

# DIVISION OF INSURANCE

80<sup>th</sup> Percentile Rule:

Public Comments  
Received



**STATE OF ALASKA**

**Department of Commerce, Community,  
and Economic Development**

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**Division of Insurance  
(907) 465-2515  
Insurance.Alaska.Gov**



June 29, 2018

Lori Wing Heier, Director  
Alaska Division of Insurance  
550 W. 7<sup>th</sup> Avenue, Suite 1560  
Anchorage, AK 99501

Re: May 2018 – 80<sup>th</sup> Percentile Comments

Dear Director Wing Heier,

Thank you for the opportunity to comment on the Notice of Public Scoping for Possible Changes to 3 AAC 26.110 – in an effort to seek input on amendments or alternatives to the regulation that requires health care insurers to pay out-of-network providers for covered services at no less than the 80<sup>th</sup> percentile of charges in the geographical area.

Aetna understands that the Division intends to evaluate the existing 80<sup>th</sup> percentile rule to determine if any changes could be made to address the current methodology for calculating reimbursement for out-of-network provider claims both for professional providers and facilities. The Alaska Division of Insurance updated the governing regulation in 2004 and added the minimum 80<sup>th</sup> percentile rule as the standard for claims reimbursement at the time. The regulation was originally adopted to protect consumers from excessive bills. For reasons outlined below, Aetna believes that the 80<sup>th</sup> percentile rule should be replaced with a methodology that does not unduly increase the cost of care for Alaskans.

Increasingly, a small number of providers control a majority of the market share for medical specialties. This means that specialty care providers are often able to command up to 100% of their full billed charges since the 80<sup>th</sup> percentile methodology is focused on billed charges in the geographical area where services are performed. By its very nature, the 80<sup>th</sup> percentile rule means that the 80% of all providers (ranked in percentile 1-80) will receive 100% of billed charges. Unfortunately, the 80<sup>th</sup> percentile rule is driving up the overall health care costs



because health care providers know that incremental increases to their billed charges to just above the 80<sup>th</sup> percentile raises the overall charge profile. Overtime, the cost of health care services has dramatically increased far beyond the amount allowed by CMS and what we experience in other states.

The Alaska Office of Management and Budget recently sought a study about the effects of the 80<sup>th</sup> Percentile Rule – this study evaluated a variety of areas which directly impact health care cost and all were impacted by the 80<sup>th</sup> percentile rule but the study identified the following services where the 80<sup>th</sup> percentile rule had a significant impact on cost since 2004: “Physician and Clinician Services” and “Other Health” i.e. residential care facilities, ambulance services and services provided in non-traditional settings. The study concluded that health care expenditures were between 8.61% and 24.65% higher as a result of the 80<sup>th</sup> percentile rule with Physician and Clinician Services showing a growth rate between 15% and 39%. The study did show that in the “... in the absence of the rule, health care expenditures would have grown between 4.95% and 6.15% a year which is as high as Alaska’s GDP growth which has averaged 5.4% between 2004 and 2014.”

There are many examples of claims for non-participating providers (non-participating or non-par = out-of-network) where the charges, and thus, the 80<sup>th</sup> percentile allowable are in excess of 400% of CMS and in some cases, above 2000% of CMS allowable amounts. Granted the examples of seeing charges in excess of 2,000% of CMS are not frequent, but the customer and the purchasers of health care are not protected from unnecessarily high health care costs. In addition to higher non-par allowable amounts, the rule has also impacted the cost of care for contracting providers, and the ability to retain these providers as contracted. If providers know that they can earn 400% of the CMS allowable amount if they are a non-participating provider then the incentive for entering into a health plan contract is greatly diminished. Thus, the contracting rates for services with many specialties result in smaller discounts of the providers’ charges.



See below for sample claims of six procedures that show the billed charges for the claims and the allowed amount at the 80<sup>th</sup> percentile vs. at a 125% of Medicare which is a common out-of-network payment methodology used in other parts of the country.

<b>Out of Network Provider or Facility</b>	<b>Claim Experience</b>	<b>Reprice to 80<sup>th</sup> Percentile</b>	<b>Reprice to 125% of Medicare</b>
<b>Procedure</b>	<b>Billed</b>	<b>80<sup>th</sup> Percentile</b>	<b>125% of Medicare</b>
<b>Echocardiogram</b>	\$802	\$743	\$242
<b>Head Injury/Concussion Testing</b>	\$2,131	\$1,648	\$376
<b>Knee Surgery</b>	\$3,245	\$3,204	\$1,014
<b>C-Section</b>	\$7,570	\$7,493	\$2,826

Some Alaska based self-insured plans have started paying a percentage of Medicare for out-of-network services; with this new shift and acceptance of more reasonable payments, more providers are now willing to join networks. Many states allow claims reimbursement for out-of-network services to be based on a percentage of Medicare. Eliminating or amending the 80<sup>th</sup> percentile rule would allow health plans to negotiate stronger networks that benefit Alaskans.



Aetna would appreciate the opportunity to participate in a robust discussion on restructuring the current payment structure with either a percentage of Medicare or other viable solutions. We appreciate that the 80<sup>th</sup> percentile rule has been in place over fourteen years and shifting to other modes of payment might require applying a sunset clause to the rule in an effort to replace it with a percent of Medicare for out-of-network payments or another methodology.

We look forward to continued dialogue with the Division on this matter. In the interim, please do not hesitate to contact me with any questions or to discuss.

Sincerely,

A handwritten signature in black ink, consisting of the letters 'D', 'L', and 'R' connected together, followed by a horizontal line.

Shannon Butler  
Sr. Director of Government Affairs

Transmitted electronically to [insurance@alaska.gov](mailto:insurance@alaska.gov)



## **Alaska Chapter Mission Statement**

*AAHU is a state chapter of the National Association of Health Underwriters. We provide professional development, promote high ethical standards of our members, advocate responsible legislation and proactively educate Alaskans on health and financial security needs.*

**President**  
*Tiffany Stock*

**Immediate Past-President**  
*Open*

**President Elect**  
*Pamela Whitfield*

**Secretary**  
*Aimee Crocker*

**Treasurer**  
*Rhonda Kitter*

**Executive Director**  
*Kate Gootee*

June 26, 2018

Lori Wing-Heier  
Division of Insurance  
Via email to [insurance@alaska.gov](mailto:insurance@alaska.gov)  
Juneau, Alaska 99811

Re: Proposal of amendments or alternatives to regulation 3AAC 26.110

Director Wing-Heier,

The Alaska Association of Health Underwriters (AAHU) appreciates this opportunity to comment on the alternatives to the '80<sup>th</sup> percentile rule' upon reviewing the ISER report on the same. AAHU is an association of health insurance agents, brokers, consultants, and advisors who work with public and private employers, as well as individuals, to design employee benefits programs, including health care management. Our members and board of directors have reviewed the report and offer the following comments:

We believe ISER has reinforced the fact that the 80<sup>th</sup> percentile is a cost driver and has supported a dialogue so that the administration may find an alternative for addressing the cost of care in Alaska and protection of consumers.

Replacing the 80<sup>th</sup> percentile rule with a reimbursement based on a multiple of Medicare or other 'reference based' pricing would help control costs and ensure that providers are paid a fair fee. AAHU recommends beginning with a reimbursement payment up to 250% of Medicare. A reference based option will need to be adopted in a way so that it does not regulate over payments for charges that are now lower than whatever percentile of Medicare is selected. We suggest wording that includes 'payment up to' language rather than 'an amount that is at least'. As noted in the Oliver Wyman report, there were some Provider Specialty's reimbursement levels lower than 250% of Medicare.

It has been said by supporters of the 80<sup>th</sup> percentile, that other states have similar language. AAHU disagrees. Our research indicates that presently, New York requires carriers in the small market space (under 50) to offer some plans (products) that have the 80th percentile used as the floor for non-network reimbursement. However, carriers in New York are NOT required to use the 80th percentile for all of their plans; the same carriers can (and do) offer other products that reimburse non-network with a different reference (Medicare as an example). Another point to be aware of is that in New York the 80th percent regulation only applies to small group (under 50) and most plans in New York, both large and small, are currently indexed off Medicare. AAHU could support this approach as a solution.

Finally, we respectfully ask that the DOI minimally move toward a once a year adjustment for whatever is used as a reference for reimbursing non-network claims. This, coupled with balance billing legislation, would protect our Alaskan consumers.

Again, we appreciate the opportunity to review and comment on these documents.

Sincerely,

*Tiffany Stock*  
Tiffany Stock  
AAHU President

P. O. Box 244065, Anchorage, AK 99524 – (907) 644-1466

## Wing-Heier, Lori K (CED)

---

**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Friday, June 29, 2018 8:12 AM  
**To:** Wing-Heier, Lori K (CED)  
**Subject:** FW: May 2018 - 80th Percentile Comments

Good Morning Lori,

Here is another 80th Percentile comment.

Thank You,

Suzy Bethel  
Office Assistant  
Alaska Division of Insurance  
907-465-4614

-----Original Message-----

**From:** Terry Allard <terrya@thewilsonagency.com>  
**Sent:** Friday, June 29, 2018 6:59 AM  
**To:** Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
**Subject:** May 2018 - 80th Percentile Comments

Terry Allard  
11619 Brook Hill Court  
Anchorage, AK 99516

June 29, 2018

Dear Lori Wing-Heier,

June 28, 2018

Lori Wing-Heier  
Division of Insurance  
Via email to insurance@alaska.gov  
Juneau, Alaska 99811

Re: Proposal of amendments or alternatives to regulation 3AAC 26.110

Director Wing-Heier,

The Alaska Association of Health Underwriters (AAHU) appreciates this opportunity to comment on the alternatives to the '80th percentile rule' upon reviewing the ISER report on the same. AAHU is an association of health insurance agents, brokers, consultants, and advisors who work with public and private employers, as well as individuals, to design

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Finally, we respectfully ask that the DOI minimally move toward a once a year adjustment for whatever is used as a reference for reimbursing non-network claims. This, coupled with balance billing legislation, would protect our Alaskan consumers.

Again, we appreciate the opportunity to review and comment on these documents. Thank you for your consideration and we look forward to continuing to work with you on this and other matters.

Sincerely,  
Terry Allard

## Wing-Heier, Lori K (CED)

---

**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Friday, June 29, 2018 2:12 PM  
**To:** Wing-Heier, Lori K (CED)  
**Subject:** FW: May 2018 - 80th Percentile Comments from Teena Applegate

**Follow Up Flag:** Follow up  
**Flag Status:** Flagged

Good Afternoon Lori,

Here is an 80th Percentile comment from Teena Applegate from The Alaska Association of Health Underwriters.

Thank You,

Suzy Bethel  
Office Assistant  
Alaska Division of Insurance  
907-465-4614

-----Original Message-----

**From:** Teena Applegate <tapplegate@risqconsulting.com>  
**Sent:** Friday, June 29, 2018 2:00 PM  
**To:** Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
**Subject:** May 2018 - 80th Percentile Comments

Teena Applegate  
3440 Hines Circle  
Anchorage, AK 99516

June 29, 2018

Dear Lori Wing-Heier,

June 28, 2018

Lori Wing-Heier  
Division of Insurance  
Via email to insurance@alaska.gov  
Juneau, Alaska 99811

Re: Proposal of amendments or alternatives to regulation 3AAC 26.110

Director Wing-Heier,

The Alaska Association of Health Underwriters (AAHU) appreciates this opportunity to comment on the alternatives to the '80th percentile rule' upon reviewing the ISER report on the same. AAHU is an association of health insurance agents, brokers, consultants, and advisors who work with public and private employers, as well as individuals, to design employee benefits programs, including health care management. Our members and board of directors have reviewed the report and offer the following comments:

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Again, we appreciate the opportunity to review and comment on these documents. Thank you for your consideration and we look forward to continuing to work with you on this and other matters.

Sincerely  
Teena Applegate, RISQ Consulting

## Wing-Heier, Lori K (CED)

---

**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Thursday, June 28, 2018 11:23 AM  
**To:** Wing-Heier, Lori K (CED)  
**Subject:** FW: May 2018 - 80th Percentile Comments

Good Morning Lori,

Here is another 80th Percentile comment.

Thank You,

Suzy Bethel  
Office Assistant  
Alaska Division of Insurance  
907-465-4614

-----Original Message-----

From: Gina Bosnakis <gina@ginabosnakis.com>  
Sent: Thursday, June 28, 2018 11:08 AM  
To: Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
Subject: May 2018 - 80th Percentile Comments

Gina Bosnakis  
801 B Street  
Anchorage, AK 99501

June 28, 2018

Dear Lori Wing-Heier,

June 28, 2018

Lori Wing-Heier  
Division of Insurance  
Via email to insurance@alaska.gov  
Juneau, Alaska 99811

Re: Proposal of amendments or alternatives to regulation 3AAC 26.110

Director Wing-Heier,

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Sincerely,  
Gina Bosnakis

## Wing-Heier, Lori K (CED)

---

**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Thursday, June 28, 2018 3:18 PM  
**To:** Wing-Heier, Lori K (CED)  
**Subject:** FW: May 2018 - 80th Percentile Comments

Good Afternoon Lori,

Here is another 80th Percentile comment.

Thank You,

Suzy Bethel  
Office Assistant  
Alaska Division of Insurance  
907-465-4614

-----Original Message-----

From: Jolene Bryant <joleneb@thewilsonagency.com>  
Sent: Thursday, June 28, 2018 2:08 PM  
To: Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
Subject: May 2018 - 80th Percentile Comments

Jolene Bryant  
3000 a Street  
Anchorage, AK 99503

June 28, 2018

Dear Lori Wing-Heier,

June 28, 2018

Lori Wing-Heier  
Division of Insurance  
Via email to insurance@alaska.gov  
Juneau, Alaska 99811

Re: Proposal of amendments or alternatives to regulation 3AAC 26.110

Director Wing-Heier,

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Sincerely,  
Jolene Bryant

## Wing-Heier, Lori K (CED)

---

**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Thursday, June 28, 2018 11:05 AM  
**To:** Wing-Heier, Lori K (CED)  
**Subject:** FW: May 2018 - 80th Percentile Comments

Good Morning Lori,

Here is another 80th Percentile comment.

Thank You,

Suzy Bethel  
Office Assistant  
Alaska Divison of Insurance  
907-465-4614

-----Original Message-----

From: Terri Good <terri@ginabosnakis.com>  
Sent: Thursday, June 28, 2018 9:38 AM  
To: Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
Subject: May 2018 - 80th Percentile Comments

Terri Good  
801 B ST STE 505A  
ANCHORAGE, AK 99501

June 28, 2018

Dear Lori Wing-Heier,

June 28, 2018

Lori Wing-Heier  
Division of Insurance  
Via email to [insurance@alaska.gov](mailto:insurance@alaska.gov)  
Juneau, Alaska 99811

Re: Proposal of amendments or alternatives to regulation 3AAC 26.110

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Sincerely,  
Terri Good

## Wing-Heier, Lori K (CED)

---

**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Thursday, June 28, 2018 1:03 PM  
**To:** Wing-Heier, Lori K (CED)  
**Subject:** FW: May 2018 - 80th Percentile Comments

Good Afternoon Lori,

Here is another 80th Percentile comment.

Thank You,

Suzy Bethel  
Office Assistant  
Alaska Divison of Insurance  
907-465-4614

-----Original Message-----

**From:** Melonie Goodhue <meloniegoodhue@gmail.com>  
**Sent:** Thursday, June 28, 2018 11:48 AM  
**To:** Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
**Subject:** May 2018 - 80th Percentile Comments

Melonie Goodhue  
1220 E 16th Ave #11  
Anchorage, AK 99501

June 28, 2018

Dear Lori Wing-Heier,

June 28, 2018

Lori Wing-Heier  
Division of Insurance  
Via email to insurance@alaska.gov  
Juneau, Alaska 99811

Re: Proposal of amendments or alternatives to regulation 3AAC 26.110

Director Wing-Heier,

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Sincerely,  
Melonie Goodhue

## Wing-Heier, Lori K (CED)

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**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Thursday, June 28, 2018 11:32 AM  
**To:** Wing-Heier, Lori K (CED)  
**Subject:** FW: May 2018 - 80th Percentile Comments

Good Morning Lori,

Here is another 80th Percentile comment.

Thank You,

Suzy Bethel  
Office Assistant  
Alaska Division of Insurance  
907-465-4614

-----Original Message-----

From: Jennifer Meyhoff <jennifer.meyhoff@marshmc.com>  
Sent: Thursday, June 28, 2018 11:28 AM  
To: Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
Subject: May 2018 - 80th Percentile Comments

Jennifer Meyhoff  
1031 W 4th Ave, Suite 400  
Anchorage, AK 99501-5905

June 28, 2018

Dear Lori Wing-Heier,

June 28, 2018

Lori Wing-Heier  
Division of Insurance  
Via email to insurance@alaska.gov  
Juneau, Alaska 99811

Re: Proposal of amendments or alternatives to regulation 3AAC 26.110

Director Wing-Heier,

Thank you for this opportunity to comment on the alternatives to the '80th percentile rule' after reviewing the ISER report on the same. As a member of Alaska Association of Health Underwriters (AAHU) and the Director of Employee

Health & Benefits for Marsh & McLennan Agency, I work with public and private employers designing employee benefits programs, both fully insured and self funded employer plans. MMA and our clients find this issue of great importance.

We believe ISER has reinforced the fact that the 80th percentile is a cost driver and has supported a dialogue so that the administration may find an alternative for addressing the cost of care in Alaska and protection of consumers.

Replacing the 80th percentile rule with a reimbursement based on a multiple of Medicare or other 'reference based' pricing would help control costs and ensure that providers are paid a fair fee. AAHU recommends beginning with a reimbursement payment up to 250% of Medicare. A reference based option will need to be adopted in a way so that it does not regulate over payments for charges that are now lower than whatever percentile of Medicare is selected. We suggest wording that includes 'payment up to' language rather than 'an amount that is at least'. As noted in the Oliver Wyman report, there were some Provider Specialty's reimbursement levels lower than 250% of Medicare.

It has been said by supporters of the 80th percentile, that other states have similar language. AAHU disagrees. Our research indicates that presently, New York requires carriers in the small market space (under 50) to offer some plans (products) that have the 80th percentile used as the floor for non-network reimbursement. However, carriers in New York are NOT required to use the 80th percentile for all of their plans; the same carriers can (and do) offer other products that reimburse non-network with a different reference (Medicare as an example). Another point to be aware of is that in New York the 80th percent regulation only applies to small group (under 50) and most plans in New York, both large and small, are currently indexed off Medicare. AAHU could support this approach as a solution.

Finally, we respectfully ask that the DOI minimally move toward a once a year adjustment for whatever is used as a reference for reimbursing non-network claims. This, coupled with balance billing legislation, would protect our Alaskan consumers.

Again, I appreciate the opportunity to review and comment on these documents. Thank you for your consideration and I look forward to continuing to work with you on this and other matters.

Sincerely,  
Jennifer Meyhoff

## Wing-Heier, Lori K (CED)

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**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Thursday, June 28, 2018 11:31 AM  
**To:** Wing-Heier, Lori K (CED)  
**Subject:** FW: May 2018 - 80th Percentile Comments

Good Morning Lori,

Here is another 80th Percentile comment.

Thank You,

Suzy Bethel  
Office Assistant  
Alaska Division of Insurance  
907-465-4614

-----Original Message-----

**From:** Stephanie Rossland <stephanier@thewilsonagency.com>  
**Sent:** Thursday, June 28, 2018 11:28 AM  
**To:** Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
**Subject:** May 2018 - 80th Percentile Comments

Stephanie Rossland  
3000 A Street  
Anchorage, AK 99503

June 28, 2018

Dear Lori Wing-Heier,

June 28, 2018

Lori Wing-Heier  
Division of Insurance  
Via email to insurance@alaska.gov  
Juneau, Alaska 99811

Re: Proposal of amendments or alternatives to regulation 3AAC 26.110

Director Wing-Heier,

The Alaska Association of Health Underwriters (AAHU) appreciates this opportunity to comment on the alternatives to the '80th percentile rule' upon reviewing the ISER report on the same. AAHU is an association of health insurance agents, brokers, consultants, and advisors who work with public and private employers, as well as individuals, to design

employee benefits programs, including health care management. Our members and board of directors have reviewed the report and offer the following comments:

We believe ISER has reinforced the fact that the 80th percentile is a cost driver and has supported a dialogue so that the administration may find an alternative for addressing the cost of care in Alaska and protection of consumers.

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Again, we appreciate the opportunity to review and comment on these documents. Thank you for your consideration and we look forward to continuing to work with you on this and other matters.

Sincerely,  
Stephanie Rossland

## Wing-Heier, Lori K (CED)

---

**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Thursday, June 28, 2018 11:07 AM  
**To:** Wing-Heier, Lori K (CED)  
**Subject:** FW: May 2018 - 80th Percentile Comments

Good Morning Lori,

Here is another 80th Percentile comment.

Thank You,

Suzy Bethel  
Office Assistant  
Alaska Division of Insurance  
907-465-4614

-----Original Message-----

**From:** Dusty Silva <dusty@silvainsurance.net>  
**Sent:** Thursday, June 28, 2018 9:58 AM  
**To:** Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
**Subject:** May 2018 - 80th Percentile Comments

Dusty Silva  
234 W Evergreen Ave  
Palmer, AK 99645

June 28, 2018

Dear Lori Wing-Heier,

June 28, 2018

Lori Wing-Heier  
Division of Insurance  
Via email to insurance@alaska.gov  
Juneau, Alaska 99811

Re: Proposal of amendments or alternatives to regulation 3AAC 26.110

Director Wing-Heier,

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Sincerely,  
Dusty Silva

## Wing-Heier, Lori K (CED)

---

**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Thursday, June 28, 2018 11:08 AM  
**To:** Wing-Heier, Lori K (CED)  
**Subject:** FW: May 2018 - 80th Percentile Comments

Good Morning Lori,

Here is another 80th Percentile comment.

Thank You,

Suzy Bethel  
Office Assistant  
Alaska Division of Insurance  
907-465-4614

-----Original Message-----

**From:** Nancy Tietje <nancy@davies-barry.com>  
**Sent:** Thursday, June 28, 2018 10:08 AM  
**To:** Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
**Subject:** May 2018 - 80th Percentile Comments

Nancy Tietje  
4205 Cambria Dr. West, Ste 201  
Ketchikan, AK 99901

June 28, 2018

Dear Lori Wing-Heier,

June 28, 2018

Lori Wing-Heier  
Division of Insurance  
Via email to insurance@alaska.gov  
Juneau, Alaska 99811

Re: Proposal of amendments or alternatives to regulation 3AAC 26.110

Director Wing-Heier,

The Alaska Association of Health Underwriters (AAHU) appreciates this opportunity to comment on the alternatives to the '80th percentile rule' upon reviewing the ISER report on the same. AAHU is an association of health insurance agents, brokers, consultants, and advisors who work with public and private employers, as well as individuals, to design

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Sincerely,  
Nancy Tietje

## Wing-Heier, Lori K (CED)

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**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Thursday, June 28, 2018 11:06 AM  
**To:** Wing-Heier, Lori K (CED)  
**Subject:** FW: May 2018 - 80th Percentile Comments

Good Morning Lori,

Here is another 80th Percentile comment.

Thank You,

Suzy Bethel  
Office Assistant  
Alaska Division of Insurance  
907-465-4614

-----Original Message-----

**From:** Joshua Weinstein <jweinstein@northrimbenefits.com>  
**Sent:** Thursday, June 28, 2018 9:48 AM  
**To:** Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
**Subject:** May 2018 - 80th Percentile Comments

Joshua Weinstein  
3111 C St. #500  
Anchorage, AK 99503

June 28, 2018

Dear Lori Wing-Heier,

June 28, 2018

Lori Wing-Heier  
Division of Insurance  
Via email to insurance@alaska.gov  
Juneau, Alaska 99811

Re: Proposal of amendments or alternatives to regulation 3AAC 26.110

Director Wing-Heier,

The Alaska Association of Health Underwriters (AAHU) appreciates this opportunity to comment on the alternatives to the '80th percentile rule' upon reviewing the ISER report on the same. AAHU is an association of health insurance agents, brokers, consultants, and advisors who work with public and private employers, as well as individuals, to design

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Sincerely,  
Joshua Weinstein

## Wing-Heier, Lori K (CED)

---

**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Thursday, June 28, 2018 11:07 AM  
**To:** Wing-Heier, Lori K (CED)  
**Subject:** FW: May 2018 - 80th Percentile Comments

Good Morning Lori,

Here is another 80th Percentile comment.

Thank You,

Suzy Bethel  
Office Assistant  
Alaska Division of Insurance  
907-465-4614

-----Original Message-----

**From:** Lon Wilson <lonw@wilsonalbers.com>  
**Sent:** Thursday, June 28, 2018 9:48 AM  
**To:** Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
**Subject:** May 2018 - 80th Percentile Comments

Lon Wilson  
11553 Discovery Heights Cir  
Anchorage, AK 99515

June 28, 2018

Dear Lori Wing-Heier,

June 28, 2018

Lori Wing-Heier  
Division of Insurance  
Via email to insurance@alaska.gov  
Juneau, Alaska 99811

Re: Proposal of amendments or alternatives to regulation 3AAC 26.110

Director Wing-Heier,

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Again, we appreciate the opportunity to review and comment on these documents. Thank you for your consideration and we look forward to continuing to work with you on this and other matters.

Sincerely,  
Lon Wilson

June 25, 2018

To the Division of Insurance:

Thank you for this opportunity to comment on the recent ISER report about Alaska's healthcare expenditures. I am an emergency physician practicing at Providence Alaska Medical Center, which is the largest Emergency Department in Alaska, providing the "safety net" for over 75,000 patients annually regardless of their ability to pay for their care. I appreciate the opportunity to work with the Division of Insurance on finding solutions to Alaska's healthcare spending that maintains life-saving access to quality care for Alaskans.

I will defer to others to debate the validity of the ISER report because I would prefer to discuss solutions. I will note that the study shows Alaska had an upward rate of growth of healthcare expenses that started in 2000, well before the introduction of the 80<sup>th</sup> percentile rule. The study also does not include the expenditures for healthcare obtained outside the State as many Alaskans traveled outside of Alaska or were transferred outside of Alaska for care before the 80<sup>th</sup> percentile rule. Because of increased access, Alaskans are able to stay in state, utilizing local healthcare resources, which has increased Alaska's healthcare expenditures. The study also confirms that as much as 90% of the increase in Alaska healthcare expenditures since 2004 are not related to the 80<sup>th</sup> percentile rule. Thus, the study shows that the 80<sup>th</sup> percentile rule has not been a dominant factor in driving up the State's healthcare costs.

As you know, the 80<sup>th</sup> percentile rule does what it was meant to do: it protects Alaskans. It's the insurance companies that do not adhere to the 80<sup>th</sup> percentile rule that have patients receiving exorbitant surprise balance bills. For example, at my Emergency Department practice we have insurance companies that pay for services at the 80<sup>th</sup> percentile level which creates no balance billing or surprise billings and no problems. Again, it is insurance companies that pay well below the 80<sup>th</sup> percentile level - attempting to not pay fair reimbursement for life saving services - that cause surprise billings. The 80<sup>th</sup> percentile rule benefits have also included the increase number of physicians – per the ISER report, a 50% increase - in the state providing much improved access to care for Alaskans. Given the important benefit to residents and the non-dominant impact on costs to the state, the 80<sup>th</sup> percentile rule continues to serve its intended purpose of consumer protection.

In general, efforts aimed at lowering the state's healthcare costs should provide access to lower cost care, minimize utilization of emergency and high cost specialty services, provide abundant primary care, prenatal care, family planning and behavioral health services, and integrate care coordination.

Specifically, for emergencies where patients cannot choose to go outside of Alaska or have time or ability to choose their physicians, you must maintain the 80<sup>th</sup> percentile rule, as this not only protects the patient from surprise bills, but it protects the safety net of our emergency care system. As emergency physicians, we are regulated by the federal government through

EMTALA law to provide care for every individual who seeks care at the emergency department regardless of their ability to pay. Many of our patients are uninsured. From a patient perspective, you must have qualified capable Emergency Physicians to care for patients in their time of need.

It seems as though there are two problems that are interrelated, the problem of controlling physician fees and the problem of balance billing. One approach would be to solve both problems with a single solution, while another would be to solve the problems separately.

One solution to control the fees is to select a year and lock physicians into their fee schedule as their starting point. Then, allow annual fee adjustments that are governed by the medical services index of the Consumer Price Index (CPI), such as a 3% increase yearly. For fees that are more than 10% above or below the current FairHealth levels, these could be adjusted to start the new base fee levels. You could also mandate that regardless of fees, insurance will pay the lesser of the physician fees or 80<sup>th</sup> percentile.

Regarding solutions to balance billing, there have been solutions proposed and implemented in multiple other states so there is already some framework for controlling balanced billing. For instance, to control balance billing it would be reasonable to limit patient out of pocket expenses to \$600 or another reasonable number. If a balance bill is greater than \$600 then you could implement an arbitration system, such as done in Texas.

If you want to eliminate balance billing in emergencies, as this is what seems to cause the most disputes, then you must hold the insurance companies accountable for a payment that is fair and reasonable. For example, at my practice an emergency room patient had a complex visit including a cardiac evaluation, IV sedation and cardioversion (shocking the patient's heart back into a regular rhythm). This is a medically complex and life saving visit as the procedure requires extensive physician expertise including qualifications for performing a sedation as well as training and expertise in resuscitation capabilities. The patient charge was \$1219. Their insurance paid \$386 which is not fair reimbursement for the complexity of evaluation, sedation, cardiac cardioversion, and recovery of the patient. The patient was balance billed \$832.42. If their insurance had paid the 80<sup>th</sup> percentile - \$1213 - then the patient would not have been balance billed. Balance billing would naturally be eliminated. It's examples like this when an insurance company chooses not to adhere to the 80<sup>th</sup> percentile during a patient's emergency that creates high surprise bills for patients. Insurance companies should be held to 80<sup>th</sup> percentile rule in emergencies, and likely this will need to be done through legislation.

A combined solution would be a three-part plan: set provider fees based on a selected year with a governor on fee increases, then pass legislation that would reimburse at the lesser of the 80<sup>th</sup> percentile or physician charges, then end ban balance billing in emergencies.

I know my colleague Dr. Anne Zink has proposed another solution based on super geo zip codes. While seemingly complex, it is also a viable solution that I would also recommend for your consideration as a solution.

For a multitude of reasons, we do not support any system that links fees or reimbursement to Medicare rates. Medicare rates do not represent fair market value of healthcare services much less cover provider costs. Also, Medicare was never intended for this purpose: It was intended for an age-specific population and is based on the federal budget. It does not take into account the cost of actually providing care in emergencies, the financial burden of emergency preparedness, boarding of patients in the ER, and it does not have codes for pediatrics or behavioral health. Medicare rates are arbitrarily low and have not kept pace with inflation much less take into account the cost of business in Alaska. Using such an arbitrary benchmark will lead to the dismantling of our healthcare safety net.

Thank you for allowing us to participate in this conversation. Please contact me at any time for any questions.

Sincerely,

Sami Ali, MD FACEP  
Business Manager  
Alaska Emergency Medicine Associates  
713-391-7369  
mrssamiali@me.com

## Wing-Heier, Lori K (CED)

---

**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Wednesday, June 27, 2018 3:26 PM  
**To:** Wing-Heier, Lori K (CED)  
**Subject:** FW: May 2018 - 80th Percentile Comments

Good Afternoon Lori,

Here is another 80<sup>th</sup> percentile comment.

Thank You,

Suzy Bethel  
Office Assistant  
Alaska Division of Insurance  
907-465-4614

**From:** Gene R. Quinn, MD <GQuinn@alaskaheart.com>  
**Sent:** Wednesday, June 27, 2018 2:47 PM  
**To:** Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
**Subject:** May 2018 - 80th Percentile Comments

Dear Sir or Madam;

My name is Gene Quinn and I am writing you to comment on the 80<sup>th</sup> Percentile rule from a physician and healthcare system perspective. By way of background, I am a practicing cardiologist in Alaska as well as the Medical Director of Quality and Population Health for Alaska Heart and Vascular Institute. I also hold a Masters of Public Health in Healthcare Management and Policy from the Harvard School of Public Health, and completed a fellowship in Quality and Patient Safety through Harvard Medical School.

I think it is common for people to try to take complex problems and boil them down into one or two simple things that they think will solve everything, often without considering the consequences of those actions. This is especially common with lay people who don't understand the intricacies of the complex problem in question. This is certainly what has happened with healthcare, as evidenced by the media coverage that seems to think if we could just get doctors to make less money or just abolish the 80<sup>th</sup> Percentile rule then healthcare in Alaska would suddenly be fixed. Digging just a little deeper would easily prove these statements false.

The reality is that taking care of people's health costs money. It is certainly true that Alaska's healthcare costs are higher than most other states (though not the highest), but it also has by far the lowest population density of any state and some of the most remote populated locations in the United States. The Anchorage Daily News opinion section unfortunately likes to say that we pay high healthcare costs, but only get health outcomes similar to the lower 48 states. As a Quality specialist, when I heard this I was amazed at how fantastic that was – after all, it's impossible to get produce or FedEx shipments or Amazon Prime packages with the same outcomes as the lower 48 states here in Anchorage, so healthcare is actually ahead of the curve. Try to get that same produce or shipment in Kotzebue and you'll get an even worse outcome (though healthcare outcomes include care given to patients in those remote

regions). In general, I would say the Alaska healthcare system could use improvement, but it works remarkably well and beyond what I would expect if indexed to other industries.

Now consider what happens when we change just one piece of this intricate system. Using physician compensation as an example, the average doctor in Alaska has higher compensation than their counterparts in the lower 48. What is not widely reported is that despite this increased compensation, we still have a shortage of both primary care and subspecialty physicians. In fact, Alaska Heart and Vascular Institute has been trying to recruit cardiologists that meet our quality standards for many years and still cannot keep up with the healthcare needs of the state – we have about half the number of cardiologists per capita as the lower 48. If the law of supply and demand holds, why aren't there physicians lining up to move to Alaska for the increased compensation? Likely the same reason that all other fields of employment in Alaska pay more than their lower 48 counterparts, but still have trouble recruiting talent. When you are trying to recruit highly trained individuals to the state but you take away that differential compensation from the lower 48, it logically follows that there will be a decrease in both the number and the quality of the healthcare providers to take care of Alaskans.

The same concept applies to the 80<sup>th</sup> Percentile Rule. Healthcare is one of the biggest industries supporting the economy of Alaska. Providence is the biggest private employer of Alaskans, and many of the best paying jobs in Alaska with good benefits are in the healthcare industry. Alaska Heart and Vascular Institute employs about 300 Alaskans and offers them good wages and comprehensive benefits. It's hard to argue that healthcare is anything but a good industry for the state – it provides jobs and economic support and the product of the industry is better health for Alaskans.

When writers that care more about selling newspapers than providing unbiased and constructive solutions for a complex system urge you to pass a law that would remove tens of millions of dollars from the healthcare industry in Alaska, we need to consider the full spectrum of consequences that entails. Mr. Wolforth's argument that saving insurance companies millions of dollars will somehow trickle down into a noticeable savings passed directly onto the consumer via reduced individual premiums is dubious at best. On the other hand, removing the 80<sup>th</sup> Percentile Rule would almost certainly lead to less jobs, less taxes collected, less investment and growth in Alaskan healthcare, and less access to care – especially for vulnerable populations. Healthcare costs more here, and if you look at a map it's not hard to see why – take away the money and you won't get more efficiency, you'll just get less health.

We are easily blinded by big dollar amounts and allegations of waste and misuse. It's good for headlines and theatre, but it's not the whole story on a complicated issue such as healthcare. Certainly you can anecdotally find a few physicians who have gamed the system and worked too little for too much profit, but these are the exceptions to the rule. Most of us are trying to build strong and integrated care systems to improve the health of our patients, and inflammatory rhetoric doesn't help us achieve that goal. I truly hope that we start to focus on the quality of healthcare that we get for the money we pay rather than waging warfare on the systems of care that patients depend on – before it's too late.

Sincerely,

Gene R. Quinn, MD, MPH, CPPS  
Medical Director of Quality and Population Health  
Alaska Heart and Vascular Institute

Phone: (907) 561-3211 x5577  
Email: [GQuinn@alaskaheart.com](mailto:GQuinn@alaskaheart.com)



# Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

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June 27th, 2018

Ms. Lori Wing-Heier, Director  
Division of Insurance - Department of CCED  
550 West 7<sup>th</sup> Ave., Suite 1560  
Anchorage, AK 99501

Via email: [insurance@alaska.gov](mailto:insurance@alaska.gov)

Dear Director Wing-Heier:

On behalf of the Alaska State Medical Association (ASMA) and its over 500 physician members, I am submitting this letter in response to your solicitation for proposals of amendments or alternatives to state regulation 3AAC 26.110.

ASMA has consistently supported and engaged in efforts to work with the State and interested stake holders on improving 3AAC 26.110 to address concerns, real or perceived, related to its current application. To be clear, ASMA supports efforts to identify and define issues around the regulation and work on those specific issues to improve the protections afforded to Alaskans within the current regulation.

Your Notice of Public Scoping for Possible Changes was specific in seeking alternatives that dually address potential impacts on the cost of care and protecting consumers from surprise balance bills from out of network providers. This past May ASMA adopted a framework to propose changes to the current regulation. While ASMA adopted this framework, we continue to be willing to engage constructively on other proposals that protect patients and ensure fair reimbursements. It is important to note that while some insurance companies admittedly are only concerned with their insured, ASMA's concern is with access to quality care of all patients regardless of whether they are Medicare, Medicaid, privately insured or self-insured. The impacts of one group can and often do impact access of others. Impacts of cost shifting must be included in any discussion around reimbursements especially if we want to preserve access to patients on plans such as Medicaid and Medicare that pay well below market rates. ASMA proposes two changes:

- 1) The State should adopt regulations that ensure it has accurate and timely data. Basing significant policy decisions on old and inaccurate data increases the risks that those decisions will have unintentional consequences that impact patient access. As an example, we know generally that the vast majority of specialists in Alaska are now in-network and yet we continue to see policy discussions based on stale data that does not incorporate this importation. Accurate and timely data is critical to building the foundation of good policy. ASMA supports a State run all-claims-database or contracting with an independent entity such as Fair Health to access such data.
- 2) The concern most often expressed over 3AAC 26.110 is that a physician or group with a market share of 20% could theoretically "set the rate" of reimbursement. While we have seen no evidence to support this has occurred we recognize the math would allow it and clearly the 80<sup>th</sup> percentile was meant to

exclude the top 20<sup>th</sup> percentile outliers while still representing a market rate. We believe the protections of the regulation can be preserved while addressing this issue by creating a tiered system that expands the geographic area to ensure competition which removes the theoretic ability for a single office to “set the rate.” This system is similar to one employed by insurance companies working in Alaska. In concept:

- a. CPT codes with five or more claims within each geographical area of the state would be reimbursed at the 80<sup>th</sup> percentile of billed charges in the region or the providers billed charges, whichever is lower.
- b. If a CPT code has fewer than five claims within the geographical area of the state would be reimbursed at the 80<sup>th</sup> percentile of billed charges in the state or the providers’ billed charges, whichever is lower.
- c. If a CPT code has fewer than five claims within the State the CPT code would be reimbursed at the 80<sup>th</sup> percentile of billed charges within the state or the providers billed charges, whichever is lower. However, the recognition of such a CPT code would trigger an investigation on the CPT code to analyze whether the reimbursement level is artificial or necessary for ensuring access to the service. We recognize this third tier may be cumbersome however we believe these codes would be few and we would welcome exploring other ideas.

We appreciate your efforts to protect patients’ access to care, your willingness to engage and listen to our input, and look forward to continuing to be a constructive participant in future discussions.

Sincerely,



Peter Lawrason MD,  
President  
Alaska State Medical Association



June 27, 2018

Lori Wing-Heier, Director  
Alaska Division of Insurance  
Via email to [insurance@alaska.gov](mailto:insurance@alaska.gov)  
Juneau, Alaska 99811

Re: 80<sup>th</sup> Percentile Regulation

Director Wing-Heier:

Alaskans for Sustainable Healthcare Costs is a group of Alaskan employers who are concerned about the current healthcare environment in the state. We are working with our employees and all Alaskans to understand and find solutions about drivers that are affecting our ability to offer affordable and attractive benefits.

One misperception about the 80<sup>th</sup> Percentile Regulation is that it protects consumers from balance billing. That is not the case and our members see it all too frequently. But, the problem goes much deeper.

In our quest to understand some of the contributing factors as to why the cost to provide our employees insurance continues to be in the top category of our expenses, we sought out data. We have received presentations from actuaries regarding the costs of insurance plans, as well as the costs of healthcare services in Alaska compared to the Lower 48 and Hawaii.

There have been comments made in the community regarding the time element of the data from the Milliman Study, stating it is from 2014 and therefore is outdated. We disagree with these opinions. Healthcare data analyses are necessarily done with claims lag. If the Study were to be updated, it would certainly show healthcare costs have only gotten higher in the past few years. This point has been made in the Oliver Wyman report. Additionally, the May 2018 ISER report has confirmed for us, again, that the 80<sup>th</sup> percentile is a cost driver.

As a group of employers from a variety of industries we offer different forms of insurance plans to our employees. We represent plans from both the fully-insured commercial carriers to self-insured employers. We do not agree that the 80<sup>th</sup> percentile regulation does not impact the self-insured employer. While there has been an increase in the number of providers within the large networks, we know that negotiations more favorable to the consumer could not be reached. Why would providers want to accept rates so much lower, which have been established by the rule? Additionally, what would be the outcome should a hospital or a medical practice leave the network? We believe this would be catastrophic, as those claims also would be adjudicated against the 80<sup>th</sup> percentile.



The Alaskans for Sustainable Healthcare Costs Coalition is before you again, asking you to eliminate the 80<sup>th</sup> percentile rule. At the very least, please consider removing the egregious increases that occur twice per year under the rule.

Conversations over the last couple of years have considered two different methods, either using a sample of UCR values from the Pacific Northwest, or a reference based on the Alaska Medicare rates.

Reimbursement based on a multiple of Medicare or other “reference based” pricing would help control costs and ensure that providers are paid a fair fee. We support the recommendation being put forward by the Alaska Association of Health Underwriters (AAHU), which recommends beginning with a reimbursement payment up to 250% of Medicare. A reference-based option will need to be adopted in a way so that it does not require over payments for charges that are now lower than whatever percentile of Medicare is selected. We suggest wording that includes “payment up to” language rather than “an amount that is at least.” As noted in the Oliver Wyman report, there were some provider specialty reimbursement levels lower than 250% of Medicare.

Lastly, we would like to reiterate that Alaska is the only state with this type of regulation. We understand that members of AAHU have done some research and confirmed that the state of New York has put in place a completely different version of the 80<sup>th</sup> percentile regulation. In fact, we at the Coalition would be supportive of the methodology adopted by New York. This version states that carriers for small group (under 50) only need to have a few plans in their state that use the 80<sup>th</sup> percentile as a reimbursement measure. It should also be noted that in New York, plans for groups over 50 lives are not subject to the 80<sup>th</sup> percentile regulation in any way. Today, most plans in New York that are regulated by the DOI are using Medicare as a reimbursement reference.

Additionally, New York passed several consumer protection measures over the past few years (as did New Jersey) to protect consumers from surprise bills. On March 31, 2015, a law was passed that protects consumers from surprise bills for out-of-network claims. That same law also protects all consumers from bills for emergency services. This was followed up recently by legislation signed this year to further restrict surprise billing. It is suggested that, in fact, the reason New York’s health insurance premiums have been held to low trends is due to this legislation and nothing to do with the 80<sup>th</sup> percentile. The Coalition would be very supportive of the State of Alaska considering legislation or regulation that mirrors the State of New York (and New Jersey).

Thank you, Director Wing-Heier.

**Executive Board Members**

Rhonda Prowell-Kitter  
PEHT

*Rhonda Prowell-Kitter*

Dale Fosselman  
Denali FCU

*Dale Fosselman*

Joe Wahl  
GCI

*Joe Wahl*

Ann Flister  
PND Engineers

*Ann Flister*

FROM THE DESK OF



June 27, 2018

Division of Insurance % Lori Wing-Heier  
550 W. 7th Avenue, Suite 1560  
Anchorage, AK 99501  
insurance@alaska.gov

Dear Ms. Wing-Heir

We write to propose amendments to regulation 3AAC 26.110, the “80th percentile rule” to improve consumer protections and help Alaska reduce its healthcare costs.

As the Division of Insurance is well aware, the 80th percentile rule was put in place to protect patients from balance bills and to ensure that the insurance coverage Alaska patients pay so much for, actually works for them, especially in an emergency. As emergency providers we are almost all in-net work for every major insurance and have been for many years but are writing this letter as this is a key regulation to protect patients in an emergency when they have no choice on who cares for them.

We appreciate the State’s efforts to study the impact of the 80th percentile rule on health care in Alaska, referred to as the Institute of Social and Economic Research (ISER) report. We are interested in understanding the true impact of the 80th percentile rule. However, we have significant concerns with the ISER report’s methodology, analysis and conclusions. Alarming, the report already seems to be misinterpreted and misused to say that the 80th percentile rule is driving up healthcare costs. In fact, as the report itself notes, the data available does not separate costs out in any way – and the study looked at total healthcare expenditures – which necessarily includes a sizable increase in healthcare utilization, as the number of people in the state with insurance increased and as access to healthcare improved over the years analyzed in the study period. The report itself noted that its analysis had significant limitations and should not be used as the basis for policy recommendations and decision making. We have attached a separate analysis outlining our concerns with the ISER report at the end of this letter.

Right now, Alaska’s 80th percentile rule is a best practice that other states are adopting. We have data from other states, including New York and Connecticut, where 80th percentile regulations have been implemented, that shows there has been no measurable

increase in charges for services after the laws were implemented. At the same time, the National Conference of Insurance Legislators (NCOIL) has endorsed model legislation for states across the country that sets out the 80th percentile of all charges in a geographic area as the benchmark states should use to define the usual and customary rate.

The rule has increased access to high quality care in the state of Alaska, a success for patients. Fair out-of-network reimbursement helps promote in-network participation, as evidenced by an increasing number of physician groups joining networks during the years the rule was in place.

### Healthcare Costs

A March 2018 study in The Journal of the American Medical Association (JAMA) by Dr. Irene Papanicolas, "Health Care Spending in the United States and Other High-Income Countries," is a great resource for health policy formation in Alaska. This study found that the driver of healthcare costs was not physician salaries; the top factor was high pharmaceutical costs, then high margin, high volume procedures, high utilization of CT and MRI imaging and finally high administrative costs. It is not surprising that specialists in Alaska are pushing back against the claim that they are driving up healthcare costs. The biggest mistake is pointing to the 80th percentile rule as the problem. The root of high costs is the type of healthcare our country has decided to provide, and utilization of procedures and imaging will not be changed by revoking the 80th percentile rule.

The 80th percentile rule was created to protect patients when insurance companies refused to pay for care that they needed. It has protected and continues to protect patients and among its critics this message has somewhere been lost.

Charles Wohlforth, a frequent critic of the 80th percentile rule, recently wrote an opinion piece for the Anchorage Daily News (ADN) and is unfortunately using the recent ISER report to draw conclusions that the report did not make. In the article he wrote "Experts say that high charges for hospitals and physicians — especially specialists — are the largest factor in the disparity, not usage levels, drug prices, insurance companies, or other factors." This statement is not consistent with research by health economist experts, as noted in the JAMA paper above.

We urge the Division to look at the facts in this instance – focusing on the protections that the 80th percentile rule offers to patients, and looking to credible research, not opinion pages, for facts about the drivers of healthcare costs.

## Medicare is Not a Solution

Before we offer our own solutions, we want to strongly oppose any proposal to use a percentage of Medicare as a benchmark for insurance company reimbursement payments. Medicare rates were not designed for the general population. Medicare was created for an age-specific group: ensuring vulnerable, elderly patients can afford quality care. It was never intended to represent the fair market value of healthcare services or fully cover provider costs for the general population. A 2017 survey showed that most insurance companies do not use Medicare to determine reimbursement, and a survey of insurance companies in Texas showed that when insurers do use Medicare solely, balance billing complaints from patients are exponentially higher. Because Medicare is meant only for a specific population, rates don't even exist for important aspects of patient care, including pediatrics and obstetrics. Most importantly, Medicare rates are set by politicians in Washington, DC, and are not at all reflective of local markets. Because these rates are tied more to the federal budget than to actual costs, they have not kept pace with inflation – in 2016, physicians were being reimbursed by Medicare only 20 percent of what they were in 1992. In the same year, U.S. hospitals reported \$48.6 billion in losses due to Medicare payment and hospitals only received an average of 87 cents for every dollar spent caring for Medicare patients.

Tying Alaska's health to a bankrupt and broken federal system does not make sense for our state in the long-term. It will result in less available care for patients, with no guarantee that insurance premiums will go down at all for patients.

## Solutions

The 80th percentile rule is a strong patient protection, and we believe it should be improved and strengthened, not removed. We all need to work together to address the cost of healthcare in Alaska — but eliminating consumer protections is not the place to start. We believe current concerns about the 80th percentile rule can be addressed through our recommendations. We strongly discourage eliminating the 80th percentile rule. We outline recommended changes to the rule that address concerns and continue to protect patients and strengthen access to care in Alaska.

Our recommendations include:

1. Increase transparency and promote better data collection.
2. Ensure appropriate competition for market forces to drive fair rates.
3. Eliminate "balance bills" for patients for unexpected (emergent) out-of-network care if the 80th percentile rule is maintained.

Increase transparency and promote better data collection: To address the concerns raised about the lack of available data to inform analysis, the State should contract with a not-for-profit data company to get a clear view of charges, allowed rates and health-care costs. This data can also be used by consumers to understand their care options and associated costs. Current transparency laws in Alaska asks providers to put forward prices, but does not help patients actually understand what their out-of-pocket costs will be based on their insurance plan coverage. Enhanced transparency will allow patients to make decisions based on real and relevant information and will protect them from unexpected charges in a way that current transparency laws do not. We would suggest the following language for the regulation based on other states models:

1. For purposes of this regulation, “usual and customary rate” [or “UCR” or “usual, customary and reasonable rate, charge or fee] shall mean the eightieth percentile of billed charges for the particular healthcare service rendered in the same geographical area within the same time period as reported in a statistically sound benchmarking database maintained by an independent nonprofit organization. The independent nonprofit organization shall not be affiliated with any insurer, provider or other stakeholder in the healthcare industry. The organization shall be specified by the Commissioner of Insurance.
2. Ensure appropriate competition for market forces to drive fair rates. If there is not enough competition in a specialty, artificially add competition by expanding the geographic region. This would essentially eliminate the potential for a group that has over 20% of a local market to drive up total healthcare costs. We can accomplish this by borrowing methodology that insurance companies are already using. We would suggest the following language for the regulation to introduce competition if needed in the market.
  - CPT codes with five or more claims within each geographical region of the state: reimburse all surgical and non-surgical codes based on the provider’s billed charges or the 80th percentile of billed charges in that region (whichever is lower).
  - CPT codes with fewer than five claims within each specific region: reimburse all surgical and non-surgical codes based on the provider’s billed charges or the 80th percentile of billed charges statewide (whichever is lower).
  - CPT codes with fewer than five claims within the state: reimburse all surgical and non-surgical codes based on the provider’s billed charges or the 80th percentile of billed charges statewide (whichever is lower). In the event that the 80th percentile charge benchmark for a healthcare service in an area exceeds an amount that is higher than the High Outlier Ceiling, it could be brought to the Insurance commis-

sioner for review. The high outlier ceiling could be defined a series of ways but one example would be as a set percent of the average of the 80th percentile benchmarks for such service comprised all 50 states and the District of Columbia, this percentage could be set by the insurance commissioner for the needs of Alaska.

3. Eliminate “balance bills” for patients for unexpected (emergent) out-of-network care if the 80th percentile rule is maintained: Reconsideration of the 80th percentile rule is an opportunity increase patient protections. When fair market compensation is ensured for out-of-network care using the 80th percentile rule, we believe patients should not be subject to any “surprise bills” in the case of unexpected out-of-network care. With the 80th percentile rule in place, these surprise bills are rare, but we support eliminating them entirely. The removal of the 80th percentile regulation only increases balance billing to the patient.

### Conclusion

The 80th percentile rule was established to protect Alaska’s patients. We should maintained and strengthen these patient protections by ensuring transparency. Controlling healthcare costs is a broad, complicated issue that we must all work together to solve. We applaud the state for helping to fund the Blue Print Committee to bring together stake holders to find solutions to high health care cost and improve quality. We look forward to participating in these efforts, and again want nothing more than to ensure patients across the state can access and afford quality health care when the need it – particularly in an emergency. Eliminating consumer protections is not the place to start.

While there is no evidence that the current rule has led to increased costs, we should all defend against that possibility, while maintaining patient protections, transparency, and access to healthcare. We offer the above changes to the 80th percentile rule and believe these changes will maintain the strong consumer and patient protections Alaskans deserve while strengthening the rule to ensure against any potential for parties to manipulate or inflate costs.

Sincerely,

Alaska ACEP

Benjamin Shelton, MD, President  
Nathan P. Peimann, MD, President Elect  
Nicholas Papcostas, MD, Secretary  
David Scordino, MD, Treasurer  
Anne Zink, MD, Immediate Past President

Russ Johanson, MD, Board Member  
Danita Koehler, MD, Board Member  
Megan Lea, MD, Board Member  
Stanley Robinson, MD, Board Member  
Mark Simon, MD, Board Member

## **A Brief Review of the ISER report**

“How Has the 80th Percentile Rule Affected Alaska’s Health-Care Expenditures?”

As policymakers, health care providers, patients, and health plans continue to work on ways to ensure that Alaskans have access to health care at reasonably affordable prices, efforts toward ensuring availability while containing cost growth remain ongoing. In recent years, this has focused attention on the “80th percentile rule,” a regulatory provision governing payment for out of network care. In consideration of that ongoing debate, Mouhcine Guettabi of the Institute of Social and Economic Research at the University of Alaska has weighed in with a study of the purported impact of that rule on Alaskan healthcare expenditures. While Dr. Guettabi emphasizes that his analysis of the data should not be seen as his taking a position in the policy debate, the paper, which concludes that the rule has had an inflationary impact, will likely be used by critics of the 80th percentile rule to promote modification or repeal. Readers will do well to ask if this is justified.

To his credit, the author clearly outlines his methodology and the limitations to his approach and the available data. The limitations are summarized as follows:

“Our analysis evaluates the effect of the 80th percentile rule on expenditures and not costs. It has some other important limitations we list below:

- Expenditures are the product of prices and quantity of services used. In this analysis, we can not disentangle usage from prices.
- The introduction of the rule might have resulted in higher usage by consumers, which could explain a portion of the higher expenditures.
- We do not have data on charges or reimbursement levels which limits what we can say about provider behavior after the rule was enacted.
- The rule was intended to reduce the consumer’s out of pocket portion of the expenditures and we do not have a way to evaluate that.
- The data we use does not isolate the expenditures incurred simply by those who have private insurance. This is an important limitation as this is the group most likely to feel
- the effects of the rule change.
- Finally, and most importantly, this analysis does not make a recommendation regarding the 80th percentile rule, since it only examines one aspect of the question.”

Notably, the study focuses on aggregate expenditures for various health care categories and is unable to address changes in costs for services provided. The report neither isolates nor measures the factors, costs and utilization, that determine the level of healthcare expenditures. Isolating these variables is particularly important given the dramatic increase in availability of health care services during the study period. As stated in the report, the number of physician offices in Alaska increased by over 50% in the study period, and there was a nearly 4-fold increase in the number of physical therapists. The report points out that the increased availability of health care services can be assumed to have resulted in increased consumption, but it lacks the data to quantify the increases in expenditures resulting from greater access. It is also not within the scope of the report to address adequately whether such increased benefits the health of Alaskan patients.

In fact, it seems that the only effort in the study to address whether increased consumption of health services has benefitted Alaskans, comes in section 10, where the author asks if Alaskans are healthier – the section immediately follows the one in which the author addresses increases in numbers of health care providers. The author concludes that “there does not appear to be a strong relationship between the self-assessment of health and the healthcare market during the period.” [emphasis added]. However, the use of self-reporting for this measure is unfortunately vague and prone to inaccuracy, and it is not likely to provide information relative to whether increased access to care has had a positive impact. Indeed, apart from careful analysis of outcomes data, conclusions that increased access to care is not a desirable policy goal would seem to be premature and unwarranted.

It needs to be noted that this is not a small question in this discussion, as policymakers addressing the question of whether health care services in Alaska are “expensive” must wrestle with the relationship of costs and access to quality care in light of Alaska’s unique and largely rural demographic. If policy decisions have the effect of reducing costs while incentivizing a loss of available care, leaving Alaskans with fewer available choices to receive medically necessary and emergent care in their communities, then supposed savings will be achieved at a significant cost.

Because the report evaluates expenditures while lacking data to support analysis of changes in costs and outcomes, it is able to validate that health care expenditures have risen during the period that the 80<sup>th</sup> percentile rule has been in effect, but it lacks data needed to show actual correlation. The reader simply does not know what other significant variables contributed to increased expenditures, nor does it address whether those variables were related to improved access to care and health care outcomes for Alaskan patients. Along these same lines, it is notable that the report gives background regarding the timing of the rule’s adoption, but it provides no indication as to why poli-

cy makers believed the rule was needed in the first place. Understanding the problems that policy makers intended to mitigate would seem to be crucial to understanding the impacts of the rule on Alaska's health care system.

In addition to these considerations, it should be noted that in order to isolate the impact of the 80<sup>th</sup> percentile rule, the study relies on comparisons of health care inflation in what it finds to be similar states based on retrospective comparisons of the health care costs in those states to Alaska prior to adoption of the rule. While that may be the best available approach to attempt to isolate variables, the limitations of the approach should not be minimized. The geographic and demographic uniqueness of Alaska makes comparisons difficult in any time period, and making assumptions during a time-frame of significant churning and change in the health care marketplace makes the effort yet more difficult.

Thus, the report compares the rate of growth in Alaska expenditures during the period after adoption of the 80th percentile rule with the rates in a group of four states (the "synthetic control"), oil states and the US as a whole. The principal comparison is to the rate of growth in expenditures in the "synthetic control."

The sole reason reported for the choice of the synthetic control as a comparison is that the four states comprising the synthetic control, California, Maine, Nevada and Vermont, had similar pre-2004 spending growth to that of Alaska and their rates of spending growth diverged from the increasing rate in Alaska thereafter. It appears that no other similarities or differences between the healthcare markets in the four states and the market in Alaska were considered. The choice of the synthetic control thus seems based on untested assumptions:

- the assumption that the causes of the similar rates of pre-2004 growth for the synthetic control and Alaska were the same in both areas;
- the assumption that there were no factors peculiar to the states in the control group post-2004 that restricted expenditure growth, such as state price regulation or a recession resulting in an increase in the number of residents formerly covered by private plans, substituting lower cost governmental programs or actually decreasing their use of healthcare; and
- without considering any other factors in the healthcare markets, in Alaska and in the synthetic control, the assumption, indeed the self-evident premise of the report, that the adoption of 80th percentile rule had contributed to the growth in healthcare expenditures in Alaska.

Regardless of the trajectory of health care expenditures prior to 2004, even a cursory look at the four states utilized will lead to the conclusion that these states have

economies and health care environments that differ substantially from Alaska and, for that matter, from one another.

### Conclusion

The report on the impact of the 80th percentile rule has inherent limitations, many of which are acknowledged in the report itself. These limitations are significant enough that the study should not be considered conclusive with respect to the effect of the adoption of the 80th percentile rule on healthcare expenditures. Starting from the premise that the report did not and could not confirm -- that the 80th percentile rule in fact had a decisive impact on increasing expenditures -- the comparative analysis underlying the report was overly narrow. It did not consider other variables that might have influenced expenditures in Alaska. Accordingly, because of the study's assumed premise, its disregard of potential market-influencing factors other than the 80th percentile rule, and its overly broad inclusion of the entire Alaska healthcare market, not merely the plans affected by the 80th percentile rule, it could not determine the extent of any impact the rule had on healthcare expenditures. While it would be extremely worthwhile to know whether specific types of policies contribute to increases in healthcare expenditures and to measure any impact, doing so will require a more comprehensive analysis.

**America's Health  
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June 25, 2018

Lori Wing-Heier, Director  
Alaska Division of Insurance  
550 W. 7th Avenue, Suite 1560  
Anchorage, AK 99501

**Re: Reimbursement of Out-Of-Network Health Care Providers**

Dear Director Wing-Heier:

I write today on behalf of America's Health Insurance Plans (AHIP) to provide comments on the Division's notice of possible changes to the reimbursement requirement for health insurers when paying out-of-network health care providers for covered services or supplies. AHIP appreciates the opportunity to submit comments on protections from balance bills for consumers.

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

We agree with the Alaska Health Care Commission, the Institute of Social and Economic Research, and the University of Alaska that the Division's current reimbursement mechanism based on out-of-network providers' billed charges is increasing health care costs for consumers. This reimbursement methodology may be resulting in difficulties for carriers to contract with providers and develop robust networks. Moreover, we believe that non-contracted hospital-based physicians are increasingly going out-of-network to increase reimbursements instead of providing patients with care that is available at affordable negotiated rates.

We applaud the Division for re-considering these rules and stress that any change must provide a balanced approach, which includes a fair payment level for health care services based on what the market is already paying for those services and a protection for enrollees from bills they are not responsible for paying.

***Balance Billing***

Health plans develop provider networks to offer consumers and employers access to affordable, high-quality care. Health plan networks have been demonstrated as an effective means of providing quality care while containing costs and limiting patient out-of-pocket costs. Patients benefit when providers contract with carriers. Enrollees who receive services from a facility

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participating in their plan's network have a reasonable expectation that their providers at that facility will also be in-network.

Unfortunately, patients may still be seen by an out-of-network providers in a contracted facility because some interactions that patients could be with other service providers (e.g. anesthesia, radiology, or pathology) who have not contracted with the health plan. Sometimes these providers – especially emergency room providers – refuse to contract with the insurers. Protecting consumers from unfair, surprise bills by providers choosing to not participate in a network is of utmost concern to health plans and we applaud the Division for addressing this important consumer protection issue.

### ***Out-of-Network Provider Reimbursement***

The rate of payment to out-of-network providers should be set at a level that does not destabilize provider contracts in the state and instead continues to encourage health plans and providers to enter into mutually beneficial contracts. Reimbursement to out-of-network providers should not be based on a methodology that uses billed charges – instead we strongly support a reasonable reimbursement based on what the market is already paying for those services (i.e. accepted rates, contracted rates, or government payment fee schedules).

Billed charges are generally higher than the amount paid to providers under negotiated health plan contracts, or Medicare or Medicaid payment rates. A study using Alaska-specific FAIR Health data has shown average billed charges at up to 1,617.4 percent of Medicare reimbursement rates.<sup>1</sup> The Alaska data shows a general trend of much higher out-of-network charges than the national average.

This data is consistent with the MarketScan data compiled by Oliver Wyman – in 2016, commercial reimbursements in the categories analyzed were all above the Medicare FFS reimbursement, from 114 percent to 1,279 percent of Medicare.<sup>2</sup> As a percentage of Medicare, the Alaska reimbursements were almost always higher than the comparative reimbursements in Idaho, Montana, North Dakota, and Washington state. Similar reimbursement patterns can be seen in the 2014 and 2015 data provided to the Division as well.

We believe that this data is consistent with the 2013 findings of the Alaska Health Care Commission that providers with high market share are pricing their services to ensure that they

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<sup>1</sup> *Charges Billed by Out-of-Network Providers: Implications for Affordability*, Page 13, America's Health Insurance Plans, September 2015. Available at [https://www.ahip.org/wp-content/uploads/2015/09/OON\\_Report\\_11.3.16.pdf](https://www.ahip.org/wp-content/uploads/2015/09/OON_Report_11.3.16.pdf).

<sup>2</sup> *Physician Reimbursement Summary by Service Category Grouping - 2016 MarketScan Data*. Available at [https://www.commerce.alaska.gov/web/Portals/11/Pub/Headlines/INS\\_PhysicianReimbursementSummary.2018.pdf](https://www.commerce.alaska.gov/web/Portals/11/Pub/Headlines/INS_PhysicianReimbursementSummary.2018.pdf)

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Page 3

are below the 80<sup>th</sup> percentile and receive payment for their full billed charge, while artificially inflating costs for consumers across the entire health care system.<sup>3</sup>

When providers can be virtually assured that they will receive their full billed charge by not contracting with health plans, this type of reimbursement methodology provides no incentive for providers to join networks, restricts the ability of carriers to manage costs through contracting with providers, and encourages contracted providers to leave the network. Using billed charges as a reimbursement rate also creates greater challenges for hospitals working to find and contract with providers of hospital-based services who will agree to participate in the same health insurance plans' networks as the hospital. Finally, requiring reimbursement at the billed charges amount would leave consumers open to higher cost sharing and charges that they should not have to incur.

The Institute for Social and Economic Research (ISER) and the University of Alaska found that the 80<sup>th</sup> percentile rule accounted for anywhere from 8% to 25% of the annual growth in health care spending.<sup>4</sup> A more reasonable reimbursement methodology, combined with a ban on balance billing, would provide important consumer protections of lowering costs and making provider networks more robust.

Instead of using billed charges, we believe that the reimbursement methodology should be based on what the market is already paying for those services and what providers are accepting as payment for such services. The simplest path is for the state to adopt the Affordable Care Act's reimbursement model for emergency services for both emergency *and* non-emergency services. This will provide further consistency to the standards used around the country and continue to promote affordability.

The federal regulations require insurers to pay out-of-network emergency providers an amount equal to the greatest of:

1. The median amount negotiated with in-network providers for the service(s) furnished;
2. An amount based on the same methods used by the health insurer to pay for out-of-network services (e.g., usual and customary amounts); or
3. The amount Medicare would pay for services provided.<sup>5</sup>

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<sup>3</sup> *Findings and Recommendations 2009-2013*. Alaska Health Care Commission. Available at <http://dhss.alaska.gov/ahcc/Documents/AHCC-Findings-Recommendations2009-2013.pdf>.

<sup>4</sup> Guettabi, Mouhcine. *How has the 80<sup>th</sup> percentile rule affected Alaska's Health Care Expenditures?* Institute of Social and Economic Research and Department of Economics and Public Policy, University of Alaska. May 16, 2018. Available at <https://www.commerce.alaska.gov/web/Portals/11/Pub/Headlines/ISER%2080th%20Percentile%20Report.pdf>.

<sup>5</sup> 26 C.F.R. § 54.9815-2719A (Department of Treasury); 29 C.F.R. § 2590.715-2719A (Department of Labor); and 45 C.F.R. § 147.138 (Department of Health and Human Services).

June 25, 2018

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These regulations were recently challenged in federal court by a physician group who argued that a billed charges database should be used instead of the usual and customary amount. In response, the Departments of Health and Human Services, Labor, and the Treasury determined that no changes to the existing rules were required because the regulations provide a reasonable and transparent methodology to determine appropriate payments for out-of-network emergency services.<sup>6</sup> Specifically regarding the Medicare component, the Departments noted:

*“The Medicare statute’s provisions on setting physician payment rates...provide payment at a level that reflects the relative value of a service. Medicare rates for physicians’ services are established and reviewed every year through a rulemaking in which all physicians and other stakeholders are invited to submit public comment on the agency’s proposed calculations.”<sup>7</sup>*

We believe that a “greater of three” methodology will avoid higher costs for consumers and will result in payment levels that will not destabilize existing provider contracts in the state, but instead continue to encourage health plans and providers to enter into mutually beneficial contracts. Similar “greater of” methodologies have been adopted by a number of states, including California, Connecticut, and Maryland.

We appreciate the opportunity to provide comments and look forward to continued discussions with you on this important issue. If you have any questions, please do not hesitate to contact me at [sorange@ahip.org](mailto:sorange@ahip.org) or 703-887-5285.

Sincerely,



Sara Orrange  
Regional Director, State Affairs

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<sup>6</sup> *Clarification of Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections under the Affordable Care Act.* Departments of Treasury, Labor, and Health and Human Services. April 30, 2018. Available at <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-09369.pdf>.

<sup>7</sup> *Id.*



June 29, 2018

VIA EMAIL

Lori Wing-Heier

Director of the Alaska Division of Insurance

550 W. 7th Avenue, Suite 1560

Anchorage, AK 99501

[insurance@alaska.gov](mailto:insurance@alaska.gov)

Re: May 2018 – 80<sup>th</sup> Percentile Comments

Dear Director Heier:

We are writing in response to your request for amendments or alternatives to Alaska's Regulation 3AAC 26.110, commonly known as the "80<sup>th</sup> Percentile" rule. We urge you to retain this important minimum benefit standard, especially for emergency medicine.

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. **Together, EDPMA's members deliver (or directly support) health care for about half of the 141 million patients that visit U.S. emergency departments each year.** We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn.

Physicians for Fair Coverage (PFC) joins EDPMA in calling for retention of the important "80<sup>th</sup> Percentile" rule. PFC is a national physician multi-specialty non-profit advocacy organization representing tens of thousands of emergency physicians, anesthesiologists, and radiologists in states across the country, including Alaska.

### **Concerns Regarding the ISER Report**

We strongly urge you not to rely on the University of Alaska's Institute of Social and Economic Research and Department of Economics and Public Policy Report (ISER Report) when making policy decisions on this issue. The ISER study estimates that between 8 and 24% of increased healthcare expenditures are due to the 80<sup>th</sup> percentile rule. The study not only focuses on the wrong conclusions, it relies on an inappropriate data set when making its conclusions.

The report focuses on the increase in healthcare expenditures. If healthcare expenditures increased because access to care improved, fewer Alaskans died, and more Alaskans received more healthcare over a longer period of time, we don't think this should raise any red flags.

A more appropriate measure is whether the rule successfully met its goals of improving access to care and reducing the patient's financial responsibility for out-of-network care. According to the study, access to care did improve after the rule was enacted. However, the ISER study does not make any conclusions about the patient's financial liability for out-of-network care. It doesn't even look at trends in charges and reimbursement rates.

Moreover, the ISER study relies on an inappropriate data set. When estimating the impact of the 80<sup>th</sup> percentile rule, the study included data from plans that are not subject to the 80<sup>th</sup> percentile rule. Further, the study lumps the cost of all clinical care into one data set. Thus, if there was increased demand for a particular procedure or from a particular specialty, or if the costs for one specialty increased substantially, that increased expenditure is attributed to all clinicians and the overall impact of the 80<sup>th</sup> percentile rule.

### **The 80<sup>th</sup> Percentile Minimum Benefit Standard Protects Access to Emergency Care**

**Emergency departments are the nation's health safety net. Even though emergency physicians are only 4% of physicians, they provide 50% of all care given to Medicaid and CHIP patients and 67% of all care to uninsured patients.** They contribute far more than their share of uncompensated and undercompensated care. If emergency physicians are also undercompensated by private insurers in Alaska, fewer emergency physicians may choose to practice in the state, lines in emergency departments in Alaska may grow, and some emergency departments may even close down. The 80<sup>th</sup> percentile standard protects access to the healthcare safety net.

Furthermore, patients shouldn't be responsible for all of the costs related to "covered" emergency care simply because it was provided by an out-of-network provider. Emergency care is an "essential health benefit" that must be "covered" whether it be in-network or out-of-network care. Insurers should contribute their fair share.

Moreover, the 80<sup>th</sup> percentile standard encourages insurers to negotiate lower in-network rates, resulting in more in-network providers. This, in turn, means fewer patients will need to cover emergency care with their deductible. Without the minimum benefit standard, there is no incentive for insurers to negotiate fair in-network rates with emergency providers because federal law (the Emergency Medical Treatment and Labor Act) requires those providers to treat everyone no matter the ability to pay. In other words, unlike with other specialties, the insurance company knows their insureds will receive emergency care without negotiating fair rates with emergency physicians. The 80<sup>th</sup> percentile standard requires insurers to at least pay the usual, customary and reasonable rate. This, in turn, helps shore up the healthcare safety net and helps ensure everyone's access to emergency care.

The minimum benefit standard is especially important in rural states, like Alaska, where many patients must travel long distances for care and do not have the luxury of checking to see if the nearest provider is in-network. Further, Alaskans in rural areas are disproportionately hurt when the closest emergency department closes down.

### **Why the 80<sup>th</sup> Percentile**

The 80<sup>th</sup> percentile means that the top 20% of charges are not considered in the calculation of the minimum benefit standard. Overly high charges - outliers - are not even part of the formula. So it is no surprise that the National Council of Insurance Legislators adopted model legislation in 2017 that defined “usual, customary, and reasonable rate” as 80<sup>th</sup> percentile of charges based on an unbiased charge database.

The fact that major insurers already choose to pay out-of-network providers at the 80<sup>th</sup> percentile is evidence that the insurers agree that it is an appropriate standard. For example, in its “Information on Payment of Out-of-Network Payments”, UnitedHealthcare states:

“Affiliates of UnitedHealth Group frequently use the 80th percentile of the FAIR Health Benchmark Databases to calculate how much to pay for out-of-network services of health care professionals ...”

(<https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits> ).

Moreover, tying the 80<sup>th</sup> percentile to the FAIRHealth database makes good sense. When CMS asked an outside contractor to look at what benchmarking database to use for the minimum payment standard for out-of-network emergency care, the National Opinion Research Center (NORC) at the University of Chicago recommended the FAIRHealth database (“Data Sources for Establishing Payment Rates for Out-of-Network Emergency Room Services” (2014)). NORC reiterated this in a similar report addressing a benchmarking databases for all out-of-network care (“Qualitative Assessment of Databases for Out-of-Network Physician Reimbursement” (2017)).

### **Tying Reimbursement to Medicare is Problematic**

We have serious concerns about tying reimbursement between two private parties to Medicare rates. Medicare rates are based on limited funding available in the federal budget. They have no relationship to fair market rate value and are not intended to reflect usual, customary, or reasonable rates.

Furthermore, a recent Medicaid Trustees Report acknowledges that long-term costs are likely to increase faster than government projections. This means that the increase in Medicare reimbursement may not keep pace with the cost of providing care. It makes little sense to tie commercial reimbursement between two private parties to this standard.

### **Solutions**

The 80<sup>th</sup> percentile rule is an important protection for patients and the healthcare safety net and it

June 29, 2018

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should be retained especially for emergency medicine. However, there is room for improvement. We believe the rule should be reiterated in statutory language. In addition, the statute and/or regulation should clearly provide that the minimum benefit standard is 80<sup>th</sup> percentile of charges based on the FAIRHealth benchmarking database. Moreover, if the insurer pays 80<sup>th</sup> percentile of FAIRHealth charges, we support banning balance billing the patient.

For these reasons, EDPMA and PFC urge you to retain the 80<sup>th</sup> percentile rule, especially for emergency care. If you have any questions, please do not hesitate to contact Elizabeth Munding, Executive Director of EDPMA, at [emunding@edpma.org](mailto:emunding@edpma.org).

Sincerely,



Andrea Brault, MD, FACEP, MMM, Chair of the Board  
Emergency Department Practice Management Association (EDPMA)



William C. "Kip" Schumacher, MD, Chair, Physicians for Fair Coverage

CC: Members of House Health & Social Services Committee  
Members of Senate Health & Social Services Committee

I am responding to the Division of Insurance's solicitation of proposals or alternatives to 3AAC 26.110, commonly referred to as the "80th percentile rule."

In terms of costs to the healthcare system generally, let me begin by commenting that I think the "80th percentile rule" – which is misleading term of art - is far from the problem. As the ISER report notes, insurers don't pay 80% of the billed amount. The purpose of the 80th percentile rule is only to set the maximum allowable amount which the insurer then uses as the basis for paying a percentage of the charges. Insurers, using this number, typically pay a lesser amount if the plan member has gone out-of-network. Insurers then take this number and make payment, typically paying a lesser amount if the plan member has gone out-of-network. The insurer does this by reducing the percentage that the plan pays. Whereas the plan might pay 70% of the "negotiated rate" for an in-network provider, it will only pay 50% for an out-of-network provider. Add to this the fact that most plans increase the plan member's out-of-pocket maximum for going out-of-network, I would expect these combined reductions do much to balance out the fact that out-of-network providers charge more than in-network providers and eliminates any hardship from the insurance side.

Far bigger problems exist on the consumer side. Among these are the lack of healthcare transparency, the unchecked ability of "hidden providers" to "surprise bill" patients, and the unfettered ability of providers to balance bill patients.

- With regard to the lack of cost transparency, consumers need to be able to get better information to information price-shopping decisions. This concern may be addressed to some degree if the governor signs SB 105. Anchorage has also undertaken to address this problem at the municipal level.
- With regard to the problem of surprise bills by "hidden" out-of-network providers, I would suggest legislation or a regulation that if a patient goes to an in-network provider for services, the patient cannot be balance billed by a hidden provider who provides services incident to those services.
- With regard to balance bills by other out-of-network providers, I would suggest legislation or a regulation that insurers must have an adequate number of in-network providers. The number must reflect not just the raw number of providers in the geographic area but also be reflective of the availability to secure timely services. There need to be some quantifiable and qualitative metrics used to determine these numbers.
- Another issue goes to the reliability of the data that's used to set the 80th percentile or whatever percentile is used by the health insurance plan as the allowed amount for purposes of paying claims. Whether the data comes from FairHealth or another source, insurers need to be required to submit claims data to ensure the data is reliable and complete. By its very definition, the UCR or amount that reflects a particular percentile of the charges in the geo-

zip ought to be one and the same in a given geo-zip for all insurers. It shouldn't vary. And it ought to be real time data – not allowed to lag behind because of updating delays by both the data provider and the insurer upon receipt of the updated data.

- Finally, experience in other states suggests that when there is a neutral third-party charged with acting as an arbiter of patient/doctor/insurer billing disputes, insurers or providers will often make adjustments to their respective payments or charges. Creating some form of mandatory informal (or more formal) billing dispute resolution process would likely go far in protecting consumers.

Lisa Fitzpatrick  
1822 Buccaneer Place  
Anchorage, AK 99501  
Lmf2822@gmail.com

June 18, 2018

Dear Ms. Wing-Heir,

Golden Heart Emergency Physicians is a partnership made up of ten Board Certified Emergency Physicians that provide care exclusively in the Fairbanks Memorial Hospital Emergency Department. While we see a majority of our patients come from the surrounding Fairbanks area, we also see a significant number of patients brought in from northern rural areas as we are the only hospital north of Anchorage.

We understand that most people do not plan to use the Emergency Department and when they need to do so they are then subject to any number of unanticipated charges for their visit. As EMTALA obligated providers, we will always evaluate and treat patients appropriately no matter financial status. We do our best to work with our patients on any outstanding balances. Out of the nearly 39,000 patients we saw in 2016, we waived most if not all of more than 5,900 accounts.

The "80<sup>th</sup> percentile" rule has served to protect patients, ensuring that the larger portion of the payment is made by the insurance company and not the patient themselves. While there is not perfect solution, realizing it may be necessary to reevaluate and adjust, this rule has done what it was intended to do.

We understand and agree that it can be beneficial to review, and possibly revise, regulations as the needs of parties involved can change from time to time. We do not feel that it is appropriate to change or eliminate any rules or regulations until thorough research has been done on the potential risks and a plan can be put into place to help with the transitions.

With a change in the "80<sup>th</sup> percentile" rule it is more than likely we will see a drop in revenue while still requiring our operating costs to maintain their current path. This will almost certainly cause an already challenged field to become even more limited in resources.

The practice of medicine in Alaska is a great adventure, but it is not without its challenges. Our patient acuity varies greatly and we struggle with limited providers and resources daily. The "80<sup>th</sup> percentile" rule has proven very beneficial in building a high quality health care system in Alaska. Though we have come quite a way from where we once were, we are still very limited in resources and find it difficult to maintain a stable medical community.

While we strive to provide as much care locally as possible there are many times we have to send our patients out of town and sometimes out of state to be treated. As a state we are limited by the number of specialists we have available to treat our residents. If we continue to add barriers to our providers, we will continue to see the number of available providers drop.

We support the efforts of the State to study the “80<sup>th</sup> percentile” rule’s impact on Alaska’s healthcare system but feel there is still significantly more to do before any changes should be made.

Sincerely,

A handwritten signature in black ink, appearing to read "Mike Burton". The signature is fluid and cursive, with a large loop at the end.

Mike Burton, MD

# **Golden Heart Emergency Physicians**

3875 Geist Road, Ste. E 381

Fairbanks, Alaska 99709

(907) 458-6943

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Michael R. Burton, MD	Chief Financial Officer
Arthur J. Strauss, MD	President
Terry A. Conklin, MD	Director
Kenneth D. Glaeser, MD	Director
Maria E. Mandich, MD	Director

Mark O. Simon, MD	Director
Stanly W. Robinson, MD	Director
Brian A. Tansky, MD	Director
Caroline E. Timmerman, MD	Director
William D. McIntyre, MD	Director

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June 18, 2018

Dear Ms. Wing-Heir

I am writing in regards to regulation 3AAC 26.110, more commonly known as the “80<sup>th</sup> percentile” rule for determining “usual and customary” charges for healthcare services provided to Alaskans.

I am a Board Certified Emergency Medicine Physician practicing in the Emergency Department at Fairbanks Memorial Hospital and the acting President for our group. I have been practicing medicine in Fairbanks since 1999. Choosing to live in Alaska I appreciate all the unique opportunities it has provided for me and my family. Those opportunities are not without their own set of sacrifices and adjustments.

Working as an Emergency Department physician I am not given the luxury of being able to assist my patients in planning for their medical care until they arrive in the Emergency Department with an immediate need for treatment. This puts both the patient and myself in a situation where we are forced to do what needs to be done in the moment and to try and resolve issues such as, follow up care and billing, at a later time.

With growing health insurance premiums, it is unrealistic to expect that patients will be able to afford to pay additional amounts for services rendered. As the number of our patients able to pay for their care continues trending downward, our practice will be forced into raising our rates for those still able to pay. This is not a sustainable business model.

As it stands now, Alaska’s fragile health care system is increasingly challenging for many to navigate. With many intricate details involved, making changes without fully understanding the potential risk could very easily cause a domino effect in a negative direction. Removing the “80<sup>th</sup> percentile” rule as it stands, will more than likely cause an increase in the responsibility of payment to shift from the insurance companies to the patients.

# **Golden Heart Emergency Physicians**

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Maria E. Mandich, MD	Director	William D. McIntyre, MD	Director

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I believe this effort to begin looking at the current health care situation is much needed. A discussion of potential solutions with those who will be most impacted is a step in the right direction. However, it is only the first step of many. I do not believe now is the time to be enacting any changes without first fully understanding what they will ultimately do to our healthcare system.

I believe that our community deserves access to quality healthcare. Alaskans should not be required to seek treatment out of state because more and more regulations have forced providers to close their practices. Emergency Departments should not have to shoulder the burden of treating patients with limited resources available and no protection for fair compensation.

Sincerely,



Art Strauss, MD

President

Golden Heart Emergency Physicians

## May 2018 – 80<sup>th</sup> Percentile Comments

My name is Dorne Hawxhurst. I work for the state but I am submitting my comments as a private citizen.

You do Alaskans a disservice by focusing on the 80% rule. That's a rule in name only and hasn't been followed by the state since 2011 when the state started aggressively shifting costs to its employees. The state only reimburses 80% of what the state says my doctor *should* charge, not what my doctor actually charges. Then my doctor bills me for the balance.

To decide what my doctor *should* charge, the state uses a database from a company in New York called FairHealth. There is no mention of this in the recent ISER report. By its own admission, FairHealth lacks a meaningful contributing database for Alaska. Therefore, as an initial matter, the state neglects the requirement and all its subparts in 3 AAC 26.110(a)(1) to "maintain or use a statistically credible profile of covered health care services." I have personally brought this to the state's attention in writing on several occasions since 2012.

When there are less than 9 claims from Alaska for even common procedures in the FairHealth database, FairHealth may regurgitate older data or use data from Outside. They call this "derived" data, and it is always lower—sometimes thousands of dollars lower—than actual charge data in the state's own possession.

And when there are 9 or more claims from Alaska for a particular procedure in the FairHealth database, the process by which data are added to it guarantees that the data is stale by the time Alaska uses it. Here's how the time lag works: FairHealth collects data for 12 months, scrubs it for 3 months, and then issues updates in May and November. The updates are not available to the public for another month after that, and the state's third party administrator (Aetna) has 6 more months to add FairHealth data into its system.

So your mammogram from June 2018 by the Providence mammogram coach that came to your town on the ferry may be paid using charge data that is two years old or just made up. And then the state will cover 80% of that.

Or, more likely, and to complicate things further, the state will forget that the Providence coach is the only mammogram available in your town and since Providence bills out of Anchorage, the state will apply its hard facility steerage rules. The state will penalize you an extra 50%, make you pay 20% more co-insurance, and double your annual co-pay maximum. Adding insult to injury, the state will also tell you that you have to have the equipment on the coach re-tooled on the fly to provide you with the lesser 2-D mammogram instead of a 3-D mammogram.

This is just the tip of the iceberg. The greater problem, of course, is that doctors, hospitals, and pharmacies charge too much up here. My surgeon charged \$400 per minute. Providers will charge what the market will bear, and when the market started to balk at the rates, the state neglected its duty to provide genuine consumer protection and instead just shifted the burden to employees and retirees.

If you want to solve these problems you need to do better than this. At a minimum, you should develop regulations that require providers and insurers to timely report actual charge data to a credible database. And if the state is going to insist on setting a “recognized charge,” it should develop regulations preventing providers from balance billing patients any amount above it. I believe these recommendations will provide the alternative you seek to “dually address potential impacts on the cost of care and protect consumers from surprise balance bills from non-network providers.”

Thank you for your consideration.



*Expert Radiology. Exceptional Care.*

June 30, 2018

Ms. Lori Wing-Heier, Director  
Division of Insurance  
Department of Commerce, Community and Economic Development  
550 West 7th Ave., Suite 1560  
Anchorage, AK 99501

Via email: [insurance@alaska.gov](mailto:insurance@alaska.gov)

Director Wing-Heier:

I appreciate the opportunity to comment on 3AAC 26.110; the regulation protecting Alaska patients which is often referred to as the 80th percentile.

Imaging Associates supports maintaining protections for Alaska patients. We want to be a part of a constructive dialog on whether there are ways to ensure the regulation meets its objective of establishing a market rate for out of network reimbursement. In that regard, we believe the Alaska State Medical Association is on the right path. While we have seen no evidence that any group or practice is controlling the market or solely "setting" the reimbursement rate we recognize that it is theoretically possible. By using a stepped expansion of the geographic area used to determine the 80th percentile the State should be able to eliminate virtually all concerns raised by critics. Furthermore, in the event there are still five or fewer codes statewide, the questions should be about why there is such limited access and what value those services are providing to Alaskans. It is imperative that the State do more than a simple benchmark when evaluating specialized services. Any such review needs a subjective element to ensure access to healthcare for Alaskans is preserved.

Additional points to consider:

- ✓ Alaskans currently have the best access to healthcare in its history.
- ✓ Data being used by critics is old, stale, and widely recognized as factually inaccurate. We know that most specialists are in fact now in-network and that charges within these specialist fields have likely gone down. Making policy decisions that impact access to healthcare for Alaskans based on 2014, and older, information is irresponsible. The State's first step in making any policy decision should be to acquire current accurate data.
- ✓ Medicaid and Medicare are government programs that survive because of cost shifting to private payors and do not reflect market costs. Furthermore, Medicare and Medicaid coverage and reimbursements are often a reflection of budget decisions and not health care decisions. As examples: First, the Walker Administration recently arbitrarily reduced Medicaid reimbursement rates for providers between 12 and 15 percent admittedly and solely to meet budget targets. Secondly, and more alarming, was the recent Walker Administration decision to remove 3D Breast Tomography from being a covered service for women on Medicaid simply to save money. Women on Medicaid had 3D Tomography available to them (standard of care) which when coupled with the services of a Breast Center of Excellence, increases early breast cancer detection by up to 40%! While Governor Walker's wife and daughters would surely have access to this care he removed this coverage for thousands of women by regulation to save money. These types of programs and their management by non-providers were never meant to preserve access to healthcare or represent a market rate. Utilization of Medicare or Medicaid reimbursement rates as a basis of private reimbursement would be a disaster for Alaskan patients, providers, and the overall health of Alaskans.

- ✓ The State should look at the issue of narrow networks and the exclusion of providers from being in-network. The Insurance Industry likes to promote the idea that providers are refusing to join networks and that is increasing the cost of healthcare. However, we are currently seeing an increase in narrow networks where exclusive contracts are offered that prevent other providers from joining the network. In fact, the State of Alaska in Anchorage will not allow many providers to join their network. This is the case even though other providers are willing to accept the same reimbursement rate. (while not germane for this comment, it is worth noting that this State decision was a sole source contract not put out to public bid). This decision by the State resulted in removing Imaging Associates from the State network, thereby removing the State's only Breast Cancer Center of Excellence in Anchorage and the Mat Su Valley from the State network and forcing hundreds of State employees to pay more out of pocket if they desired to stay with their current provider associated with a center of excellence. And the out of pocket costs for out of network continue to increase becoming draconian - resulting in State employees not having a choice when it comes to cost, quality and access. Note those beneficiaries associated with Medicaid and Workers Comp still have choice.

Imaging Associates would join the State network at the reimbursement rate but is precluded due to the State's adoption of a narrow network business model. Another similar example of this is the Anchorage School District's recent decision to contract for exclusive coverage for primary care. It is not surprising that this provider can reduce charges if their payor mix moves from Medicaid and Medicare to solely private payors. However, this business model assumes others will take on the responsibility of care for our seniors and those less fortunate. While insurance companies and the Anchorage School District admit they don't see access to healthcare for the Medicaid or Medicare population as their responsibility it is the State's responsibility. Any decision to change the 80th percentile regulation should include an analysis of potential impacts to all payors and the potential impacts to healthcare access in general.

It wasn't too long ago that the Anchorage Daily News was running articles about seniors not being able to find providers in Alaska willing to take Medicare. During this same time the legislature subsidized the capital expenses to build a Medicare clinic in Anchorage to see if it was possible to provide these seniors with healthcare access by only covering operating costs. The result of this experiment was a demonstration that Medicare could not support the operating costs of a clinic designed to be as efficient as possible for seeing Medicare patients. Why do Medicare patients now have access? Because of cost shifting to private payors. While all Alaskans are enjoying the highest access to healthcare ever seen, the public debate solely seems focused on cost which we believe is based on inaccurate information. The State needs to recognize the value that is being provided by the significant gains in number of providers in Alaska. Simply looking at costs without analyzing the impacts to all Alaskans risks reducing care.

Thank you for your efforts. Listening to your testimony and presentations to the public has been encouraging. We hope your voice continues to be heard by Governor Walker and the Alaska Legislature and we work deliberately and collaboratively to first ensure access to healthcare while exploring ways to lower costs while expanding access.

Sincerely,

*Ward Hinger*

Ward Hinger  
CEO – Imaging Associates

## Wing-Heier, Lori K (CED)

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**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Monday, July 02, 2018 8:32 AM  
**To:** Wing-Heier, Lori K (CED)  
**Subject:** FW: 80th Percentile Rule Comment from Ellen Izer

Good Morning Lori,

Here is a comment on the 80<sup>th</sup> Percentile from Ellen Izer.

Thank You,

Suzy Bethel  
Office Assistant  
Alaska Division of Insurance  
907-465-4614

**From:** eaizer100 <eaizer100@gmail.com>  
**Sent:** Saturday, June 30, 2018 8:08 AM  
**To:** Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
**Subject:** 80th Percentile Rule Comment

June 30, 2018

Lori Wing-Heier  
Division of Insurance  
Via email to [insurance@alaska.gov](mailto:insurance@alaska.gov)  
Juneau, Alaska 99811  
Re: 80<sup>th</sup> Percentile Regulation  
Director Wing-Heier:

As an Alaskan citizen I implore you to eliminate, change, or modify the 80<sup>th</sup> Percentile Rule. It is hurting Alaskans. I am concerned about the current healthcare environment in the state. I do believe there is a healthcare bubble and it is eventually going to pop and hurt everyone if we do not take drastic steps to resolve it NOW.

What is a bubble? Wikipedia lists it as “trade in an [asset](#) at a price or price range that strongly exceeds the asset's [intrinsic value](#).<sup>[1][2][3]</sup>” The next question is how big are you willing to let the bubble grow? The bigger it gets the more pain it will cause when it pops. I much prefer tackling this as a small bubble or correction to the market. More of a fizzle than a pop would be best.

I have read the Emergency Room doctors tactics and I where would all of our doctors run off to and not take a huge cut in pay elsewhere? We are all in this together. Let's work together to solve it.

The last time I looked at my health plan it pays the same co-insurance percentage in the event of emergency whether I land in or out of network. The only difference is out of network doctors get to come to me later and ask for any amount over allowable charge and say I have to pay. And as you have stated before you can't prevent that. The 80<sup>th</sup> Percentile Rule can't prevent that from happening. It doesn't protect me the consumer at all.

We have enough data telling us the system is broken. The cost of healthcare in Alaska cannot continue to grow beyond reasonable. It must be brought into line. You must believe that. If it bursts people of the State of Alaska will turn to the Division of Insurance and wonder why you sat idly by. Don't let that happen. Change it and change it now.

Thank you Director Wing-Heier.

Sincerely,

Ellen Izer  
Eagle River, AK  
[eaizer@outlook.com](mailto:eaizer@outlook.com)

^ [Jump up to:](#) <sup>a</sup> <sup>b</sup> King, Ronald R.; Smith, Vernon L.; Williams, Arlington W.; van Boening, Mark V. (1993). "The Robustness of Bubbles and Crashes in Experimental Stock Markets". In Day, R. H.; Chen, P. *Nonlinear Dynamics and Evolutionary Economics*. New York: Oxford University Press. [ISBN 0-19-507859-4](#).

[Jump up](#) ^ Lahart, Justin (16 May 2008). "[Bernanke's Bubble Laboratory, Princeton Protégés of Fed Chief Study the Economics of Manias](#)". *The Wall Street Journal*. p. A1.

[Jump up](#) ^ Shiller, Robert (23 July 2012). "[Bubbles without Markets](#)". *Project Syndicate*. Retrieved 17 August 2012. *A speculative bubble is a social epidemic whose contagion is mediated by price movements. News of price increase enriches the early investors, creating word-of-mouth stories about their successes, which stir envy and interest. The excitement then lures more and more people into the market, which causes prices to increase further, attracting yet more people and fueling 'new era' stories, and so on, in successive feedback loops as the bubble grows.*

Sent from my Verizon, Samsung Galaxy smartphone



June 29, 2018  
Ms. Lori Wing-Heier  
550 West 7th Avenue, Suite 1560  
Anchorage, AK 99501-2567

Subject: 80<sup>th</sup> percentile rule

Dear Lori Wing-Heier, Director of the Division of Insurance,

I am writing on behalf of the almost 13,000 members of NEA-Alaska to encourage you to eliminate the language relation to “the 80<sup>th</sup> percentile of charges.” We do not believe that this language has worked as intended, and we believe that it has had the unintended consequence of increasing health costs in Alaska.

Increasing health costs are a burden to every Alaskan. Costs of health care in Alaska have risen at a faster rate than any other place in the country and created a serious problem for our state. Specialty medical areas within Alaska just do not have the competition to make a rule such as “the 80<sup>th</sup> percentile” work.

Educators across Alaska care a great deal about health care. In fact, we probably care more than most employee groups. During the bargaining process, we often make adequate health care a top priority, even over salary. For this and other reasons, we urge you to eliminate the language related to “the 80<sup>th</sup> percentile of charges.”

Sincerely,

A handwritten signature in black ink, appearing to read 'Tim Parker', is located below the word 'Sincerely,'.

Tim Parker  
President, NEA-Alaska president

## Wing-Heier, Lori K (CED)

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**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Friday, June 29, 2018 8:11 AM  
**To:** Wing-Heier, Lori K (CED)  
**Subject:** FW: May 2018 – 80th Percentile Comments.

Good Morning Lori,

Here is another 80<sup>th</sup> Percentile comment.

Thank You,

Suzy Bethel  
Office Assistant  
Alaska Division of Insurance  
907-465-4614

**From:** Nathan P Peimann <npeimann@gmail.com>  
**Sent:** Thursday, June 28, 2018 7:04 PM  
**To:** Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
**Subject:** May 2018 – 80th Percentile Comments.

June 28, 18

Division of Insurance % Lori Wing-Heier  
550 W. 7th Avenue, Suite 1560  
Anchorage, AK 99501  
[insurance@alaska.gov](mailto:insurance@alaska.gov)

Dear Ms. Wing-Heier,

I am writing in response concerning 3AAC 26.110, the “80th percentile rule” to improve consumer protections and help Alaska reduce its healthcare costs. I am writing on behalf of the emergency medicine physicians practicing in Juneau, Alaska. Juneau Emergency Medical Associates has been at Bartlett Regional Hospital for more than 25 years and during that time, the complexity and cost of healthcare has greatly increased. We support the “80<sup>th</sup> Percentile rule” for emergency, unexpected care as the main way to preserve access to specialty services and to avoid further cost-shift from insurance companies to consumers.

1. We support solutions that maintain the 80<sup>th</sup> Percentile for emergency or unexpected circumstances and would hope transparency for insurance companies moving forward would be part of that solution. Specifically, regulate that insurance companies report reimbursement to [fairhealthconsumer.org](http://fairhealthconsumer.org) or other unbiased, non-affiliated benchmarking database that contracts with the State of Alaska. The State should create its own all claims database to get a clear view of charges,

allowed rates and healthcare costs. This data can also be used by consumers to understand their care options and associated costs. Current transparency laws in Alaska asks providers to put forward prices but does not help patients actually understand what their out-of-pocket costs will be based on their insurance plan coverage. Enhanced transparency will allow patients to make decisions based on real and relevant information and will protect them from unexpected charges in a way that current transparency laws do not.

Proposed language is:

“usual and customary rate” [or “UCR” or “usual, customary and reasonable rate, charge or fee] shall mean the eightieth percentile of billed charges for the particular healthcare service rendered in the same geographical area within the same time period as reported in a statistically sound benchmarking database maintained by an independent nonprofit organization. The independent nonprofit organization shall not be affiliated with any insurer, provider or other stakeholder in the healthcare industry. The organization shall be specified by the Commissioner of Insurance.

2. Ensure appropriate competition for market forces to drive fair rates. If there is not enough competition in a specialty, artificially add competition by expanding the geographic region. This would essentially eliminate the potential for a group that has over 20% of a local market to drive up total healthcare costs. We can accomplish this by borrowing methodology that insurance companies are already using. We would suggest the following language for the regulation to introduce competition if needed in the market:

CPT codes with five or more claims within each geographical region of the state: reimburse all surgical and non-surgical codes based on the provider’s billed charges or the 80th percentile of billed charges in that region (whichever is lower).

CPT codes with fewer than five claims within each specific region: reimburse all surgical and non-surgical codes based on the provider’s billed charges or the 80th percentile of billed charges statewide (whichever is lower).

CPT codes with fewer than five claims within the state: reimburse all surgical and non-surgical codes based on the provider’s billed charges or the 80th percentile of billed charges statewide (whichever is lower). In the event that the 80th percentile charge benchmark for a healthcare service in an area exceeds an amount that is higher than the High Outlier Ceiling, it could be brought to the Insurance commissioner for review. The high outlier ceiling could be defined a series of ways but one example would be as a set percent of the average of the 80th percentile benchmarks for such service comprised all 50 states and the District of Columbia, this percentage could be set by the insurance commissioner for the needs of Alaska.

3. Eliminate “balance bills” for patients for unexpected (emergent) out-of-network care if the 80th percentile rule is maintained: Reconsideration of the 80th percentile rule is an opportunity increase patient protections. When fair market compensation is ensured for out-of-network care using the 80th percentile rule, we believe patients should not be subject to any “surprise bills” in the case of unexpected out-of-network care. With the 80th percentile rule in place, these surprise bills are rare, but we support eliminating them entirely. The removal of the 80th percentile regulation only increases balance billing to the patient and does not address healthcare costs.

I appreciate your time and attention to this very important matter and hope you will contact me with any questions regarding these suggestions.

Sincerely,

Nathan P. Peimann, MD  
Vice-President  
Juneau Emergency Medical Associates  
PO Box 22269  
Juneau, AK 99802  
(907) 209-2584  
[nathan@jema.email](mailto:nathan@jema.email)

Via e-mail to: [lori.wing-heier@alaska.gov](mailto:lori.wing-heier@alaska.gov)  
[insurance@alaska.gov](mailto:insurance@alaska.gov)

Director Lori Wing-Heier  
Alaska Division of Insurance  
550 W. 7<sup>th</sup> Avenue, Suite 1560  
Anchorage, Alaska 99501

June 29, 2018

Subject: May 2018 – 80<sup>th</sup> Percentile Comments

Dear Director Wing-Heier:

I am responding to your Notice of Public Scoping for Possible Changes to 3 AAC 26.110. We appreciate the opportunity to comment on the report prepared by the University of Anchorage (“ISER Report”), as well as on the rule itself and on possible solutions. As you know, Premera has had significant concerns about the current rule and its effects, and has expressed those concerns and suggested changes repeatedly over a number of years. The ISER study points out that healthcare spending in Alaska was similar to that found in other states prior to the adoption of the 80th percentile rule; it is only after the effective date of the rule that costs diverge and Alaska’s costs rise more drastically.

We welcome this step by your agency to open the topic for discussion, and are looking forward to working with you.

**80<sup>th</sup> percentile rule concerns**

Premera understands that the underlying intent for the rule as it currently exists is to protect consumers from exorbitant medical bills when they cannot access in-network providers.

Unfortunately, time has shown that in practice, the rule does not serve to protect consumers effectively; in fact, its ramifications are detrimental to Alaskans in several ways. As the report states, the current requirements drive up claims costs, of which consumers pay a share, typically as a coinsurance percentage. When the provider's charges go up, the 80<sup>th</sup> percentile rule requires payers to increase the amounts they pay to providers, and this, in turn drives up the coinsurance amounts that patients are required to pay. The cost escalations driven by the rule are further exacerbated by the twice-a-year adjustment requirement, which is unnecessarily frequent and compounds the cost increases year over year even more.

In addition, the detrimental effects of the rule are not limited to only the cost of services paid to non-contracted providers by employers and consumers enrolled in fully insured benefit plans. We have found that the rule sets the level for billed charges in the entire market; many providers begin their contract negotiations at the 80<sup>th</sup> percentile level, knowing that this is the payment level they will receive should they choose not to contract. Many self-funded employer plans pay the same rates that are driven by the rule. Contrary to the rule's original intent of protecting consumers, the rule sets a reimbursement floor without providing a ceiling.

A further effect of the rule is to discourage contracting. Unwillingness by many providers to contract with carriers is a widespread issue in Alaska, and one that the rule does not take into account. Our experience shows that a rule that so clearly places non-contracted providers at a financial advantage simply exacerbates this unwillingness and hinders contract negotiations. And, for those specialty providers who have a monopoly on services in a specific geographic area, the rule affords complete control over their claims reimbursements by unilaterally setting their own rates.

We also do not believe that the current rule serves consumers by keeping providers from leaving the state. We are unaware of any evidence that this will happen. It is critical to keep in mind that this kind of rule does not exist in any other state, and that the other states typically have strong network structures. Moving elsewhere would place providers in a position where they need to consider network participation at potentially lower fee schedules. The myth of providers leaving the state if the rule is not kept as is must be dispelled.

Consumers are disadvantaged in multiple ways under the existing rule: they are less likely, in many geographic areas within Alaska, to find in-network services, thus having to seek such services from non-contracted providers or having to travel long distances; they pay higher coinsurance amounts to providers who use the rule to escalate charges; and they pay higher premiums driven by high claims costs. This is not in the best interest of Alaskans.

### The ISER Report

Premera appreciates that the ISER report reaches the same conclusions regarding cost escalation that we have been observing over the years, and that have also been reinforced in other recent studies. As

we noted above, the study found healthcare spending in Alaska similar to spending in other states before Alaska adopted the 80<sup>th</sup> percentile rule, but rising significantly after the effective date of the rule.

That stated, we do find that a number of elements of the study need to be approached with caution:

- The comparison against other oil-rich states is not useful, and distracts from the key messages regarding cost escalation. Any separate consideration of oil-rich states does not account for other factors that make Alaska's situation different – its demographics, its geographic size and location. This analysis is not pertinent.
- The growth in provider availability is not analyzed sufficiently. This growth is not universally applicable to all areas of the state. Additionally, this growth does not necessarily ensure greater availability of in-network providers, as willingness to contract with carriers is generally lower in Alaska than it is in any other state, to the best of our understanding.
- The study does not adequately highlight nuances in the Alaska market, and the results of such nuances on cost of and access to care. As one example, the situation – in terms on provider costs, availability of specialist care, percentage of in-network providers – of Anchorage is different from the rest of the state. These distinctions are not sufficiently accounted for.

### Suggestions

As noted above, the ISER study clearly reinforces the need to reevaluate and change the current regulation, as the study documents the significant cost escalation that ensued following adoption of the regulation. We point out again that no other state has such a rule in effect, and further, that the underlying statute does not require setting allowed amounts at a percentile of charges. Therefore, we believe that it is within the authority of the Division to adopt changes that eliminate the detrimental effects of the current rule.

We believe that the following elements must be considered within the discussion of possible solutions; we view these elements as components of an overall set of changes to address the issues that currently exist:

- Reduce the frequency of allowed-amount review and adjustments from twice annually. We believe that an annual review is fair and adequate.
- Limit the applicability of the rule to services received within Alaska. The Division has taken the position that the current rule applies world-wide. Lack of geographic data in other areas results in payment based on actual billed charges.
- Set the allowed amount for non-contracted providers at a percentage of Medicare; Medicare rates are already adjusted to take into account the unique aspects of the Alaska health care market, and

Director Lori Wing-Heier

June 29, 2018

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therefore constitute a fair basis. Medicare rates are also updated annually to adjust for changes in medical practice resource needs and costs. We recommend 250% of Medicare as the minimum required, but are open to further discussion. Most lower-48 states allow for the standard use of 15% of Medicare for non-contracted services.

- We also suggest that the unique variations in provider availability, access to care, and willingness to contract throughout the State of Alaska may necessitate solutions that are more geographically specific. This may include a different approach for the greater Anchorage area than for remote and underserved parts of the state, where the latter calls for greater consumer protections than the former.
- Prohibit balance-billing by non-contracted providers – i.e., the practice of collecting from the patient the difference between the allowed amount set by the carrier and the actual amount billed by the provider. We caution, however, against an attempted solution that addresses only balance-billing, without including the other elements listed above.

We respectfully request that your office consider the above recommendations and comments as a productive starting point for collaborative work on changes to this rule. And of course we make ourselves available for any follow-up questions and discussions. Please contact me at your convenience.

Sincerely,



Sven Peterson

Vice President of Compliance, Ethics, and Regulatory Services

cc: Jim Grazko, President, PBCBSAK  
Len Sorrin, Vice President, Congressional and Legislative Affairs

## Wing-Heier, Lori K (CED)

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**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Monday, June 25, 2018 12:22 PM  
**To:** Wing-Heier, Lori K (CED); Latham, Anna M (CED); Bailey, Sarah S (CED); Lauten, Jacob R (CED); Campbell, Gregory J (CED); Mitchell, Grey R (CED)  
**Subject:** FW: May 2018 – 80th Percentile Comments

**From:** Tobias Schwoerer <toschwo@gmail.com>  
**Sent:** Monday, June 25, 2018 11:39 AM  
**To:** Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
**Subject:** May 2018 – 80th Percentile Comments

Dear Mrs. Wing-Heier,

The analysis by Guettabi provides concrete and quantitative evidence that the 80th percentile rule is costing Alaskans real money.

Therefore, the rule should be cancelled. Cancelling the rule immediately is a better outcome for consumers than leaving it in place.

Guettabi's analysis showed that the intention of the rule to protect consumers clearly failed.

Please reverse the 80th percentile rule immediately.

Sincerely,

Tobias Schwoerer

## Wing-Heier, Lori K (CED)

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**From:** Insurance, Insurance (CED sponsored)  
**Sent:** Friday, June 29, 2018 1:23 PM  
**To:** Wing-Heier, Lori K (CED)  
**Subject:** FW: 80th percentile - Nancy Tietje

**Follow Up Flag:** Follow up  
**Flag Status:** Flagged

Good Afternoon Lori,

Here is a comment on the 80<sup>th</sup> Percentile from Nancy Tietje from Davies-Berry Insurance.

Thank you,

Suzy Bethel  
Office Assistant  
Alaska Division of Insurance  
907-465-4614

**From:** nancy@davies-barry.com <nancy@davies-barry.com>  
**Sent:** Friday, June 29, 2018 1:03 PM  
**To:** Insurance, Insurance (CED sponsored) <insurance@alaska.gov>  
**Subject:** 80th percentile

Director Lori Wing-Heier,

I have responded to the business survey for our office, but I would like to respond now as a health insurance agent. Health care and health insurance has become almost an unaffordable luxury. Premiums for those over 400% of poverty are unaffordable for many. For all, the complete out of pocket is almost unattainable particularly when it is reached year after year. Many insurance covered people who work for the government or businesses that are large and can afford to cover lower deductibles and out of pockets are protected from these problems and are oblivious to the issues. In our state there have been a lot of mechanisms developed to lower costs. Among them are sending people south for care to preferred providers, having large claims negotiated and agreed upon, restrictive preauthorizations, all as ways to curb the cost of health care.

Of the areas that I see as problems are no cap to the 80<sup>th</sup> percentile rule, the restrictions on managed care concepts and the entire idea of spreading the risk.

In regards to the 80<sup>th</sup> percentile rule, there needs to be a cap or index of some sort to limit the ever increasing costs. The cap can be done via a percentage of Medicare, it can be an indexing cap that says everyone starts a cap of 1 which is 80% of your current master bill. I remember when the rule went into place. It was immediate that dental bills increased and for about a year, the most common complaint I heard was the over reasonable and customary costs occurring all the time. And it didn't stabilize. Now everyone is more compliant. Our dental costs have now skyrocketed. Chiropractic also did it, as did every provider who wouldn't become preferred providers or carriers. Now people are deciding at what point they should see a doctor for care or check on what could be happening.

Managed care concepts I sort of lump together. Balanced billing can be overwhelming in some case. I just read an article about a court case from Kentucky where a surgery of \$75,000 which was deemed to be an appropriate amount had a balance bill of \$150,000. (I'm rounding numbers) The court deemed that inappropriate. We have had clients with balance bills that have cost them thousands of dollars. In Ketchikan that has been primarily around our emergency room situation, but it has caused patients to go bankrupt or very near to it. The other tool for managed care is who the carrier has to pay, the provider or the patient. To help carriers encourage providers to become contracted, the rule that checks only be sent to the provider should be lifted. It seems obvious to me that over the years in Alaska, the cost has become so high and restrictions have been so steep that we are not doing anyone any favors to help control costs.

Spreading the risk in Alaska is a very tough thing to do. I will start with the assumption that Alaskans aren't the healthiest, for those with good insurance they are entitled and use health care freely, they have high risk life styles in many ways, and are for lack of other words, abusive to themselves and others. Our pools of insurance are many and it causes an inability to spread the risk. So that means that each little pool causes each other to handle that risk. This is a cost driver that insurers seek to alter. Then the providers try to counter. That is what I see happening. We have Medicare recipients staying in Alaska which drive cost shifting, which drives the insured market to ever higher costs.

Of the issues that are drivers, the low hanging fruit is the 80<sup>th</sup> percentile rule. Either of the ways I have suggested (Medicare base or index based) would be worth a start.

Thanks for taking time to review the topic. I do understand the place that you are in, sitting between the carriers, the patients and the providers. It can't be easy.

Sincerely

*Nancy Tietje*

NPN# 4638784



[nancy@davies-barry.com](mailto:nancy@davies-barry.com)

office phone 907-225-9841

direct phone 907-228-6363

direct fax 907-225-9842

# THE WILSON AGENCY

AN ALERA GROUP COMPANY

June 25, 2018

Lori Wing-Heier  
Division of Insurance  
Via email to [insurance@alaska.gov](mailto:insurance@alaska.gov)  
Juneau, Alaska 99811

Re: 80<sup>th</sup> percentile regulation

Director Wing-Heier,

The Wilson Agency works with over 250 Alaska based employers. As you are aware, the cost of healthcare in AK is an extreme concern for them so we appreciate your willingness to take input on the recent 80<sup>th</sup> percentile study.

Premiums for health plans in Alaska commonly run 2x more than those of other states (United Benefit Advisors annual benchmark survey). Our firm is a prime example, we have historically purchased small group Premera coverage for both our Alaska and Washington offices; premiums in AK were 2x more than WA for the same benefit design.

This high cost of coverage is impacting Alaska business' ability to compete. Recently one of our clients was challenged in her ability to submit a competitive RFP because her lower 48 counterparts and Alaska Native Corporation competitors do not have to include the same high healthcare premiums in their overhead (some ANCs can purchase health insurance through the Federal Employee Benefit program which offers lower premiums than one would find from an insurance company based in AK).

We believe one factor that is contributing to high health insurance premium cost is the 80<sup>th</sup> percentile regulation. This point has been corroborated in many reports including the recent ISER report commissioned by the State so we won't take time to reiterate that information.

3000 A Street, Ste #400 Anchorage, AK 99503  
[www.thewilsonagency.com](http://www.thewilsonagency.com)  
907-277-1616

# THE WILSON AGENCY

AN ALERA GROUP COMPANY

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We also believe that because the 80<sup>th</sup> percentile exists, insurance companies are not able to negotiate reasonable contracts with all providers because the 80<sup>th</sup> percentile serves as a backstop in negotiations. Additionally, we are concerned about the possible outcome should a hospital or a medical practice leave the network. We believe this would be catastrophic as those claims also would be adjudicated against the 80<sup>th</sup> percentile.

Public discussion over the last couple of years have considered two different methods; using a sample of UCR values from the Pacific Northwest or referenced based pricing to Alaska Medicare rates.

Reimbursement based on a multiple of Medicare or other 'reference based' pricing would help control costs and ensure that providers are paid a fair fee. We support the recommendation being put forward by the Alaska Association of Health Underwriters (AAHU) which recommends beginning with a reimbursement payment up to 250% of Medicare. A reference based option will need to be adopted in a way so that it does not regulate over payments for charges that are now lower than whatever percentile of Medicare is selected. We suggest wording that includes 'payment up to' language rather than 'an amount that is at least'. As noted in the Oliver Wyman report, there were some Provider types with reimbursement levels lower than 250% of Medicare. We would also be willing to participate in a work group to work through the final wording of a revised regulation.

Lastly, on behalf of the Alaska Association of Health Underwriters and my own firm, I have researched the fact that Alaska is the only state with this type of regulation. In fact, the state of New York has put in place a completely different version of the 80<sup>th</sup> percentile regulation which may be contrary to what others have interpreted. The Wilson Agency would be very supportive if Alaska would consider implementation of the 80<sup>th</sup>

# THE WILSON AGENCY

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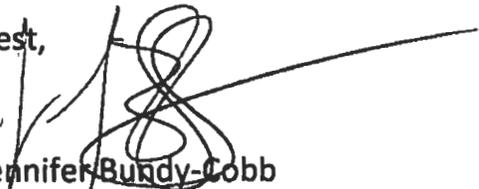
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percentile rules as NY has done. Their version states that carriers for small group (under 50) only need to have a few plans in NY that use the 80<sup>th</sup> percentile as a reimbursement measure. It should also be noted that in NY, plans for groups over 50 lives are **not** subject to the 80<sup>th</sup> percentile regulation in any way. Today, most plans of all sizes in NY that are regulated by the DOI are using Medicare as a reimbursement reference.

Additionally, NY passed several consumer measures over the past few years (as did NJ) to protect consumers from "surprise bills." On March 31, 2015 a law was passed that protects consumers from surprise bills for out-of-network claims. That same law also protects all consumers from surprise bills for emergency services. This was followed up recently (June 2018) by legislation signed this year to further restrict surprise billing. It is suggested by industry experts that in fact the reason NY's health insurance premiums have been held to low trends recently is due to this legislation and nothing to do with the 80<sup>th</sup> percentile.

We implore you to take some action on the 80<sup>th</sup> percentile and again would be very supportive if you considered legislation that was passed in New York and New Jersey to continue the quest on consumer protection.

Best,



Jennifer Bundy-Cobb  
Health & Welfare Services Director

Cc Lon Wilson, President