specialty physicians.

The law also contains some significant gaps, particularly with respect to surprise balance bills that occur when patients are misinformed about their providers’ network status and when patients are taken to out-of-network facilities in an emergency. Additionally, like all states, New York must await federal action to amend ERISA before it can act to protect patients enrolled in self-funded employer plans.

## Endnotes

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7. *An Unwelcome Surprise: How New Yorkers Are Getting Stuck with Unexpected Medical Bills from Out-of-Network Providers*. New York State Department of Financial Services.
8. 23 NY Code Rules, and Reg. §400.7 (2015).
9. The "Explanation of Benefits" or EOB form is an insurance company's written explanation regarding a health care claim, describing what the company paid and what the patient must pay.
10. See e.g., Root J, Najmabadi S. "Thousands of Texans Were Shocked by Surprise Medical Bills. Their Requests for Help Overwhelmed the State," *Texas Tribune*, February 12, 2019, <https://www.texastribune.org/2019/02/12/texas-mediation-balance-billing-faces-massive-backlog/> (accessed March 2019).
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15. Benjamin E. "New York Surprise Bill Law: The Consumer Perspective and Ongoing Challenges."

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