



Emergency Responders Health Center

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September 30, 2026

Ms. Frances G. Lippitt
Legislative Staff, Idaho Health Insurers Working Group
Legislative Services Office
P.O. Box 83720
Boise, ID 83720-0054

RE: Regence reimbursement and threatened access to healthcare for approximately 2,000 Idaho Police, Fire and EMS first responders

Dear Ms. Lippitt:

I am writing as Medical Director of Emergency Responders Health Center (ERHC) to request the Working Group's attention—and an opportunity to meet and provide testimony—regarding an issue directly relevant to its work: the effect of health-insurer reimbursement practices on provider sustainability and patients' access to care.

ERHC is an independent, locally owned health center dedicated to the unique medical, occupational, and mental health needs of Idaho's Police Officers, Firefighters, EMS personnel, and their families. More than 30 Idaho public-safety agencies rely on ERHC, including Idaho State Police (ISP). Regence is now our largest insurer, and its reimbursement has reached a point where continued participation may become financially unsustainable. If ERHC is forced to discontinue accepting Regence insurance, approximately 2,000 Idaho first responders could lose in-network access to the first-responder-specific healthcare model their agencies have come to rely upon. I respectfully ask for an opportunity to share ERHC's story and supporting data with the Working Group before that occurs.

ERHC's mission extends well beyond conventional primary care. Our integrated services include family and sports medicine, occupational medicine, mental health, physical therapy, cardiac and cancer screening, and comprehensive department-funded annual wellness examinations. Our "Depth-of-Care" model includes longer visits, after-hours consultation, specialty-care coordination, follow-up after hospitalization and diagnostic testing, and patient advocacy. We also provide agency-wide workforce wellness support, including infectious-disease response, occupational-health protocols, responder-specific health education, and fitness and injury-prevention initiatives. Many of these services are either not billable to insurance or are under-reimbursed, while department-sponsored wellness examinations are funded directly by employers rather than insurers. This model allows ERHC to address multiple health needs proactively and coordinate care in ways that can reduce fragmented care, unnecessary delays, and avoidable higher-cost utilization.

Our principal concerns with Regence are:

- **A decade of limited reimbursement growth.** Between January 2015 and February 2025, Regence reimbursement for our two most common medical office-visit codes (99213 and 99214) increased only 6.38%—

6.67%. Over the same period, reimbursement from our second-largest insurer increased 63.8%–66.4% for these same codes. This discrepancy is similar in all other E&M codes.

- **A six-year rate freeze.** From January 2019 through January 2025, Regence provided no increase in ERHC's medical reimbursement rates, including throughout the COVID-19 pandemic, while the costs of staffing, equipment, technology, insurance, training, and facilities have risen exponentially. For six consecutive years, ERHC received a 0% increase in all E&M and CPT code medical reimbursement rates.
- **A significant impact from the State of Idaho's transition to Regence.** When the State of Idaho moved its employee health plan from Blue Cross to Regence on July 1, 2024, ERHC experienced a reduction of approximately 40% in reimbursement for care provided to Idaho State Police commissioned officers.
- **Mental-health reimbursement that does not support the cost of the program.** Suicide in the #1 cause of death for first responders, and there have been over 10 Police, Fire and EMS suicides in Treasure Valley since ERHC began in 2004. ERHC's commitment to this work became especially personal in 2019 after a Boise Firefighter hung himself on-duty from a ladder truck at Station #1. Within several months, ERHC established its integrated Mental Health Services program in 2020, which has become an important part of our first-responder care model. Approximately 80% of ERHC's mental-health therapy visits are billed under CPT 90837 (55-minute psychotherapy, face-to-face). Regence reimbursement for this code is currently 58.6% below that of our second-largest insurer and does not cover the cost of operating the program. ERHC therefore subsidizes these services in order to recruit and retain qualified therapists and preserve access for first responders and their families.
- **Persistent disparities despite a 2025 adjustment.** After extensive negotiations, Regence increased reimbursement for 99213 and 99214 by approximately 20%–26% in February 2025. Even after that adjustment, the rates remained approximately 35% below those of our second-largest insurer on average.
- **Unsuccessful negotiations for 2026.** During the 2024 negotiations, Regence offered an automatic 2% increase for 2026 and advised ERHC that a request for a larger adjustment would require documentation of increased operating costs. Rather than accept a 2% increase that would leave the existing disparity largely unchanged, ERHC submitted detailed examples of operating-cost increases and requested a multi-year approach to help close the longstanding gap. Regence ultimately denied any increase for 2026 (0% increase) and could not assure an increase for 2027.
- **A widening gap between the cost of insurance and reimbursement for providing care.** Using ERHC's Regence data for 2018–2026, health-insurance premium rates increased 73.2% over eight years—equivalent to approximately 7.1% compounded annually—while Regence reimbursement rates to ERHC for providing medical care increased only 0.67% between years 2015-2025 (amortized at 0.63% annually). If including our one-time negotiated increase in 2025, our annual rate improves to 2.3% annually (amortized). Premiums and provider reimbursement are not identical measures, and ERHC is not suggesting that they should move in lockstep. However, the magnitude of this difference raises an important transparency question: how have substantial increases in the cost of health insurance translated into payment for the clinicians and health centers actually delivering care?
- **Documented financial consequences.** For codes 99213 and 99214 alone, the difference between Regence payments and what the same visits would have generated under our second-largest insurer's rates totaled approximately \$193,525 from January 2022 through June 2024 (30 months). These 2 codes represent approximately 20% of our total revenue from insurers, and exclude the many other E&M/CPT codes and other service lines for which ERHC has experienced reimbursement disparities.
- **Current rate disparities as of September 2026.** For several of ERHC's most frequently used services, Regence reimbursement remains substantially below our other major payers (including our 2nd, 3rd and 4th largest insu):
 - **99213:**
 - Physicians: ≥ 36.5% lower
 - APPs (NP/PA): ≥ 60.5% lower
 - **99214:**
 - Physicians: ≥ 37.9% lower

- APPs (NP/PA): ≥ 62.2% lower
- **90837 (Mental Health Therapy):**
 - Licensed therapists: ≥ 58.6% lower than our second and third largest insurers

ERHC has absorbed these shortfalls through other payer contracts, department-funded wellness examinations, and separate care programs. That cross-subsidy cannot continue indefinitely, nor can it adequately support the staffing, facilities, equipment, and infrastructure required for a growing first-responder population. We have begun internal planning for how we would notify affected agencies and members if ending Regence participation becomes necessary, potentially by January 1, 2028. Our objective is to avoid that outcome—not to end our relationship with Regence. We want to remain in network and continue caring for these first responders, but the reimbursement model must be financially sustainable.

I ask the Idaho Legislature’s Health Insurers Working Group to examine the effects of prolonged reimbursement freezes, the limited negotiating leverage of smaller independent practices, and transparency around insurer premium and provider-payment trends. ERHC’s concern is that when a practice becomes highly dependent on a dominant payer, there may be limited practical leverage to obtain reimbursement that reflects the cost of delivering care. Most importantly, I respectfully request the opportunity to meet with members and, if possible, provide testimony at an upcoming meeting. We are prepared to share our reimbursement schedules, historical rate data, operating-cost information, and the potential consequences for the agencies and first responders we proudly serve. Our purpose is not necessarily to ask the Working Group to resolve a private contract dispute, but to provide a real-world example of how insurer reimbursement practices can ultimately affect healthcare access in Idaho.

Personal Note:

I grew up in Eagle, Idaho, attended elementary and high school in the Boise area, completed medical school through the WWAMI program, and then completed my family medicine residency and sports medicine fellowship in Boise. Truly Idaho at heart. ERHC is locally owned and operated, with a single mission: to provide exceptional healthcare for first responders and their families. Our health center model began in September 2004 after Boise Fire asked me to provide wellness examinations for its Special Operations Dive Team. What began as a small effort to meet one department’s needs grew, largely through relationships and word of mouth, into comprehensive first-responder healthcare model serving agencies across Idaho (and nationally recognized).

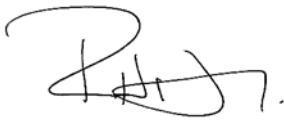
For the past 22 years, much of my professional life has been devoted to building this model. The goal has never been simply to provide more healthcare; it has been to provide better coordinated, proactive care that keeps first responders healthy and on duty while using healthcare resources responsibly. That means addressing multiple concerns during a single visit, after-hours care when an urgent issue can be managed without an ER visit, developing targeted screening and prevention programs, integrating medical and mental-health care, and helping patients navigate specialty care. Our second-largest insurer has consistently recognized ERHC in its “Premier Tier,” based on measures that include quality of care and cost per diagnosis. To me, that’s a testament to our service.

Writing this letter was not an easy decision. ERHC is now facing a choice I have worked for years to avoid: continue absorbing reimbursement that does not adequately support the cost of care and place the long-term sustainability of the health center at risk, or terminate our Regence contract and restrict in-network access for many of the first responders and families we were created to serve. As both physician and business owner,

neither outcome is acceptable to me. That is why I am asking for the opportunity to tell our story directly, provide the underlying data, and participate in a constructive discussion before access to care is lost.

Thank you for considering ERHC's experience and the importance of preserving access to specialized healthcare for the Police Officers, Firefighters, and EMS professionals who protect Idaho's communities.

Sincerely,

A handwritten signature in black ink, appearing to read 'Rob Hilvers', with a stylized flourish at the end.

Rob Hilvers, MD

Medical Director, Emergency Responders Health Center

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