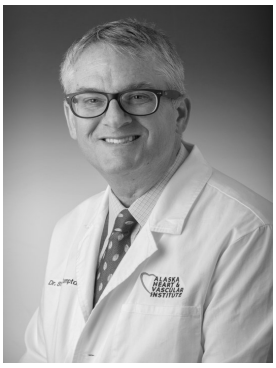
HEARTBEAT

THE BIMONTHLY NEWSLETTER OF THE ALASKA STATE MEDICAL ASSOCIATION August 2023

PRESIDENT'S COLUMN

Alaskan insurance monopoly and the death of the 80th percentile rule
Steven Compton MD
President, ASMA

The Alaska 80th percentile rule has been notoriously difficult to explain—there are no simple sound bites. In this article I will share the rule's purpose, misinterpretation, occasional abuse, and recent demise. Every Alaskan health care provider should be aware of recent developments out of Juneau.



Steven Compton, MD

SOME HISTORY:
In the late 1990s and early 2000s, many Alaska physicians and surgeons remained outside of the state's limited insurance networks. If you were in-network, and treated an insured patient, you would be compensated a negotiated rate for your services. If you were out-of-network, then tough luck. The state's lone insurer would decide what to pay you, using made-up rates from out-of-state databases. The insurer would tell you that your rates were too high, and you would have no way to dispute this. You would be stuck billing the patient for the balance of the bill. We providers face a fundamental asymmetry in billing information. Any health insurance company is well aware of each provider's charges, but by law, each provider remains ignorant of any-

Compton Continued Page 5

NEW DIRECTORY COMING IN 2024

The Alaska State Medical Association has partnered with E&M Consulting, Inc. to produce our 2024 Directory. The publication will be available in both print and digital formats. E&M will be managing the project, including advertising sales and layout/graphic design. They are highly professional and produce a high-quality publication, and we ask that you give them a moment of your time. E&M will be contacting all members about the advertising opportunities available. The publication will be mailed to every member – a great opportunity to promote and give your company additional exposure.

To view the ad rates/options and sign-up online, please visit: https://reserveyourad.com/AKSMA/

If you have any questions or want to advertise, please contact an E&M sales associate at 800-572-0011 ext. 8005 or advertising@eandmsales.com. As always, your support is greatly appreciated!

SAVE THE DATE

ASMA Fall General Membership Meeting – In person and Virtual

Wednesday, October 4th, 5-8 pm

BP Energy Center

Bylaws amendments
What's happening with medical insurance in Alaska
Anticipated legislation in Juneau, 2024

Light refreshments provided

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- For those that have not logged in yet, the site did not carry over your password. You **WILL** need to reset it in order to login.
- If you don't have an address in the "personal" field you will not receive mailings. Please login to update your profile.
- Physician images were **not** imported to the new site so please be sure you log in and upload a new photo for the OMD (Online Medical Directory).
- The system currently does not support Company Admin's uploading individual physician photos. You may email photos to Cjeanes@asmadocs.org, but please include the physician name and company so that we can be sure we're uploading to the proper profile.

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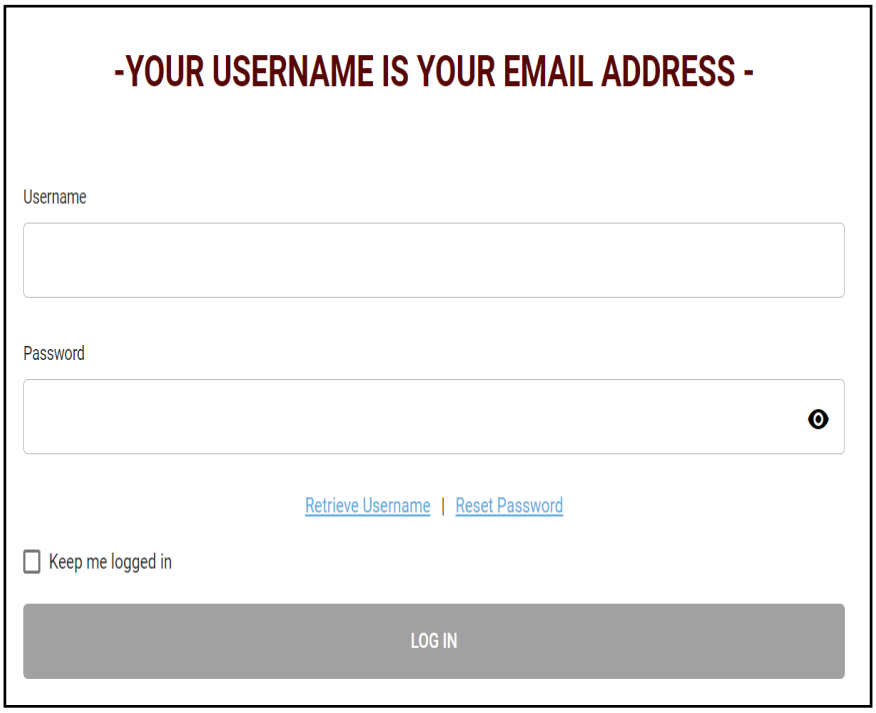
Log-in to ASMA's new site

Many of ASMA's user's haven't created a new password after we launched the new website last year. The vast majority of ASMA's membership benefits are on the member page of the site and only available after you've logged in. Please take advantage of all that is available to you by resetting your passwords and logging in today!



Your username should be your email, but if you aren't sure which email it's under you can click the retrieve username button and the system should send you an email.

If you haven't logged in yet, you'll have to create a new password. Old passwords did not carry over from the previous site. Click on the "reset password" link and the system will send you an email.

If you don't get one, please check your junk folders to ensure it didn't go to the wrong place. If you still haven't received the emails your system security may be blocking our platform emails.

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one else's charges. Insurers use this asymmetry to their advantage to deny or reduce payments and pass costs on to consumers.

Insurance companies base their payments for out-of-network claims on what they call the "usual, customary, and reasonable" (UCR) charge for a service, rather than on a provider's actual charge. In the late 1990s, a subsidiary of UnitedHealth ended competition in the UCR data market by purchasing the remaining two databases that provided this information to the insurance industry. Predictably, the UCR determination mechanism became a black box (called Ingenix), and since the black box was owned by the insurance industry, the underpayment problem worsened.

By 2009, deceptive insurance industry practices had led to a US Senate investigation entitled "UNDERPAYMENTS TO CONSUMERS BY THE HEALTH INSURANCE INDUSTRY." You can Google that title to read an appalling report. At the same time, New York State fined United Health Group $50 million over fraudulent out-of-network reimbursement practices. The attorney general described a "defective and manipulative" database used by most major health insurers to set reimbursement rates for out-of-network medical expenses. He said the system "forced consumers to write a blank check" for procedures without knowing how much they would ultimately have to pay out of their own pockets. Despite the $50 million-dollar lesson, United Health recently had to pay another $15.6M settlement for continuing this practice from 2013 to 2021.

Alaska was not spared this insurance pain, and in the early 2000s the Alaska Division of Insurance was receiving frequent consumer complaints regarding under- and non-payment for out-of-network care. In 2004 the Murkowski administration implemented the 80th percentile rule, moving away from the black box model and toward a system that would recognize the increased costs of providing care in Alaska. The regulation remained on the books for 19 years, an unusually long time span, due to its success in preventing insurance company abuse. (See sidebar for an explanation of the rule.)

What has changed since 2004? Costs of care have climbed. Alaska Office of Management and Budget commissioned a UAA/ISER study, published in 2018, to address whether the 80th percentile rule might contribute to increased health costs. This non-peer-reviewed study compared Alaska to other oil states, and other states with similar levels of growth prior to the 80th percentile rule. Growth rates were monitored through 2014. The idea was that the 80th percentile rule was the only remaining variable, and was therefore responsible for a 9 to 25% increase in costs compared to those states. The study failed to account for the concurrent, profound change in Alaska demographics, during which Alaska's over-65 population doubled from 43K to 87K, faster than any other state and 230% greater growth than the overall US.

THE 80th GOES DOWN

Since the flawed ISER study did not examine data past 2014, it was irrelevant by the time of its 2018 publication, as most Alaskan providers had settled into insurance contracts. Meanwhile our boomer-fueled growth in health care costs continued. A handful of providers gamed the 80th percentile by annually ratcheting up their billing in small markets, accelerating local inflation. The increasing costs attracted the ire of local employers, who cited the old ISER study and identified the 80th percentile rule as the source of Alaska's cost woes. In 2019 town hall meetings were held in Juneau, resulting in a proposed Alaska All - Payer Claims Database to allow all parties to understand the local market and allow accurate estimates of UCR.

By early 2023 the Alaska Chamber of Commerce was running radio ads calling for dismissal of the 80th percentile rule, and a Premera Blue Cross executive penned an ADN op-ed calling to remove it. When the Division of Insurance announced dropping the rule, over 600 physicians wrote in to object, thanks to the rapid and diligent efforts of ASMA and anesthesiologist John Morris. While the 80th percentile decision sat on the Governor's desk, the ASMA Board was tasked with finding a noninflationary replacement for the 80th percentile UCR model. Following numerous meetings, and thoughtful guidance from ASMA lobbyist Kevin Jardell, we do indeed have solid proposals for UCR reform.

THE SURPRISE

Physician pushback initially seemed to give pause to the "drop-the-80th juggernaut." We were surprised May 12th when Julie Sande, DCCED Commissioner, proposed dropping the 80th percentile rule as part of a more ambitious comprehensive reform. In the Commissioner's press release, and a subsequent meeting with Director of Insurance, Lori Wing-Heier, the administration has shared far larger goals of reforming health care reimbursement to improve the affordability of care for Alaskans. ASMA was invited to participate in a newly formed Health Care Costs and Reimbursement Working Group, to tackle payments, regulatory roles, consumer protections, network adequacy, and the claims database. In short, the Dunleavy administration is proposing overhaul of the state's health care system, well beyond the 80th percentile rule, which will be repealed as of January 1, 2024.

ASMA's CONCERNS

We remain concerned that potential payer reductions will result

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in reduced access to care, to include government-pay patients in an environment where many are currently unable to be seen by a primary care provider. Current out-of-network providers are more likely to be providing care in remote Alaska, and this care may become difficult to provide. Following removal of UCR guardrails, insurers are expected to slash their in-network reimbursement, and we have already heard some reports of this as individual groups renegotiate with insurers. A potential physician exodus is a very real possibility, not to mention adding to the already difficult prospect of physician recruitment.

ASMA's NEXT STEPS

The 80th percentile rule is one strategy for dealing with UCR, and was established as a consumer protection from abusive behavior from the insurance industry. Without some sort of UCR guardrail, we expect the insurance industry to resume the same predatory behavior. Unfortunately, Alaska is a small market, and is limited to the same single, out-of-state insurer that created the 1990s consumer problem in the first place.

Alaska claims data remain opaque to all but the insurers. Ideally an all-payer claims database would be maintained by an independent, not-for-profit entity that would allow transparency regarding costs. Alaska is a unique market, and is in the process of setting up its own claims database, a move supported by ASMA since 2019 as the most viable strategy for UCR reform.

ASMA will advocate strongly for network adequacy. We recognize that health care cost, access, and quality cannot all be simultaneously improved. In other markets, insurers game the system by putting very narrow networks together, reducing access and quality. The National Association of Insurance Commissioners have developed national standards for network adequacy, ensuring that consumers have access to needed care without unreasonable delay. Washington state has incorporated these standards, and we should, too.

Clinically integrated networks (CINs) have been shown to reduce health care costs using value-based care. Alaska has three Clinically Integrated Networks, all of which have been turned down by the current statewide monopoly insurer.

The 80th Percentile Rule provided a guardrail against predatory monopolistic insurance company behavior. This behavior is not limited to Alaska, and is endemic to the economic forces of that industry. When patients ask you about the 80th percentile rule, explain the goal of consumer protection. Stay tuned to this column. Remind your non-member provider friends to join ASMA. ASMA is working closely with John Morris to provide messaging on these topics through a new 501(c)(3) organization, the Coalition for Medical Access, https://www.reliablemedicalaccess.org. We encourage you to log on, and donate to support the media campaign. Contact me, or any ASMA board member to become more involved.

Explaining Alaska's 80th Percentile Rule: It Does Not Mean Insurers Have to Pay 80% of Billed Charges

The name "80th percentile rule" is confusing, because it leads people to think it requires health-insurers to pay 80% of whatever are determined to be customary rates for medical services. That's not true. Here's how it works:

- Say your hip is worn out. You go to a surgeon and have it replaced.
- You have health-insurance, but the surgeon who replaces your hip is outside your insurance network. Surgeons in your network have agreed to charge some specific amount for your new hip—but those outside the network set their own rates.
- Your out-of-network surgeon bills your insurance company, at a rate that may be more or less than other surgeons in your area charge to replace a hip.
- Under the 80th percentile rule, your insurance company has to base its payment on the billed amount that is at the 80th percentile of all providers for that procedure in that region of Alaska—that is, 80% of bills are below that amount, and 20% are above.
- The bill at the 80th percentile of all bills becomes the basis—called the allowed amount— for what insurance pays for your hip surgery. It pays whatever share of that allowed amount your policy calls for—in many cases, that's 60% for out-of-network providers

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FACT-CHECKING the insurance people:

80th percentile rule was written for physicians. FALSE. It came from the Division of Insurance as a consumer protection in 2004.
Alaska is the most expensive state. FALSE. Google Forbes: Most and Least Expensive States for Health Care, Ranked. Alaska is ranked #12 of 50.
The No Surprises Act renders the 80th rule moot. FALSE. No Surprises Act only covers emergent and inpatient care.
Alaska is the only state that uses the 80th percentile for UCR determination. FALSE. Just Google it: "80th percentile UCR". Most insurance companies set UCR at the 80th percentile.
Cheaper to go with single-payer for the state of AK (Alan Gross editorial). FALSE. Oregon tried this and failed. State of AK would have to pay $13K per resident, well beyond the current PFD.
ISER study showed that 80th percentile was responsible for increased costs of AK care. FALSE
ISER studied change in expenditures, not charges. Expenditures = rates x units. The number of physician offices increased from 368 in 1998 to 569 in 2015. This 55% increase in physician offices would result in increased utilization, as shortages are addressed, leading to increased expenditures. The study author notes, "In this analysis, we can not disentangle usage from prices" Premera and the Chamber ignored this aspect of the study.
ISER neglected to account for changing demographics (see text), which were not seen to the same extent in the comparator states (CA, ME, NV, VT)
It's 2023, the ISER study data are a decade old.
Private landscape has changed in Alaska. Most providers are now in-network.

Insurance companies are losing money. FALSE
Google: "3 big health insurers stockpile $2.4 billion as rates keep rising" This included Premera Blue Cross.
Google: Premera to invest $50M of tax refunds in Alaska.
Premera entered the pandemic with a surplus of nearly $700 million, after raising rates 19% in 2017 and 35% in 2018 (https://www.seattletimes.com/business/local-business/premera-plans-to-slash-workforce-8-seeking-to-offer-more-affordable-health-plans-during-pandemic/)
Premera had >$2B reserve as of 2018. (https://www.premera.com/documents/031109_2018.pdf)

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Proposed Bylaw Amendment to be voted on at ASMA's Fall General Assembly Meeting.

See Page 1 for meeting details.

> ARTICLE II - GENERAL ASSEMBLY
>
> Section A - Meeting of the General Assembly
>
> 1. The General Assembly shall meet twice a year in the spring (annual meeting) and fall, at a
time and place chosen by the President.
> 2. Only members with their dues current may vote during a meeting of the General Assembly.
Fifteen regular members present constitute a quorum. Each regular member has one vote and
proxies may not be voted.
> 3. The General Assembly may review and reconsider the actions of the Board of Trustees.
> 4. Only members, staff, and invited guests may attend a General Assembly meeting. The
President may declare a meeting or a portion of a meeting to be in executive session, excluding
all but members and invited staff and guests.
> 5. Minutes are approved at the next meeting of the General Assembly.
>
> Section B - Special Meetings of the General Assembly
>
> 1. Special meetings may be called by the President, with the approval of *(twenty regular
members)* **the Board of Trustees**.
> 2. The general membership must be notified in writing of a call for a special meeting at least
thirty days in advance. Shorter notice may be given in an emergency situation.
> 3. Only members, staff, and invited guests may attend a special meeting of the General
Assembly.
> 4. All members may vote at a special meeting of the General Assembly. Fifteen members
constitute a quorum. Each member has one vote and proxies may not be voted.
> 5. The President may declare a meeting or a portion of a meeting to be in executive session
excluding all except members, staff and invited guests.
> 6. Minutes are approved at the next regular meeting of the General Assembly.
Term of Office:
Section B - Election of Officers
1. Nominations may be made by any member prior to the annual meeting of the General
Assembly. Other nominations may be made from the floor at the annual meeting of the General
Assembly.
2. Elections may be conducted:
(a) by mail ballot.
(b) By vote at the annual meeting of the General Assembly. In the event that there is only one nominee for an office, by acclamation at the annual meeting.
3. Officers are elected by a simple majority of regular voting members in attendance.
Section C - Terms for Officers
1. The President and Secretary-Treasurer serve one year terms running from *(July 1 to the next
June 30)* **the close of the annual meeting until the close of the annual meeting the following
year**.
2. The President and Secretary-Treasurer are elected one year in advance of taking office and
serve as President-Elect and Secretary-Treasurer-Elect during that year from *(July 1 to the next
June 30)* **the close of the annual meeting until the close of the annual meeting the following
year**.
3. The Immediate Past President serves one year.
4. The Delegate and Alternate Delegate to the American Medical Association each serve two
year terms staggered by one year, running from January 1 to the second December 31.
5. The Speaker of the General Assembly serves a three (3) year term, from *(July 1 to the next
June 30)* **the close of the annual meeting until the close of the annual meeting the following
year**..
6. The three Trustees from specific geographic locations shall each serve three year terms
staggered by one year each running from *(July 1 to the next June 30)* **the close of the annual
meeting until the close of the annual meeting the third following year**. The Initial terms to be
staggered by vote of the General Assembly.
7. Physician Assistant serves a two year term from **the close of the annual meeting until the
close of the annual meeting the second following year**.
8. Intra-term vacancies are filled as follows:
(a) When an intra-term vacancy occurs in the office of President, Secretary-Treasurer, or
Delegate to the AMA, the officer-elect or alternate completes the term of office.
(b) An intra-term vacancy in the office of Immediate Past President remains vacant until the
end of the term.
(c) Intra-term vacancies in the offices of President-Elect, Secretary- Treasurer-Elect, Alternate
Delegate to the American Medical Association, physician assistant or geographic Trustee are
filled by individuals appointed by the Board Trustees. Intra-term appointees are subject to
election by the membership at the next annual or special meeting of the General Assembly.

National Prescription Drug Take Back Day – October 28, 2023, 10 am to 2 pm.
Watch for local announcements.

The best option is to utilize drug take back sites – In Anchorage at Providence Medical Arts Pharmacy, some Fred Meyer and Carrs pharmacies, JBER, ANMC, Anchorage Neighborhood Health Center.

Or call 800-882-9539 to find a location near you. Or go to Google Maps and type in "drug disposal near me".

Follow the FDA instructions for disposing of the medicine in household trash. Follow these steps:

Remove the medicine from the original containers and mix them with something undesirable, such as used coffee grounds, dirt, or cat litter. This makes the medicine less appealing and unrecognizable.

2. Put the mixture in something you can close to prevent the drug from leaking or spilling out.
3. Throw the container in the trash.

Scratch out all your personal information on the empty medicine packaging to protect your identity and privacy. Throw the packaging away.

While it is usually preferable to dispose of medications in other ways, the following drugs may be flushed if necessary because they pose a danger to children, pets and other people.

Drugs That Contain Opioids	
Any drug that contains the word:	Examples of products on the Flush List:
"buprenorphine"	BELBUCA, BUAVAIL, BUTRANS, SUBOXONE, SUBUTEX, ZUBSOLV
"fentanyl"	ABSTRAL, ACTIQ, DURAGESIC, FENTORA,ONSOLIS
"hydrocodone" or "benzhydrocodone"	APADAZ, HYSINGLA ER, NORCO, REPREXAIN, VICODIN, VICODIN ES, VICODIN HP, VICOPROFEN, ZOHYDRO ER
"hydromorphone"	EXALGO
"meperidine"	DEMEROL
"methadone"	DOLOPHINE, METHADOSE
"morphine"	ARYMO ER, AVINZA, EMBEDA, KADIAN, MORPHABOND ER, MS CONTIN, ORAMORPH SR
"oxycodone"	CODOXY, COMBUNOX, OXADYDO (formerly OXECTA), OXYCET, OXYCONTIN, PERCOCET, PERCODAN, ROXICET, ROXICODONE, ROXILOX, ROXYBOND, TARGINIQ ER, TROXYCA ER, TYLOX, XARTEMIS XR, XTAMPZA ER
"oxymorphone"	OPANA, OPANA ER
"tapentadol"	NUCYNTA, NUCYNTA ER
Drugs That Do Not Contain Opioids	
Any drug that contains the term "sodium oxybate" or "sodium oxybates"	XYREM, XYWAV
Diazepam rectal gel	DIASTAT, DIASTAT ACUDIAL
Methylphenidate transdermal system	DAYTRANA

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If you or your patient has Medicare and take insulin, we have some great news for you. Now you'll pay $35 per month (or less) for each covered insulin drug you take, and you don't have to pay a deductible. That means for a 90-day supply, no more than $105. This applies to everyone who takes insulin, even if you get Extra Help.

Medicare covers insulin in 2 ways:

Part D (drug coverage) - Part D covers insulin you get from your Medicare drug plan. (Note: If your Part D plan covers disposable insulin patch pumps, the pump is considered an insulin supply, and might cost more than $35.)
If you use an insulin drug covered under Part D, and decide you'd like to be in a different Medicare Part D plan for the rest of 2023, you can add, drop, or change your Part D coverage one time between now and December 31, 2023. Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Part B (Medical Insurance) or Part C (Medicare Advantage) if you use an insulin pump that's covered under Medicare Part B's durable medical equipment benefit, or you get your covered insulin through a Medicare Advantage Plan, your insulin costs will be capped at $35 for a one-month supply. The Part B deductible won't apply. If you have Medicare Supplement Insurance (Medigap) that pays your Part B coinsurance, that plan should cover the $35 (or less) cost for insulin you get under Part B.

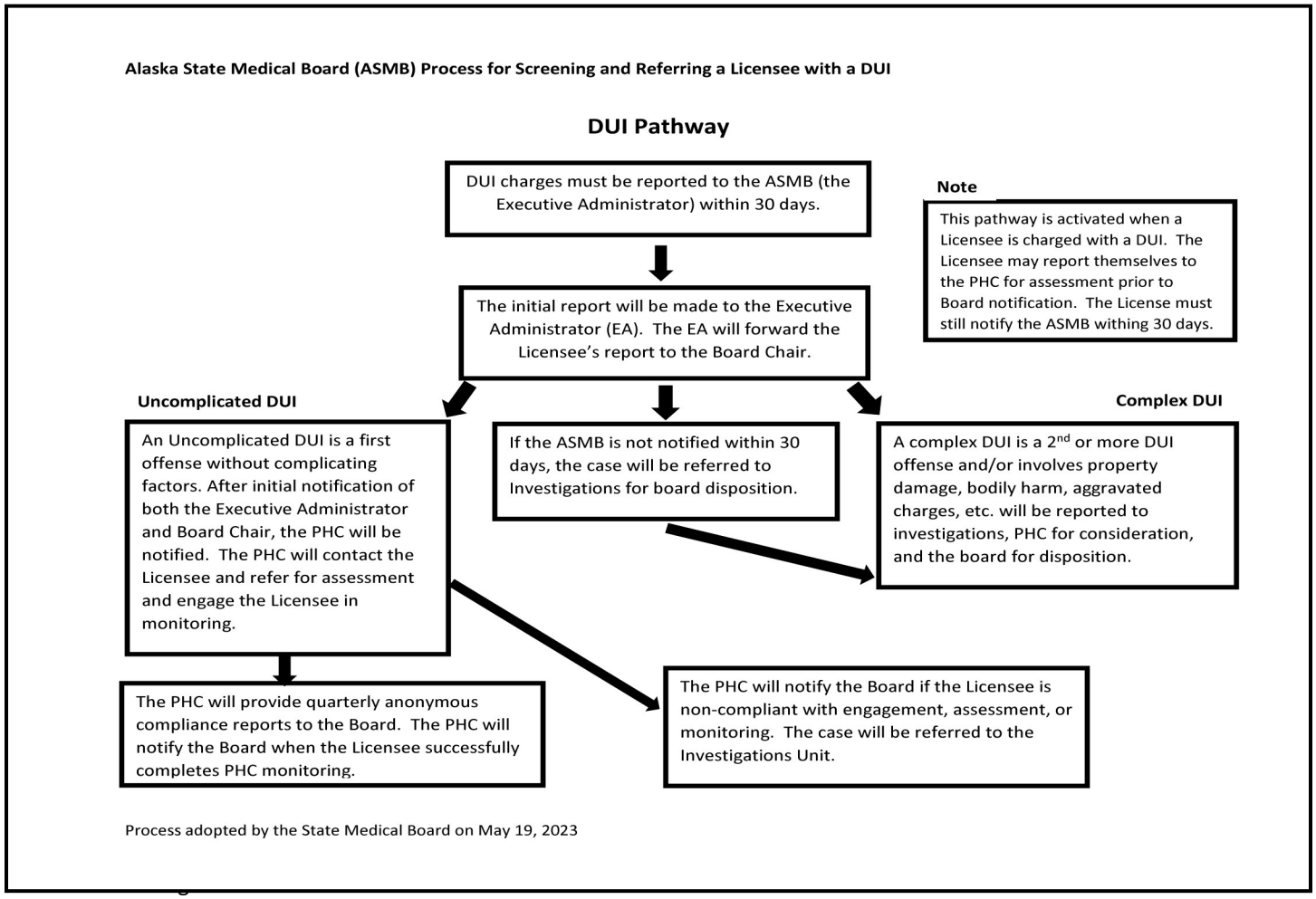
To learn more:

• Visit Medicare.gov/coverage/insulin.

• Visit Medicare.gov/about-us/inflation-reduction-act.

• Call 1-800-MEDICARE.

• Contact your local State Health Insurance Assistance Program (SHIP) at shiphelp.org to get free personalized health insurance counseling.



Process for Referring Licensees with DUI Offense to the Physician Health Committee

Licensees who fall under the jurisdiction of the Alaska Medical Board (MD, DO, DPMs and PA's) are required to report to the Medical Board within 30 days of being charged with a DUI.

1. A Licensee reports a DUI charge to the Medical Board. The report is received and reviewed by the Executive Administrator (EA). At a minimum, the Licensee's report should include a copy of the charging document and police report.
2. The (EA) forwards the Licensee's report to the Board Chair. Based on the information provided by the Licensee, a determination is made by the Board Chair regarding whether the incident is considered an "Uncomplicated" offense or a "Complex" offense.

   An Uncomplicated offense is defined as a first offense without complicating factors. Examples of complicating factors are provided under the definition of a complicated offense.

   A Complicated Offense is defined as a 2nd DUI offense and/or includes but is not limited to an incident that involves property damage, bodily harm, or aggravated charges.
3. If the Board Chair determines the offense is Uncomplicated, the Licensee will be referred to the PHC.
   - The PHC will contact the Licensee and refer the Licensee for assessment and engage the Licensee in monitoring.
     - If the Licensee is determined to be compliant with engagement, assessment, and monitoring by the PHC; the PHC will provide quarterly anonymous compliance reports to the Board. The PHC will notify the Board when the Licensee successfully completes PHC monitoring.
     - If the Licensee is determined to be non-compliant by the PHC, the PHC will refer the Licensee to the Board (the EA and Board Chair) and the EA/Board Chair will refer the Licensee to the Investigations Unit.
4. If the Board Chair determines the offense is Complicated, the Licensee will be referred to the Investigations Unit.

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