December 20, 2016

Honorable Governor C.L "Butch" Otter
700 West Jefferson
Second Floor
Boise, ID 83702

Dear Governor Otter:

The Coalition of Hospital Based Physicians (College of American Pathologists (CAP), American College of Radiology (ACR), American Society of Anesthesiologists (ASA)) is writing you directly as our prior communication of concern regarding a legislative proposal of the Insurance Department was not effective at making changes to their draft. (See attached: "October 27, 2016 Memorandum to Idaho Department of Insurance.")

The legislative proposal of the Idaho Insurance Department to regulate payments by health insurance plans to out-of-network facility based providers rejects the widely acknowledged need for maintaining marketplace equilibrium between physicians and health insurance payors, and, instead, decidedly favors health insurance payors over physicians and the patients we serve. It has been communicated to us that the draft submitted to you by the Department will not address any of the concerns we raised.

Specifically, the proposed legislation of the Department of Insurance would deny out-of-network Idaho physicians the legal authority to negotiate appropriate payment with health insurance plans for medical services that were rendered to their enrollees. The out-of-network care that is rendered is frequently the result of the *health plan's failure* to contract for such services that would otherwise be available to the patient. Of great concern, the Department is proposing to statutorily tie physician out of network payment to "the carrier's contracted payment rate." The unquestionable financial effect of this legislation, if enacted, is to confer state mandated unilateral control over physician payment in the private sector (excluding ERISA plans) to the rate setting decisions of the health insurance payer.

The likely direct consequence of this public policy will be: a devaluation of physician services reflected in both the contracted rates and non-contracted rates; the dismantling of physician networks by both plans and providers who will have no economic incentive to contract; and a decreased availability in physician services that will come as the result of the state's unfavorable reimbursement environment. The scope of Idaho legislation that keys to in-network rates as proposed by the Department is unprecedented in the nation.

The Department has also proposed to key physician payment to the Medicare program. This alternative is equally inequitable and unworkable as Medicare rates are usually less than the in-network rate and, moreover, Medicare does not uniformly cover some physician services which are currently covered by health plans. In some instances Medicare rates, which are driven by federal budgetary requirements and not by the cost of providing care, are so low that they do not even cover the cost of the treatment provided. Thus, there is no incentive for these plans to contract with physicians for their services.

Where legislation or regulation on this issue has been enacted, regardless of partisan composition, or ideological inclination, states and policy makers have recognized the need to maintain marketplace equilibrium between insurance payors and physician providers. In December 2015, the non-partisan National Association of Insurance Commissioners (NAIC) in their annotations on this issue (MDL 74-22) noted that States should consider a payment formula such as: "a) some percentage of a public, independent database of charges for the same or similar services in the same geographic area, or b) some percentage of usual, customary and reasonable (UCR) charges in the state, if defined in state law or regulation." Importantly, the NAIC notes the imperative need for states to recognize the need for payment equilibrium in the market:

> "In setting a benchmark or benchmarks state should carefully consider the impact on the market. Setting a rate too high or too low may negatively impact the ability of facility based providers and heath carriers to agree on a contract."

For these reasons, even states as politically divergent as New York and Florida have keyed physician payment for out-of-network services to a market based charge formula that historically has been the basis for the "usual and customary" physician charge and health insurance plan payment. We support the use of the FAIR health database for determining "usual and customary" rates for reasons elucidated in a report made to the federal Health and Human Services Department (HHS) in 2014 by the University of Chicago (NORC). The report found:

> "The mission of FAIR Health is to provide transparency to the health care and health insurance marketplaces. FAIR Health grew out of a lawsuit with United Healthcare and Aetna where plaintiffs claimed the insurers were misrepresenting usual and customary charges for services...Sixty insurers and employers donate medical claims to FAIR Health. FAIR

> Health has medical claims for approximately 150 million covered lives, 16 billion medical procedures and these figures are growing....For the immediate future, FAIR Health is the database best suited to help address CMS' concerns about establishing comprehensive and transparent out of network payment benchmarks."

It is of great concern to us, and to our physician colleagues around the nation, that, in lieu of FAIR Health, the State of Idaho would consider embracing an unprecedented action that overtly favors health insurance plans with a state mandated payment based on their arbitrary rate setting practices that would apply to all out-of-network facility based physicians. Accordingly, we urge you to reject the proposal of the Department of Insurance. Thank you for your consideration of our comments.

Sincerely,

College of American Pathologists (CAP)
American College of Radiology (ACR)
American Society of Anesthesiologists (ASA)

Cc: Tammy Perkins, Health Adviser, Office of the Idaho Governor
Susie Pouliot, CEO, Idaho Medical Association