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Mark Shurtleff, Attorney General
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Dear Mark:

Over the past several months you have been reading and hearing about issues regarding consumer access to healthcare providers. A bipartisan group of legislators is concerned about the apparent abuse of market power by an increasingly concentrated group of managed care organizations ("MCOs"). The American Medical Association recently released a report that showed that near-monopolies are being created "in virtually all reaches of the United States."

We have been informed that consumer access to good quality, competitively-priced outpatient care provided by qualified ambulatory surgery centers ("ASCs") is threatened by an insurance practice known as "selective contracting." Left unchecked, this practice could severely impact quality of care, patient access, and the exercise of independent physician judgment, in addition to interfering with overall health care competition. As innovative competitors, ASCs are an especial target of selective contracting abuses because ASCs can threaten the comfortable status quo enjoyed by the health care establishment in many respects.

Selective contracting occurs when powerful MCOs control patient access to treatment by channeling consumers to a narrow cadre of providers while limiting access to a wider range of treatment alternatives, often contrary to physician preferences and certainly not by consumer choice. This practice has negative implications for patient welfare and may unlawfully restrain trade. In the short term, convenient and accessible health care facilities can be effectively "locked out" of a consumer's choice of treatment alternatives, even though coverage has been purchased which supposedly provides out-of-network health plan benefits. In the long run, the abuse of MCO market power diverts patients and can undermine the bona fide competitive process, causing a further reduction in consumer choice and fewer competitive alternatives.

The increasingly negative effects of selective contracting in the marketplace can be reflected in various ways. The following list of issues, although anecdotal, illustrates the scope of the problem:

- failure of MCOs to cooperate with out-of-network ASCs in scheduling surgical procedures in a timely, businesslike manner, despite the stated availability of such benefits under a consumer's health plan.
- failure of MCOs to provide comprehensible reimbursement data to consumers, an increasingly significant issue as the use of high deductible, "consumer driven" health coverage expands via Health Savings Accounts and otherwise.
- efforts to "gag" physicians with penalties which may sanction a practitioner if he or she discusses the benefits of treatment at one facility (e.g., hospitals vs. ASCs, in-network vs. out-of-network) rather than another to promote informed decision-making by patients.
- failure of MCOs to clearly explain available out-of-network plan benefits, including substantial out-of-pocket cost –differentials assessed against consumers for services delivered at hospital outpatient departments instead of lower-priced ASCs.
- anti-competitive reduction in consumer choice and market efficiency flowing from an increased concentration of economic power in a small cluster of third party payers.
- overreaching efforts to steer patients to in-network providers by aggressively manipulating enrollee out-of-pocket financial obligations, so that costs of clinically appropriate treatment at an out-of-network facility are not properly credited to the patient.
- refusal to honor the otherwise valid assignment of benefits from a patient to an out-of-network provider.
- unreasonably long payment schedules which cause stress to already burdened patients in recovery.

The growth of selective contracting by powerful MCOs risks creating a dysfunctional health care marketplace which needlessly increases costs, impairs competition and threatens the delivery of good quality health care, both now and in the future. Consumer choice and market innovation are facing substantial threats while MCO profits (lead by executive compensation) rise to nearly unconscionable levels.

Unlike purchasers of life, property, casualty, and auto insurance, consumers have few choices in selecting providers of benefits. Because of the current structure consumers are restricted to limited providers selected by their insurance company or in a few cases their employer, with little regard to the wishes and concerns of an already stressed consumer (patient).

I believe it is the public sector's responsibility to provide more transparency which will allow patients to research and more effectively select (shop) health care suited to their individual needs and comfort zone.

In Utah consumers have fewer and fewer choices in insurance. Twenty years ago we had about forty insurers in the market and today about ten. Realistically only about five are widespread and viable. Even with this scenario most consumers have only one or two choices. We need to be part of the movement nationally to provide innovative solutions.

Doctors are beginning to go to cash only procedures which require patients to deal; with their insurers. This is healthy because it decreases overhead costs and encourages doctors to do what they do best; practice medicine rather than run collection agencies and bookkeeping offices. If we do not help find the solutions, Utah will find itself with a shortage of physicians, limited providers of health care and will fall behind other states and the world in providing a healthy lifestyle and workplace.

We can and should facilitate dissemination of consumer friendly information like costs of procedures, prescriptions, therapies and commonly billed charges. We should provide a central source for information listed above as well as infection rates that are a concern to patients and seen to be increasing in some facilities. Medicare had started publishing its reimbursement rates for 30 elective procedures. This is a good start and a pattern we can follow and expand upon.

Finally we must do something to help the uninsured. The U S Census bureau estimates there are 337,000 uninsured in Utah. This is unconscionable. It leads to poor health of our citizens, a drain on our HIP Utah funds, additional medicare and medicaid spending, human services increases, and most significantly increased insurance cost and emergency room usage for minor problems. This is not the most efficient way.

Therefore, I am asking you to invoke the appropriate powers of your office to review, investigate and rectify these systemic flaws in the health care system to minimize injury to important public interests. We would like to meet with you in the very near future to discuss this matter.

Very truly yours,

A handwritten signature in black ink, appearing to read "Michael Waddoups". The signature is fluid and cursive, with a long horizontal stroke at the end.

Michael Waddoups