OIC Rules Coordinator

From: craig kagetsu <craigkagetsu@yahoo.com>
Sent: Tuesday, July 29, 2025 2:42 PM
To: OIC Rules Coordinator
Subject: R2025-05 First Prepublication draft comment"

Dear Office of the Insurance Commissioner,

I am writing to express my deep concern about the use of the FAIR Health database by auto insurers to unilaterally reduce reimbursement for medically necessary care. As a licensed chiropractor with over 25 years of experience serving patients in Washington state, I've seen firsthand how this opaque and arbitrary practice is harming both patients and providers.

Despite patients paying high premiums for Personal Injury Protection (PIP) coverage, many are now being denied the care they need—or are forced to pay out-of-pocket—because insurers are slashing reimbursement based on FAIR Health's secretive algorithm. The database does not account for clinical necessity or regional cost variations in a fair way. Instead, it averages urban and rural data behind closed doors and allows insurers to cap payments at just 80% of billed charges, with no justification or appeal process provided.

This is not insurance—it's cost-shifting disguised as policy. It forces me as the provider to either write off legitimate charges or pursue the patient for the balance, putting me in direct conflict with the people I'm trying to help. Insurers often step in, not to resolve the issue, but to pit the patient against the provider.

This form of "cookbook medicine"—using rigid fee caps without regard for individualized patient care—undermines the provider's clinical judgment and diminishes quality of care. It's especially unjust when the treatment has already been delivered and documented as medically necessary.

These cuts are unsustainable. If my bills are arbitrarily reduced to 80%, it creates a ripple effect that raises overall health care costs, delays recovery, and

increases legal disputes. Providers cannot be expected to absorb these losses or compromise care.

We need full transparency in how FAIR Health data is used in Washington, and insurers must be held accountable for undermining access to care through unjustified payment practices.

Please take immediate steps to:

1. Require insurers to disclose how FAIR Health data is used and calculated;
2. Mandate a fair and open appeals process;
3. Prohibit unilateral fee reductions without clinical or geographic justification.

Patients and providers deserve better.

Sincerely,

Craig Kagetsu, DC

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From: craig kagetsu <craigkagetsu@yahoo.com>
Sent: Thursday, July 31, 2025 9:47 AM
To: OIC Rules Coordinator
Subject: R2025-05 First Prepublication draft comment

External Email

To the Washington State Office of the Insurance Commissioner:

I am writing on behalf of the Washington State Chiropractic Association to express strong support for the proposed rule changes that would prohibit property and casualty insurers from denying or reducing reimbursement for claims without conducting a reasonable investigation. Specifically, we support the inclusion of the following language to WAC 284-30-330 (4):

“Any denial or refusal to pay claims in part or in full without conducting a reasonable investigation. A reasonable investigation includes, but is not limited to, conducting an individual assessment of either the covered loss or damages, or both, and cannot rely solely on the use of a database.”

We also support, and recommend additional language to, WAC 284-30-380 (8):

"If any insurer uses a database or survey to account for either material pricing, or labor rate, or both, and upon request of the claimant, the insurer must provide the claimant with the date the data was collected, where the data was collected from, which businesses provided the data, and whether the business will honor the price provided if the insured were to consider using them."

We suggest that you consider language that would include reference to the use of artificial intelligence (AI) for claims processing decisions. Consumers deserve to know if technology is the deciding factor or if an insurer uses other metrics or artificial information for claim decisions of all types. As we have learned with the use of third-party vendors who manage claim decision making in commercial health insurance, this section could be further tightened to include language requiring disclosure of all vendors and third-party entities that are either owned by, or contracted with, the carrier to make claims decision especially when the claim amounts are reduced.

This rule is essential to address a growing and harmful trend in the insurance industry: the arbitrary reduction or denial of chiropractic claims based solely on database-generated pricing benchmarks, such as those provided by Fair Health, which are not

public nor is the process used by the database owners.

Insurers are increasingly using the Fair Health database as a shortcut to reduce reimbursements to chiropractic providers—without reviewing the clinical documentation, medical necessity, or outcomes of care. These database-driven decisions lack transparency, consistency, and fairness. Most importantly, they disregard the individual assessment that is fundamental to ethical and lawful claims handling. The database also does not consider specialized provider training that considers populations that may present with greater risk factors for recovery.

Chiropractic care is a proven, cost-effective treatment for many musculoskeletal conditions, including back and neck pain, which are among the leading causes of disability and lost productivity in Washington State. Multiple studies and authoritative bodies have affirmed the value and cost savings associated with chiropractic care:

- **A 2016 study published in the *Journal of Manipulative and Physiological Therapeutics*** found that patients receiving chiropractic care for low back pain incurred significantly lower overall healthcare costs compared to those receiving conventional medical care.
- **A 2013 report from OptumHealth** revealed that incorporating chiropractic care into health benefit plans reduced overall treatment costs by more than 40%.
- **The Washington State Department of Labor and Industries** has consistently supported the use of chiropractic care as an effective treatment that reduces disability durations and expedites return to work.
- **The Joint Commission and the CDC** recommend non-pharmacological therapies like chiropractic care as a first-line defense against chronic pain, helping reduce reliance on opioids and costly interventions.

These findings highlight that chiropractic care delivers both clinical and economic value—yet insurers continue to devalue these services by using pricing databases that are not designed to reflect individualized care or real-world outcomes.

The proposed rule appropriately requires insurers to move beyond automated claim denials and engage in a genuine investigation—one that includes an individualized assessment of the loss or damage, and which does **not** rely solely on a database, or outside vendors, to justify underpayment.

Patients and providers deserve a fair and transparent claims process. Insurers must be held accountable for ensuring that denials or reductions are based on reasoned evaluation, not algorithmic shortcuts. This rule is a step toward restoring integrity to the claims process and ensuring that patients retain access to essential chiropractic care. Patients are paying a premium for services that the carrier is not covering, leaving either the patient, or the provider, or both, left to pay for the lack of promise in the insurance policy.

Thank you for your attention to this issue and for proposing language that protects both providers and the public.

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