BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of	)	
	)	
W S-B	)	OAH No. 15-1143-PER
	)	Agency No. 2015-0604

FINAL DECISION AFTER REMAND

I. Introduction

W S-B appealed the Division of Retirement and Benefit's denial of her claim for full coverage of a medical expense. Her argument that the expense should be fully covered because she has two insurance policies is rejected. Under the coordination of benefits rule that governs both policies, she is only entitled to reimbursement for covered expenses. That means doctor's bills that are more than the recognized charge will not be paid.

Ms. S-B's second argument is that the Division has miscalculated the recognized charge for the procedure at issue. She has evidence that shows that the Division did not use the most recent data available for calculating how much doctors in the Anchorage area charge for the procedure she received. On this argument, Ms. S-B has met her burden of proof. The Division is required to reimburse her for the recalculated recognized charge.

II. Facts

K B had a long tenure working for the Alaska Marine Highway System. For purposes of retiree health insurance, his employment had two distinct iterations. First, from 1981 to 1990, he worked as a member of the Inland Boatman's Union. Under his employment contract for that job, his retirement health care is provided through the Alaska Public Employment Retirement System, commonly known as "PERS."[1] He became fully vested in this system, so he was able to take early retirement from PERS in 2008 with full health care coverage.

Mr. B's second incarnation (for retiree health care insurance) began in 1990 when he began work as a licensed engineer. He joined a new union, the Marine Engineers' Beneficial Association, known as "MEBA."[2] MEBA had negotiated with the state to fund its own retiree health care plan. The MEBA plan was separate from PERS, but it was managed and administered by PERS. Mr. B became fully vested in this system. As a result, when he retired from his MEBA job in 2011, he and his dependents were covered under two separate health insurance plans, PERS

[1] B testimony; S-B Response to Motion for Summary Judgment/Cross Motion (Nov. 20, 2015).

[2] B testimony; S-B's Response.

and MEBA. Both plans were administered by PERS, and both had exactly the same terms and coverages.

In 2014, Mr. B's wife, W S-B, needed surgical procedure called a "laparoscopic partial colectomy." She received pre-approval that the surgery was covered under both of her insurance plans from the third-party administrator for both plans, Aetna Life Insurance Company.

Only one clinic in Alaska, Alaska Colorectal Surgery in Anchorage, specialized in the surgery needed by Ms. S-B. Alaska Colorectal performed the surgery on October 16, 2014. It billed $12,640.00 for the primary surgeon, and $12,640.00 for the assistant surgeon. It submitted this bill to Aetna.

Some medical providers in Alaska are enrolled with Aetna as "preferred providers," for whom Aetna will consider 100 percent of the provider's fee for approved services to be a covered expense. Alaska Colorectal Surgery is not a network provider.

When determining the appropriate reimbursement amount for a non network provider, Aetna will pay only the "recognized charge." The recognized charge is the lesser of the actual charge or "[t]he 90th Percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies."[3]

For the procedure that Ms. S-B received (procedure number 44204), Aetna determined that the 90th percentile charge for the primary surgeon in the geographic area denoted under zip codes beginning with 995—Anchorage, Alaska—was $10,682. One hundred percent of this amount was paid by Ms. S-B's primary insurance company.[4] (The record is not clear on whether the primary carrier was MEBA or PERS, but it does not matter for purposes of this appeal, because both have exactly the same policies, and the outcome would be the same without regard to which was primary.) Thus, $1,958.00 of the primary surgeon's charge was not paid by the primary insurance carrier.

The secondary insurance carrier (also administered by Aetna) also refused to reimburse Ms. S-B for the $1,958.00. The secondary insurance carrier applied precisely the same analysis, and determined that only $10,682.00 was a covered expense. Because that charge had already been paid by the primary insurance carrier, nothing was left for the secondary carrier to reimburse. Thus, with regard to the primary surgeon's charge, Ms. S-B received no benefit from having two insurance policies subject to coordination of benefits.

[3] Admin. Rec. at 76.
[4] Admin. Rec. at 84.

With regard to the assistant surgeon's charge, the same scenario occurred—the primary carrier reimbursed at the maximum allowed under the policy (16 percent of the recognized charge for the primary surgeon), and the secondary carrier paid nothing. Eventually, however, the provider waived the noncovered portion of the fee for the assistant surgeon.[5] That meant that the only amount Ms. S-B was out of pocket for the surgery was the $1958.00. That is the amount that is on appeal here.

During the course of the proceedings in this case, the Division submitted a motion for summary adjudication. Ms. S-B opposed the motion and submitted a cross-motion. Both motions were denied. An initial hearing was held on November 18, 2015. A supplemental hearing was held on January 21, 2016. Supplemental briefing was permitted after the January 21 hearing. The record closed on February 12, 2016.

III. Discussion

Ms. S-B raises two arguments on appeal. First, and most important to her, she asserts that coordination of benefits between her primary and secondary health insurance policies should result in payment of the $1958.00 unpaid charge for her October 16, 2014, surgery. In her view, the secondary carrier was obligated to pick up any charges not paid by the primary insurer, up until the amount it paid reached the coverage limits. As she put it, "what one benefit policy doesn't cover, the other one should."[6]

Ms. S-B's second argument is that Aetna has miscalculated the 90th percentile of the charges made by surgeons for this surgery in the Anchorage market. She believes that the primary surgeon's fee in this case—$12,640—represents the 90th percentile. Therefore, she believes, the full amount is subject to reimbursement. She stresses, however, that she makes this argument only in the alternative. She wants to have her argument on coordination of benefits addressed before we discuss her argument on the correct amount of the recognized fee.

A. Can coordination of benefits pay the unreimbursed costs?

Ms. S-B is entitled to coordination of benefits because her husband is eligible for two separate retiree health plans. Under Ms. S-B's argument that the secondary insurance must fill the gap up to what it would pay as covered expenses, which expenses were paid by the primary insurance is not relevant. That the primary has already paid the same expense that the secondary would reimburse as covered expenses is not relevant. Ms. S-B's theory is that money is fungible,

[5] S-B testimony.

[6] S-B Response to Motion for Summary Judgment/Cross Motion (Nov. 20, 2015).

so it does not matter which expenses were covered by the primary carrier—if expenses remain, the secondary should pay until it reaches its coverage limit.

The Division does not contest that Ms. S-B is eligible for coordination of benefits. It asserts, however, that the secondary plan will not pay for expenses that are not covered. Therefore, in the Division's view, knowing which expenses were paid by the primary insurance is crucial to determining what the secondary insurer will pay. If the primary insurer paid all of the covered expenses, nothing would be left for the secondary insurer to pay.

The difference between the two approaches is shown under the following simplistic hypothetical:

- Retiree X has two plans. Both provide the following coverage for surgery:
  - 100 percent of the surgeon's fee;
  - Charges for bandages are limited to a maximum of $100.
- Retiree X has surgery, and the hospital sends the following itemized bill:
  - $1,000 for the surgeon;
  - $500 for bandages

Under both Ms. S-B's interpretation and the Division's interpretation, the primary insurer would pay $1100. $1000 for the surgeon (100 percent of $1,000) and $100 for bandages (the maximum reimbursement for bandages).

Under Ms. S-B's interpretation, the secondary insurer would then pay $400. In her view, it would not matter that the $400 would go to the cost of the bandages and that the secondary insurer had a policy against paying more than $100 for bandages. All that matters is that some of the bill remained unreimbursed. She believes that the secondary insurer had promised to pay up to $1100 for this procedure. Therefore, it had to reimburse her any nonpaid expenses up to this amount, without regard to which expenses were paid by the primary.

Under the Division's interpretation, on the other hand, the secondary insurer would pay nothing. It would pay nothing for the surgeon because that fee was already paid in full. It would pay nothing for the bandages because Ms. S-B had already been reimbursed at the policy limit for bandages.

One additional comment on this hypothetical. Note that if the plans had provided for 80 percent payment of the covered surgeon's fee (the plans do require a "coinsurance" payment, such as 80 percent, until an out-of-pocket maximum is reached), under the Division's interpretation, the secondary insurance would pay the unpaid 20 percent of the surgeon's fee in this hypothetical

because that would be an uncompensated covered expense.[7] It would still pay nothing for the bandages, however, because all of the reimbursable covered charges for bandages had already been paid.

Turning back to the facts of this case, the Division concludes that the secondary insurance could not pay the $1958.00. To the Division, that amount represents an uncovered, non-reimbursable expense. To Ms. S-B, on the other hand, the $1958.00 is well below the maximum that the secondary insurance promised to pay. Without regard to whether the $1958.00 is a covered expense, Ms. S-B believes the secondary insurance must pay it.

The scope of the coverage provided by a health insurance plan is governed by the contract between the parties.[8] Therefore, resolving the dispute between the parties will depend on the terms of the two different insurance contracts. The terms of the contract are described in the plan's booklet.[9] The next inquiry, then, is to ask what the language in the booklet governs how benefits are coordinated between the two plans?

First, however, we must address one concern that arose in this case—whether the MEBA plan was governed by the PERS booklet. At the outset, the parties were unsure whether MEBA might have negotiated for some different coverages than were provided by PERS, particularly in the area of coordination of benefits, which governs this dispute. The parties were asked to research the issue. Neither party submitted any information indicating that the MEBA health care plan had different terms or policy/coverage limits than the PERS health plan. The parties proceeded with this hearing under the understanding that both plans were governed by the PERS plan booklet. Therefore, the terms of the PERS booklet will control the outcome of this dispute.

The booklet explains how coordination of benefits works as follows:

- The primary plan pays benefits first, without regard to any other plan.
- When the retiree plan is secondary, the amount it will pay will be figured by subtracting the benefits payable by the other plan from 100% of expenses **covered** by the retiree plan on that claim. The plan pays the difference between the amount the other plan paid and 100% of expenses the retiree plan would cover.
- Neither plan pays more than it would without coordination of benefits. Benefits payable under another plan include the benefits that would

[7] The plan will pay 80 percent of covered expenses up to $4000 when it will pay 100 percent of a covered expense. Admin. Rec. 52. Here, the primary plan paid 100 percent of covered expenses.

[8] *See, e.g., In re GJ.T,* OAH No. 10-0415-PER at 7 (Office of Admin. H'rgs 2011) (analyzing whether a procedure was covered by reference to the terms of the plan).

[9] *See id.; In re R.S.*, OAH No. 06-0176-TRS at 3 (Office of Admin. Hr'gs 2007).

have payable whether or not a claim was actually submitted to the plan.

- Services which are limited to a maximum number of services in a year are not increased by having other coverage. For example, if you have two plans that each cover a single vision exam each year, the plans coordinate to cover up to 100% of a single vision exam; they do not pay for two vision exams in a year.[10]

The answer to Ms. S-B's argument is found in the second bullet. A secondary plan will only pay for unpaid ***covered*** expenses. Because we start with 100 percent of the maximum covered amount for each charge when determining how much the secondary insurance will pay, the secondary could never pay more than the covered amount—which, in this case, is the recognized charge for the lead surgeon.

In sum, under the plain terms of the plan booklet, the plan will not pay for costs that exceed the recognized charge, even when the retiree has more than one insurance plan. Unless some other evidence shows that the terms of the plan booklet do not control, this means that in this case Aetna properly coordinated benefits between Ms. S-B's two plans. We will next discuss, however, whether the past practice of the Division affects how benefits are to be coordinated in this case.

B. Does the past practice of the third-party administrator mean that the secondary insurer must pay the $1958.00?

Ms. S-B testified that in previous years she or her husband have had medical charges from out-of-network providers. At first, the third-party administrator did not pay for uncovered charges in those bills. When the third-party administrator discovered that they were covered by two separate plans, however, it paid 100 percent, even though the provider was an out-of-network provider.[11] From this conduct, Ms. S-B concluded that having coverage under both the MEBA plan and the PERS plan meant that all medical bills would be paid. She asserts that both plans must be applied as stand-alone plans, fully applied at up to an 80 percent benefit level. She believes that past practice has "nullif[ied] the 'recognized charge.'"[12] This means that the plans must continue to pay for 100 percent of their medical bills in the future, up to the combined coverage limit. Anything less would be a diminution of benefits, which is not permitted.

The Division disputes that past coordination of benefits for Ms. S-B resulted in payment of charges for uncovered services. The Division believes that the bills paid by the secondary

[10] Exhibit 7 to Division Motion for Summary Judgment (Oct. 14, 2015) (bolding in original).
[11] S-B testimony. Ms. S-B specifically cited the [No Name] bills in the record at A-1 – A-6.
[12] S-B Supplement Brief (Feb. 5, 2016).

insurance in the past may have been for charges that were compensable but only eligible for partial reimbursement by the primary insurer. That is different from the situation here, where the unpaid fee is not a covered expense.

Although I find the exhibits in the record inconclusive as to what that the third-party administrator paid in the past, I accept Ms. S-B's testimony. Therefore, this analysis will based on an understanding that past practice of the agency did result in full payment, some of which payment resulted in reimburses for charges that were in excess of the recognized charge.

Ms. S-B's argument suggests three lines of inquiry: (1) whether past practice is evidence that the contract provides for full coverage upon coordination of benefits; (2) whether a change from past practice is an illegal diminishment of benefits; and, (3) whether, under the legal doctrine of "equitable estoppel," the Division must continue to offer the benefit.

First, past practice can be an indication of how parties are interpreting a contract.[13] Here, however, the language of the plan booklet regarding coordination of benefits states a clear limitation to covered expenses. Although extrinsic aids to contract interpretation may be used without regard to ambiguity in the contract, here, the evidence submitted by Ms. S-B is not sufficient to overcome the clarity of the plan booklet.

The second issue (and the argument raised by Ms. S-B) is whether the change in how the contract was administered amounted to a diminution of her benefits. In Ms. S-B's view, the contract was previously administered to provide payment of all expenses. She believes that a change in interpretation to reduce her benefits is "a change in the plan and is in fact combining benefits, which diminishes the value of the second policy."[14] She cites to *Duncan v. Retired Public Employees of Alaska, Inc.*, for the proposition that a diminution in health care benefits is a violation of the Article XII, Section 7 of the Alaska Constitution.[15]

The issue in *Duncan,* however, was whether the changes made to the terms of the plan in 1998 were a reduction in the benefit level promised to retirees.[16] To fit neatly under a *Duncan* analysis, Ms. S-B would have to establish that the level of coverage promised to MEBA employees had changed. This is why I put so much emphasis in this case on asking the parties what specifically had been promised to MEBA employees during the term of Mr. B's

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13 *Municipality of Anchorage v. Gentile*, 922 P.2d 248, 256 (Alaska 1996) ("The parties' expectations are assessed by examining the language used in the contract, case law interpreting similar language, and relevant extrinsic evidence, including the subsequent conduct of the parties.").

14 S-B Response to Cross Motion (Nov. 13, 2015).

15 *Id.* (citing 71 P.3d 882 (2003)).

16 *Duncan v. Retired Public Employees of Alaska, Inc.*, 71 P.3d 882 (2003).

employment. Had MEBA employees been promised one level of benefits (full coverage for all expenses upon coordination of benefits), and then that promise was either broken or diminished, Ms. S-B might be able to state a case for breach of contract, either through a diminishment theory or a straightforward breach theory.[17]

Here, in contrast, no change has been made to the plan itself. Mr. B was not initially promised one level of care and then provided a lower level of care. The promise has been consistent: upon coordination of benefits, the secondary insurer will pay only covered expenses. That is what occurred here. Even if a past third-party administrator of the plan made an error, and misinterpreted the terms of the plan so as to allow reimbursement of non-covered expenses, a retiree "does not have a vested right in a mistaken application of the retirement system."[18] A mistaken interpretation cannot be the basis of a diminishment. Therefore, Ms. S-B's theory that her benefits have been diminished by a change in practice is not persuasive.

Third, although the government might be obligated to allow a benefit in some circumstances under the doctrine known as "equitable estoppel," the court has limited the doctrine as follows:

> estoppel may apply against the government and in favor of a private party if four elements are present: (1) the governmental body asserts a position by conduct or words; (2) the private party acts in reasonable reliance thereon; (3) the private party suffers resulting prejudice; and (4) the estoppel serves the interest of justice so as to limit public injury.[19]

With regard to element (1), merely making a mistake and overpaying a benefit would not generally qualify as an assertion of position that binds the government in the future.[20] Here, where the booklet is clear that coordination of benefits will only provide payment for covered expenses, a mistaken payment in excess of the recognized charge is not an assertion of a position that binds the agency in future transactions. For element (2), given the clarity of the booklet, any reliance on an erroneous interpretation might not be reasonable reliance. On element (3),

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[17] Diminishment analysis for changes to health care benefits is complicated, so merely showing that a particular benefit was no longer available would not automatically establish diminishment. *See Duncan*, 71 P.3d 882, 890-92. The point here is that a misapplication of the plan booklet is not sufficient to begin the diminishment inquiry.

[18] *Flisock v. State, Div. Ret. and Ben.*, 818 P.2d 640, 644 n.5 (Alaska 1991).

[19] *Crum v. Stalnaker*, 936 P.2d1254, 1256 (Alaska 1997).

[20] *In re Romanzof Fishing Co., LLC*, OAH No. 0795-TAX (Office of Admin. Hr'gs 2006); *Wien Air Alaska, Inc. v. Department of Revenue, State of Alaska*, 647 P.2d 1087, 1095 (Alaska, 1982) ("The doctrine of equitable estoppel is not a bar to the correction by the Commissioner of a mistake of law" (quoting *Automobile Club of Michigan v. Commissioner of Int. Rev.*, 353 U.S. 180, 183 (1956))).

prejudice is not established on this record—no evidence indicates that Ms. S-B likely would not have had the surgery had she known for certain that coordination of benefits would not pay the full cost. Given that all four elements must be present for the doctrine to apply, the past practice of the agency does not estop the agency from correcting its error and applying the correct interpretation of the plan to Ms. S-B's claim.

In sum, Ms. S-B's interpretation of the plans' promises to mean that "what one benefit policy doesn't cover, the other one should," is not supported by the plan booklet. Ms. S-B does not have any support for a theory that the MEBA plan promised different or more extensive coverage than is provided under the PERS plan. Neither the MEBA plan nor the PERS plan nullifies the recognized charge—the explicit terms of both plans adopt the recognized charge, and adopt a coordination of benefits policy that limits reimbursement at the level of the recognized charge. Moreover, the past practice of the third-party administrator does not affect the Division's ability to deny coordination of benefits for charges that exceed the recognized charge. Therefore, the Division's decision that it is not obligated to pay charges that exceed the recognized charge for a retiree who is insured under both MEBA and PERS is affirmed.

C. Has the Division correctly calculated the recognized charge for Ms. S-B's lead surgeon?

Ms. S-B's second argument is that the Division did not correctly calculate the recognized charge in the Anchorage area for the procedure that she received. The 2014 Plan Amendment to the 2003 Plan Booklet (effective January 1, 2014) explains the "recognized charge" as follows:

> "Recognized Charge" means the negotiated charge contained in an agreement the claims administrator has with the provider either directly or through a third party. If there is no such agreement, the Recognized Charge is determined in accordance with the provisions of this section.
>
> - Medical, Vision, and Audio Expenses
>
> - As to medical, vision and audio services or supplies, the Recognized Charge for each service or supply is the lesser of:
>
> - What the provider bills or submits for that service or supply; or
>
> - the 90th percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna

reimbursement policies.[21]

The documents in the record include an excerpt from a 2011 report for Aetna from FAIR Health, Inc.[22] The Division explained that FAIR Health, Inc., is a consulting firm that provides it with data on physician charges for medical procedures. The Aetna report shows that nine procedures were billed under procedure code 44204 (the surgical procedure that Ms. S-B received) in zip code 995 (the zip code for the Anchorage area).[23] It does not state the dates that these nine procedures were performed. It reports the average charge and the percentile charges as follows:

AVERGE	PERCENTILES						
CHARGE	50TH	60TH	70TH	75TH	80TH	85TH	90TH
9,528	9,528	9,350	9,350	9,350	10,682	10,682	10,682[24]

Thus, under this report, the recognized charge for the lead surgeon for Ms. S-B's procedure would be $10,682. This is the amount that Aetna paid.

Ms. S-B challenges this report. She has submitted a different report. This report is called a "Customized Fee Analyzer."[25] It was prepared for Alaska Colorectal Surgery on March 25, 2013, by a company called "Optum."[26] The report has a copyright claim for "Optuminsight, Inc."[27] It then notes a second copyright claim that states "Data only © 2013 FAIR Health, Inc."[28]

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[21] Retiree Insurance Information Booklet at xii-xiii (2014 amendment) *available at:* http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2016amendment.pdf. The booklet also contains the following explanation of the recognized charge pre-amendment:

> The recognized charge percentage is the charge determined by the claims administrator on a semi-annual basis to be in the 90th percentage of the charges made for a service or supply by providers in the geographic area where it is furnished. The recognized charge is determined by collecting the claims submitted for each procedure, defined by the procedure code, in a specific geographic area. The highest and lowest charges are ignored and the charge that allows 90% of all the claims to be paid in full is set as the recognized charge for that procedure.

Id. at 12. The booklet is not clear on whether this language is superseded or whether the two different definitions are to be harmonized.

[22] Admin. Rec. at 66.

[23] *Id.*

[24] *Id.* Although this letter and the letter denying Ms. S-B's Level II appeal mention other possible methodologies under the heading "How we made our decision," it appear that the decision was, in fact, made solely on the basis of the FAIR Health database. *See id.*, Admin. Rec. at 8. Aetna's discussion of "derived charge" is a red herring and will be ignored.

[25] S-B Exhibit C.

[26] *Id.*

[27] *Id.* at 3.

[28] *Id.*

Based on this FAIR Health copyright, Ms. S-B asserts that the database used to prepare this report is the same FAIR Health database used by Aetna.

The Custom Fee Analyzer submitted by Ms. S-B contains the following percentile charges for procedure code 44204 for zip codes 995 and 997:

50th	60th	75th	80th	85th	90th	95th
9,958	11,229	12,577	12,632	12,633	12,633	12,640[29]

$12,640, which shows up here in the 95th percentile charge for the procedure, is the actual charge for Ms. S-B's lead surgeon. Based on this report, Ms. S-B concludes that the recognized charge for her procedure should be $12,640. She requests that she be reimbursed for the full charge for her lead surgeon.

The Division asserts that the database used in this report is different from the database used in the Aetna report. It argues that Ms. S-B cannot challenge Aetna's database with reference to the data in a different database. In the Division's view, the existence of other databases is not relevant because the plan booklet refers only to a specific database, and we must use the information in that database.

The Division is mistaken. A retiree may challenge the administrator's calculation of the recognized charge.[30] In *In re DT,* for example, a retiree was able to prove that "the Health Plan did not properly calculate the recognized charge percentage."[31] Accordingly, in that case, the Division's denial of a claim was reversed, the recognized charge was determined under a different methodology, and the retiree's medical claim was reimbursed in full, using the medical provider's actual charge as "[t]he only relevant benchmark for reimbursement."[32]

Here, neither party has provided any testimony to explain the data or the difference between the two databases. The Division has not challenge the authenticity of the Optum database submitted by Ms. S-B, and, given that her surgeon apparently relied on it in setting her fee, I conclude that the Optum database is the type of evidence that a reasonable person would rely upon for decisionmaking. Therefore, I may rely on it here.[33]

In comparing the two reports, the Optum report is the more reliable. Although we do not know the dates of the charges used to calculate the percentiles in either report, the Optum report

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29 *Id.* (percentile data for other procedures omitted).

30 *In re DT,* OAH No. 10-0577-PER at 3 (Office of Admin. H'rgs 2011).

31 *Id.* at 7.

32 *Id.*

33 *See* 2 AAC 64.290(a)(1) ("The administrative law judge may (a) admit evidence of the type on which a reasonable person might rely in the conduct of serious affairs.").

has a date of 2013, which indicates that it was likely updated at that time. The Aetna report, on the other hand, is dated 2011. The plan booklet requires that recognized charge be based on "the prevailing charge." The term "prevailing" connotes recency—rates that were charged in the past might no longer be "prevailing," so the more recent the data, the better the compliance with the Division's promise for how it will compute the recognized charge. In addition, the booklet still contains a promise that the data will be updated semiannually.[34] Neither party's report would comply with this requirement, but, as the plan's promise to use recent data highlights, the more recent data in the Optum report is more reliable.

In addition, in the Aetna report, several of the percentiles are identical: it has the same number for the 60th, 70th, and 75th percentiles, and then the same number for the 80th, 85th, and 90th percentiles. In the Optum report, however, the numbers are different in each percentile except that the 85th and 90th are the same. No testimony or explanation was received on why these numbers are the same or different, but a reasonable inference here is that the Optum report may be based on a larger number of data points, making it more reliable.[35]

Thus, here, as in *In re DT,* the retiree has met her burden of proving that the Division has not followed its own plan booklet in calculating the recognized charge. The most reliable data in this record for establishing the recognized charge based on "the 90th percentile of the prevailing charge rate for the geographic area where the service is furnished" is the Optum report. Therefore, I will use that report to determine the recognized charge.

Ms. S-B has erred, however, in concluding that the 90th percentile identified in the Optum report is the $12,640 charged by her physician. In fact, the 90th percentile is $12,633 ($12,640 is the *95th* percentile). Therefore, the prevailing charge is $12,633. Because the Division has already paid $10,682, it is required to reimburse Ms. S-B the difference between $12,633 and $10,682, which is $1951.00.

D. Should Ms. S-B's insurance reimbursement for the cost of the assistant surgeon be increased to reflect the recalculated prevailing charge?

In her proposal for action, Ms. S-B argued that the recalculated prevailing charge rate should be applied to the 16 percent reimbursement level for the assistant physician. The Division

[34] Retiree Insurance Information Booklet at 12.

[35] To be clear, this decision is not holding that the Aetna report is per se unreliable. In the absence of any evidence or testimony supporting and explaining the Aetna report, however, the evidence in this record supports an inference that the Optum report is more reliable.

was provided an opportunity to respond to Ms. S-B's argument. The Division did not oppose awarding the additional reimbursement.

Therefore, the amount owed = 16% x 12,633 = $2,021.28.

The amount paid was 16% x 10,682 = 1709.12.[36]

The difference, which is payable to Ms. S-B, is $312.16

IV. Conclusion

The Administrator shall reimburse Ms. S-B an additional $2,263.16 for the cost of her surgical procedure performed on October 16, 2014, by Alaska Colorectal Surgery, PC. Combined with the payments already made by the Administrator for this procedure, this reimbursement is the full and final reimbursement for the cost of this procedure from both health insurance policies held by her husband, K B, based on his employment with the State of Alaska.

DATED this 11th day of May, 2016.

By: *Signed*
Stephen C. Slotnick
Administrative Law Judge

Adoption

I adopt this Final Decision after Remand under the authority of AS 44.64.060(e)(1) as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 11th day of May, 2016.

Signed
Stephen C. Slotnick
Administrative Law Judge
Dep't of Administration

[This document has been modified to conform to the technical standards for publication.]

[36] Admin. Rec. at 40.