

**Illinois College of Emergency Physicians
Illinois Radiological Society
Illinois Society of Anesthesiologists
Illinois Society of Pathologists
Illinois Chapter American Academy of Pediatricians**

July 26, 2010

Senator William R. Haine
Senator David Koehler
Representative Gregory Harris
Director Michael T. McRaith

RE: Amendment to House Bill 5085, Sections 356z
(Nonparticipating facility-based physicians and providers)

Dear Senators Haine and Koehler; Representative Harris and Director McRaith:

We write you today to express our concerns and views regarding out-of network (OON) charges for facility-based physician (FBP) services provided to patients. It is an issue that is crucial for patients, providers, facilities, employers and insurers and we are pleased that you have made this a priority on your legislative agenda. However, we believe that there are facts and considerations that you need to be aware of in developing a policy fix for this issue and appreciate the opportunity to provide additional information.

As independent physicians who provide services that are almost exclusively facility-based (anesthesiology, emergency medicine, neonatology, pathology, and radiology), we are placed in a unique situation that other types of physicians do not face in their practices. Our business is a product of the volume and payor mix of the facilities where we provide services. It is part of our mission to provide the best possible care to all patients without regard to the patient's financial or insurance status. In aggregate we represent over five thousand physicians who provide facility-based services throughout Illinois.

As a result of a Department of Insurance ruling, health insurers have recently found themselves accountable for the entire balance of payment for out-of-network charges by facility-based physicians. There has been a problem, in some instances, where the network of caregivers available to patients enrolled in these plans is much "thinner" than the patients were aware of. When specific facilities are advertised to employers/patients as being "in network," it is not unreasonable for patients to assume that all the services provided in that facility are "in network."

For a number of reasons, physicians do not have contracts with every insurance company covering patients in the physician's service area. This occurs for both FBPs and non-FBPs. Insurers, however, frequently blame the FBPs for being out-of-network, citing an unwillingness to contract by these physicians, and often blaming exclusive contracts which the facilities have

with these providers. In contrast, many FBPs we represent have found that it often is the insurance companies that are unwilling to negotiate fair and equitable contracts for facility-based services. In our experience, the large majority of Illinois FBPs have many contracts with many insurance companies and managed care plans. This is particularly true at larger volume facilities, where exclusive contracts are common. It is only logical that we favor having contracts with insurance companies that cover individuals that live and work in the areas where we provide care.

The physicians we represent desire to have contracts in place for the majority of insurance companies covering lives in our service area, and the failure to contract between FBPs and individual insurers has more to do with the insurer, the provisions of the specific contract, or other issues. The assertion that physicians are simply unwilling to contract with insurance plans is not true.

If an insurer contracts with a facility to provide services to a group of insureds, it seems reasonable that the insurance company should also do its best to ensure that the services of necessary FBPs are also included in their system. The physicians that provide these facility-based services are usually not employed by the facility. Thus, in order to have those services available, the insurance plans must negotiate contracts with these physician groups.

Instead of trying to address the problem of ensuring adequacy of network coverage for patients, the insurance industry's answer to this issue has been to push for legislation that would limit reimbursement to facility-based physicians' for out-of-network charges. We find this approach fundamentally flawed and unfair. Very basically, our concerns are outlined as follows:

Truth in Advertising

Private insurers who offer employers and members/patients an out-of-network option (i.e., PPOs and point of service plans) do not typically inform patients that FBPs may not participate in the network, while advertising that the facility where the FBP practices is an in-network facility. This misleading advertising leads to *unanticipated* out-of-network charges for the patient, as most patients aren't aware that FBPs usually are not employed by the facility. This practice benefits the insurer by shifting costs to the patient through increased premiums upon renewal, avoiding negotiations (or not conducting reasonable negotiations) with the FBP, and shifting blame for the additional payment to the FBP. If an insurer advertises an "adequate network," then good faith negotiations reflecting market conditions need to be made with FBPs at participating facilities.

Determination of Reimbursement Methodology

Insurer "usual and customary" rates (UCRs), upon which a patient's out-of-network payments are calculated, have been demonstrated to be artificially low relative to established market values. The Ingenix database, used as a source of UCRs by many major healthcare insurers, was found to be "fraudulent and conflict-ridden" by the New York State Attorney General in 2009. The UCRs from this database resulted in many patients paying a larger portion of their out-of-network bills, and insurers profiting from the difference.

As a group we are all concerned with the frame of reference used to establish reimbursement for out-of-network care. We are unified in our position that Medicare cannot be a basis of payment to FBPs. The Medicare Physician Fee Schedule is more a matter of Congressional budgetary constraints than a reflection of marketplace reality. Federal and state laws require physicians to stabilize and treat anyone with an emergency medical condition as defined by prudent layperson standard regardless of the patient's ability to pay and without asking about coverage until after the care is provided. Moreover, FBPs, unlike their office-based colleagues, do not have the ability to refuse other patients, since they must care for all patients their facilities admit. Furthermore, Medicare and Medicaid payments to physicians have not kept pace with practice expense inflation or general inflation over the last twenty years. Many of the most frequently provided services have had reimbursements reduced intensifying our reliance on private insurers to provide necessary practice revenue.

Also, we cannot endorse a system where non-participating physicians are paid at the insurer's participating rate. Such a system forces all FBPs to accept whatever insurers offer, thereby destroying any capacity for FBPs to negotiate. This practice will eventually lead to the erosion of practice revenues, inability to attract adequate numbers of physicians and a decrease in access to these critically required specialists. Physicians need to be able to reject an inadequate contract offer from an insurer. Insurers already have a tremendous advantage in the marketplace given their size and financial resources. Physicians are unable to organize because of anti-trust laws, dramatically limiting their bargaining power.

Physician Insurance Plan Participation

FBPs routinely participate with insurer networks. Two recent (2007 & 2008) studies in Texas demonstrate that 90% of 1.7 million claims made by Texas FBPs were *in-network* and that non-FBPs had similar participation rates. There is no compelling reason to think this is any different in Illinois, given the size of the Texas study, the similarities between the states demographics, and the fact that participation results in faster payment, less paperwork and fewer patient complaints.

This legislation should be expressly limited to in-patient services as this is a facility based issue that arises when patients are being treated at in-network facilities by non-network physicians. Moreover, inpatients may not have cognizance or control of the referral process in this setting. Accordingly, the scope of this legislation should be expressly limited to facility based referrals for treatment and diagnosis as this was the stated intention of the bill. Furthermore, any effort to extend the scope of this bill beyond facility based referrals will implicate the billings of multiple, non-facility based medical specialties that may refer patients to facility based services and bill on behalf of physicians in these facilities. Accordingly, we believe that the whole of medicine will be impacted and will oppose such efforts.

The physician specialties of anesthesiology, emergency medicine, neonatology, pathology, and radiology have discussed the issues at length and agree that the best solution is to promote an environment conducive to good faith negotiation resulting in fair terms and rates. We believe in a multifaceted approach where the appropriate incentives are aligned to include the following provisions:

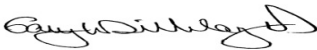
- 1) **At the point of purchase of an insurance policy by an employer, employer group or individual all the information regarding in-network vs. out-of-network services are disclosed. This must include information regarding a complete scope of facility-based services.**
- 2) **When an insurance company contracts with a facility, good faith contract negotiations with all facility-based physicians should be commenced. Any proposed contract must include fair contractual terms and rates.**
- 3) **If no contract exists, reimbursement of physician services will be at 76% of actual charges or the fee set by the Illinois Workers' Compensation fee schedule, whichever is greater.**

We believe these provisions properly incentivize both insurers and physicians to negotiate fairly and in good faith. We thank you for your time and consideration on this issue and look forward to further discussions with you on August 5, 2010.

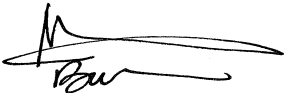
Sincerely,



Dino P. Rumoro, D.O.
President, Illinois College of Emergency Physicians



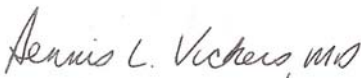
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