



THE STATE
of **ALASKA**
GOVERNOR MIKE DUNLEAVY

Department of Commerce, Community,
and Economic Development

BOARD OF PHYSICAL THERAPY AND
OCCUPATIONAL THERAPY

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April 18, 2025

The Honorable Jesse Bjorkman
Chair, Senate Labor and Commerce Committee
Alaska State Capitol, Room 427
Juneau, Alaska 99801

Dear Senator Bjorkman,

The Alaska Physical Therapy and Occupational Therapy Board would like to vocalize support for SB121. This bill addresses standards for settlement of health insurance claims and allowable charges for health care services. The Board feels that this bill will result in a positive impact to Alaskans by increasing access to health care services, including physical therapy and occupational therapy services. This bill addresses challenges related to geographic isolation and provider shortages, which directly impacts Alaskans' health.

The geographic spread between communities in Alaska presents a unique challenge compared to other states, and this bill improves the patient's ability to access medical and rehabilitative services. Compared to Alaska, a patient can travel between health care providers with less challenges in the lower 48 states. For instance, if a patient in other states does not have an in-network provider in their hometown, then they are able to drive to another town to access an in-network provider. In many Alaskan communities, this is not possible due to the geographical distance between communities. Because the 80th Percentile Rule was revoked, our communities are at increased risk of healthcare disparity and medical desert.

A patient may have access to only a single health care provider in their community. If insurance limitations prevent a patient from treatment with that sole healthcare provider, then the patient may need to fly to another region to obtain care. Those travel requirements are often not covered by insurance providers, which results in a financial burden. Additionally, the time spent travelling for health care services leads to time away from responsibilities at home, such as work, caregiving to family members, etc.

SB121 addresses these challenges in Sec. 21.36.497 (a): "In the absence of a contract between a health care insurer and health care provider that sets allowable charges for health care services and supplies furnished to a covered person, the director shall set by regulation the standards that a health care insurer must use to set allowable charges for health care services or supplies furnished to a covered person by a health care provider in the state." This language addresses

concerns related to care provided by out of network health facilities, which increases a patient's ability to see the local health care providers in their community.

Insurance reimbursement is a strong factor in the growth of the healthcare market, including the volume of service providers. By increasing the volume of healthcare providers in Alaska, Alaskans have increased access to healthcare services. Alaskans cannot access healthcare services if providers are not able to financially establish their practices. SB121 addresses this need by establishing statutory regulation for reimbursement of healthcare services through language related to allowable charges in Sec. 21.36.497 (a):

“Allowable charges must be based on the most current data available that shows amounts charged by health care providers in the state for the service or supply over a 12-month period and must be the same across the state. An allowable charge may not be less than the 75th percentile of charges in the state for a health care service or supply as defined by the Current Procedural Terminology adopted by the American Medical Association or other industry standard method of coding, but the director may set an allowable charge at a higher percentile. Allowable charges for primary care providers must be the greater of the allowable charge or 450 percent of the federal Centers for Medicare and Medicaid Services fee schedule for the state in effect at the time of delivery of the health care service or supply.”

In May 2018, the University of Alaska Anchorage prepared the following document for the Alaska Office of Management and Budget: “How Has the 80th Percentile Rule Affected Alaska's Health-Care Expenditures?” This document was written by Mouhcine Guettabi with the Institute of Social and Economic Research and Department of Economics and Public Policy.

This document describes that after the implementation of the 80th percentile rule, health care expenditures for physician and clinician services experienced significant growth. “For this category [physician and clinical services], we find that the 80th percentile explains between 15% and 39% of the growth rates. This means the yearly growth would have been between 1.06% and 2.74% lower in the absence of the 80th percentile rule.” This document demonstrates “that Alaska has considerably more physicians, and more doctor offices than it did in the early 2000's. The number of Physician offices, for example, increased from 368 in 1998 to 569 in 2015. Those of physical therapists increased from 37 in 1998 to 134 in 2015. This increase in availability and variety of healthcare facilities has made it easier for Alaskans to obtain medical services.”

This document establishes a correlation between the prior 80th Percentile Rule and the growth in volume of medical and therapy offices in Alaska. By increasing the volume of healthcare providers in Alaska, Alaskans have increased access to healthcare services. It is important to highlight the role of reimbursement guidelines in allowing therapist and other medical providers to establish financially viable facilities, which in turn allows for Alaskans to have access to health care services. This challenge seems to be especially impactful in smaller communities who are at risk of facing a healthcare desert.

In short, the Alaska Physical Therapy and Occupational Therapy Board is supportive of SB121.

Signed by:
Sincerely,
Valerie Phelps

Valerie A. Phelps, PT, ScD

Chair, Board of Physical Therapy and Occupational Therapy

April 17, 2025

Dear Senators Bjorkman, Dunbar, and members of the Senate Labor and Commerce and Health and Social Services Committees:

I am writing in support of Senate Bill 121. Reestablishing a 75th percentile rule means insurers will again be required to pay their fair share of Alaskans' health care bills as well as compete fairly for their business. Repeal of the 80th percentile rule was based on faulty data. Insurers holding flat or decreasing what they will pay has not changed the fact of increasing costs for providers. The only remaining options for providers are to decrease take-home pay, decrease the number of Medicare/Medicaid insured patients the practice sees, pass the cost on to patients, or some combination of all three. Alaska already faces a healthcare workforce shortage. Everything costs more here. All we ask is that insurers pay their fair share.

Sincerely,

Marin Granholm, MD
Anchorage

Let's Be Honest About the Real Drivers of Health Care Costs in Alaska

By Dr. Joseph T Hawkins, Chiropractic Physician, Palmer, Alaska

As a chiropractic physician who has practiced in Alaska for 28 years—25 of them as a preferred provider for Premera Blue Cross Blue Shield of Alaska—I feel compelled to respond to Jim Grazko's recent editorial on the state's health care costs and the impact of Senate Bills 121 and 122.

Mr. Grazko argues that these bills would raise premiums and harm access to care. But from my front-line experience, it's not the cost of care itself that's breaking the system—it's the insurance middlemen who continue to manipulate the system to their advantage, shifting more burden to patients and squeezing out small, community-based providers. The corporations buying up the small practices and this new corporation is contracted with the insurance company – hence, the physician that follows with the buyout is now a preferred provided. This I believe is how their “network” is growing, not because of some wonderful benefit of being part of their system as a physician.

The Reality Behind the Numbers

When I began practicing, the reimbursement for common procedures was higher than it is today. Despite rising living costs, inflation, and the ever-growing administrative burden, many providers—myself included—are being paid less today than we were 15 years ago for many codes. When I declined to renew my preferred provider agreement with Blue Cross because they wanted lock in all the physician for a year- not the usual 30 days I felt it was no longer a partnership but coercion.

After I left the network because of the hours of staff on hold with the insurance companies and constant conflict with BCBS of Alaska. After I refused to sign back on as a preferred provider with BCBS of Alaska, Premera sent notices to my patients implying I no longer met their standards. Let me be clear: I left because their terms were no longer tenable for a small, independent clinic focused on personalized care, not because I failed to meet some corporate benchmark. Call them as if you were a provider and 15- 50 minutes on hold.

Bureaucracy Over Care

Every week, my staff spends countless hours on hold with insurance companies—Premera among the worst—just to clarify coverage or submit pre-authorizations. Patients often assume their doctor's office is inefficient. They don't see the reality: third-party contractors hired by insurers playing gatekeeper, bouncing responsibilities back and forth in an endless loop that delays care and drains resources from small practices.

The claim that these bills will "skyrocket" costs doesn't match reality. Physicians don't get to set the reimbursement terms (unless you are a large corporation then you may have more pull). We're told what we'll be paid, and when insurance companies tie those payments to a percentage of or equal to Medicare's outdated fee schedule, we're left with little choice but to raise our listed prices—not to make more money, but to survive.

Big Business, Shrinking Access

What's truly driving consolidation in health care isn't innovation or efficiency. It's survival. Small-town doctors are being swallowed into corporate-owned mega-clinics where decisions are made by management teams, not caregivers. If you prefer an experience where your care begins with entering a Social Security number into a kiosk and ends with a denial from a faceless algorithm, then maybe Mr. Grazko's vision is for you. But if you still believe in the value of a provider who knows your name, your family, and your story, then SB 121 and 122 offer a fighting chance for that model to survive.

A Better System Is Possible

I don't intend to complain without offering some sort of possible solution. Years ago I started advocating that our local credit union to partner with Matsu Regional which had recently be sold to a big hospital corporation to pre-approve loans for essential medical procedures—at the same discounted rates insurance companies negotiate behind closed doors. The idea? Level the playing field for Alaskans without insurance or with high deductibles so they simply have to pay the lower rates the insurance companies pay to the physicians. The proposal was rejected by the health foundation and the hospital because they had entered into a agreement that they could not make any arrangements that would decrease their profits. – (Fact check me with Elizebeth Ripley or any member of the MVFCU Board of Directors or past CEOs.) So if simply asking to be paid 80% of what they would be paying for a preferred provider is causing them to lose money- please explain the math to me.

We need transparency, fairness, and local control—not more consolidation and top-down mandates from insurers their phone tree and treatment algorithms. If SB 121 and 122 level the playing field even slightly, they're worth supporting. Because the people who suffer most in today's system aren't the corporations. It's the working Alaskans without deep pockets or insider deals.

I encourage every Alaskan to ask their doctor this question: "Based on your experience with insurance companies—not your passion for helping others—would you encourage your own child to go into health care?" The answer may be more sobering than you think.

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March 21, 2025

Senator Dunbar

Senator Bjorkman

RE: Senate Bill 122

Dear Senator:

I am writing in support of Senate Bill 122. I support Senate Bill 122 and I am writing to inform you of this. I am a strong believer in timely access to care and I try to implement this on a daily basis in my clinic setting, but it is becoming more difficult. Currently, my wait time is about 15 minutes, but this seems to be increasing and it is more difficult to refer my patients to other providers in a timely fashion. Sometimes these referrals have to wait 2-4 weeks.

If other neurosurgeons were offered a contract from a major insurer and I was not, this would devastate my business since I would lose the majority of my referrals. I have experience with narrow network markets outside of Alaska and I think they are deleterious to the quality of healthcare, but they certainly empower insurance companies.

Please help us keep medical care in the hands of medical professionals. Being cut out of network would devastate my business and it certainly would reduce to possibly zero out of network reimbursement. These limited networks would definitely impact negatively patient's health in Fairbanks.

Thank you for your time and consideration.

Sincerely,

John A. Lopez, MD
JAL/lrh

cc:

My name is Tim Mullen. Currently I am the CEO for Orthopedic Physicians Alaska and Primary Care Associates. To the chair, Senator Bjorkman, thank you for allowing me time to share my thoughts on Senate Bill 121. Additionally, thank you to Senator's Dunbar, Yundt, Gray-Jackson, and Merrick – I sincerely appreciate your willingness to allow me to speak before you today. Thank you to Senator Giessel for asking for my participation. While I wasn't around when the 80th percentile rule was implemented, I was in Alaska in the days when healthcare providers were balance billing patients because working with insurance companies was untenable. I have been working in healthcare, either as a provider or leader since the early '90's. These two practices have been providing high quality care for decades and hope to for decades to come. I have 4 advanced degrees and over 30 years' experience in healthcare and I am concerned like never before.

I want to start my time with you about a story as a patient. When I first moved here, I needed my wisdom teeth removed. I was slated to have the procedure completed in Michigan, so I was aware of the cost to me at that time. I did not have time get the procedure finished before relocating. I met with the financial counselor in Anchorage who explained what insurance would pay and what my responsibility would be. It was easy to do the math and plan a trip back to Michigan to receive this care to save money. There are countless stories like this, I am not unique. This is image many of you likely have, this is certainly the story payers like to tell to demonize the healthcare system in Alaska. Keep this image in your mind because I want to come back to it.

Now I want to share my experience as a leader of a healthcare organization. Executive leadership in our organizations began having conversations about contracting or going in network with the payers in our communities in 2015 or so. In 2017, we in fact went in network and immediately lost better than 30% of our revenue. We were doing our part to reduce the economic burden. This was the right thing to do for Alaskan's. To this day, we proudly provide care for all in need at contracted rates, not what we think or want to get paid. We see other sectors in our communities raising prices to combat higher labor costs, higher prices for goods and services and general cost of living. Our reimbursement from insurance companies have certainly not increased commensurate to any economic standards all other sectors are employing.

As a healthcare business, our cost of doing business increased exponentially when we went in network. Our billing team spends unimaginable amounts of time working on preauthorization's and managing payment denials, none of which happened when we were out of network. The 30% reduction in reimbursement is now compounded by the increased staffing demands to meet insurance company requirements. Additionally, our providers must often complete "peer-to-peer" phone evaluations, typically from unqualified

physicians to explain why a person who has lost control of their leg, bowel, and bladder needs a spine surgery. Doing business with insurance companies is less than desirable. Eliminating the 80th Percentile Rule, gave payers even more power dynamics in this dance we chose just to take care of patients.

Continuing my story as a business leader this time. We certainly expected the premiums we pay for our employee's health insurance would be impacted by this. As a medium sized business in Alaska, our health insurance premiums have continued to rise double digits every year since we accepted a 30% reduction in reimbursement. Alaskan employers should be outraged by the rising premiums. The fact is, however, our charges remain unchanged since 2017. My math and the stories being told by Washington-Based payers do not match. Countless Alaskans are being told physicians are the cause for rising premiums, how can that be? It turns out these out of state insurance companies are still using research data that is riddled with errors from 2014, before most healthcare providers went in network. In fact, these Washington based folks convinced our insurance commissioner to eliminate the consumer protection in place with decade old faulty data. That's just bad business. I am a data guy, I believe the decisions we make should have sound facts behind them, not just a feeling that a payer might leave the market if we do not follow their rules. So, should we go back to the days where we were out of network to demand respect from Washington on the backs of Alaskan's? That's not right. I don't want to travel to the lower 48 to receive care.

Alaskan healthcare consumers are being used, not helped. Most are not as savvy as the bureaucrats, actuaries, attorneys and salespeople from Washington. They have been playing the long game, and they won. An insurance broker asked a Premera representative recently if premiums would go down now that the 80th percentile rule has been eliminated, and they were told no. Is that what they also told the insurance commissioner? By eliminating the 80th percentile rule, payers are free to reduce reimbursement to whatever level they like. The options, as I see it for providers are accept precipitously declining reimbursement or to go out of network. If providers go out of network, we return to the days where patients will get balanced bill just like the wisdom tooth example I gave earlier. If Alaskan providers work to endure declining reimbursement, many things will likely happen. First, recruiting and retaining providers. Higher salaries are needed to recruit and retain because not everyone fully embraces how far away Alaska is or how delightful the weather is every day. We will see the decline in specialists first and then primary care. Most cities used to compare Alaskan prices have a county hospital, subsidized by taxpayers. These hospitals do not exist in Alaska, so hospitals and individual providers must balance their payer mix to keep their doors open for business. Seeing only patients with Medicare does not cover the cost of our facilities, operations and staff. Care will clearly have to be

rationed to balance that payer mix. While that is not the problem of the Washington insurance companies, that is the problem caused by their lobbying efforts. I have not met an Alaskan provider not interested in improving the rising cost of healthcare, but everyone one of them I have met insist on a level playing field where recent data and facts are used to make the decisions.

This new world order created by the elimination of the 80th percentile rule, puts Alaskans in a compromised position. The return of out of network providers, loss of specialists, inability to find primary care, are coming back as the state yielded power to the out of state insurance companies. Everyone seems to like to discuss rankings. On 10/4/2024 Forbes published an article ranking Alaska as the 11th least accessible for healthcare. As a consumer – this is important! On January 2, 2025, Forbes published an article listing Alaska as the 18th most expensive state for healthcare not number one, like that 2014 data suggests – using current facts in the discussion is also important. Blue Cross Blue Shield is a tax exempt, nonprofit 501©4 organization that is classified as a social welfare organization. In 2020 (most recent data I could find), the CEO of the Premera division made over \$4.7M, the 7th highest of the 28 divisions of BCBS. I can assure you no provider in the organizations I represent come close to that. I mention this because we are often ranked according to healthcare spend, but no one seems to take note of the compensation packages afforded to these nonprofit leaders. Additionally, in 2018 they were forced to pay back \$50M to Alaska because Alaskan's were over charged. Alaska has 2 primary commercial payers; most other states have dozens of payers. This also creates a bit of imbalance in favor of the insurance companies. This is the group with the loudest voice steering decisions made to remove consumer protections. I urge you all to look at relevant and recent facts and data to bring consumer protection back to Alaska. With insurance companies admitting they will not be lowering premiums but are actively reducing reimbursement, the recipe of our history is on the table ready to be served. I can assure you that is not what Alaskans want or deserve. For the sake of consumer protection, please bring the 75th Percentile Rule in Senate Bill 121 into reality. Thank you for your time today.



01/31/2026

Dear Colleagues and Legislators,

I have practiced medicine in the State of Alaska as an independent primary care provider since 2007. I completed both my undergraduate and graduate education at the University of Alaska Anchorage, have lived in Alaska since 1997, and have raised my family here. Early in my career, I served Alaska Native populations as a registered nurse—an experience that deeply shaped my commitment to accessible, community-centered care.

Last year alone, my clinic provided more than 6,561 primary care visits. My intention is to continue serving the people of Alaska for many years to come. To do so responsibly, I must expand services and recruit additional providers in response to the growing demand for primary care.

As many of you are aware, Alaska has experienced significant disruptions in health care delivery since the pandemic. Numerous physicians have retired, clinics have closed, medical providers have relocated out of state, and an increasing number of graduating physicians are entering subspecialty practice rather than primary care. At the same time, Alaska faces severe shortages in key specialties—rheumatology and endocrinology waits now extend up to a year in some cases. As a result, primary care providers are



increasingly managing complex, high-acuity conditions that would otherwise be co-managed with subspecialists.

Access to primary care is imperative—and it is also cost-effective. Comprehensive, well-supported primary care reduces emergency visits, hospitalizations, and long-term health care costs. Yet despite this reality, I am experiencing increasing barriers to providing care. The most significant and growing obstacle is not clinical complexity—it is insurance practices that lack transparency, consistency, and accountability. Over the past decade, administrative burden, reimbursement instability, delayed credentialing, unilateral payment reductions, and opaque claims processing have increasingly interfered with patient care and workforce sustainability.

At the same time, the cost of insurance itself has become unsustainable for families and employers. Employer-sponsored insurance in Alaska has risen to levels that no longer align with household income or actual health care utilization. In one BCBS plan this year, employer-sponsored coverage is approximately \$1,100 per employee per month (approximately \$3,600 per month for a family plan), not including deductibles and co-pays. Families are being forced into impossible choices between paying for housing and paying for health care. Most people do not consume \$3,600 worth of health care services in a given month—yet they are paying that amount simply to hold coverage, and still face significant out-of-pocket costs before benefits apply. Plans priced like



catastrophic coverage is being marketed as standard insurance, while patients, employers, clinics, and the health care workforce bear increasing financial risk.

I am asking for your support in addressing these systemic barriers. Alaska cannot afford policies or practices that undermine primary care access, discourage providers from practicing here, or delay care for patients who already face geographic and economic challenges. My hope is to work collaboratively with policymakers, regulators, and colleagues to ensure Alaska's health care system remains viable, fair, and patient-centered. The future of care in our state depends on it.

Below is a summary of key issues and proposed solutions.

Focus: Insurance Accountability, Workforce Access, and Care Parity

1. Telemedicine Parity Remains Inadequate

Issue: Despite Alaska's geographic realities, insurers continue to reduce reimbursement for telemedicine services compared to in-person office visits. SB 83 was introduced on 5/9/25 by Senator Claman.

Impact:

- Reduced access for rural and remote patients



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- Disincentive for clinics to offer telehealth
- Increased travel burden and delayed care
- Telemedicine expands access for home-bound and acutely ill patients and enables closer follow-up for chronic conditions

Proposed Solutions:

- Enforce true telemedicine parity laws with equal reimbursement for equivalent services
- Require insurers to justify any telehealth payment reductions
- Prohibit post-service denials based solely on modality of care

2. Reimbursement Parity Rollbacks for Doctorally Trained Providers

Issue: Insurers have reduced reimbursement to 85% of fee schedule for nurse practitioners, psychologists, acupuncturists, and naturopathic doctors. These professions require doctoral or terminal degrees, yet MD reimbursement remains unchanged. Alaska previously had parity similar to Oregon; insurers unilaterally reversed it.

Impact:

- Mental health access crisis
- Devaluation of highly trained professionals
- Clinic closures and provider burnout
- Reduced incentive to practice in Alaska

Proposed Solutions:

- Statutory payment parity based on scope and licensure, not degree title
- Prohibit unilateral reimbursement reductions without regulatory review

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- Require justification and transparency for fee schedule changes

3. **“Uniform Fee Schedules” Lack Transparency and Fairness**

Issue: Insurers claim uniform fee schedules while offering selective contracts, inconsistent rates, and ongoing reductions.

Impact:

- Unfair competitive landscape
- Financial instability for small clinics—reimbursement has dropped compared to years prior while operating costs continue to rise
- Employers pay more while providers are paid less

Proposed Solutions:

- Mandate public disclosure of fee schedules by insurer and specialty
- Require equal access to negotiated rates for similarly situated clinics
- Regulatory oversight of fee schedule reductions, including protection against reductions and consideration of inflation adjustments.

4. **Barriers to Health Care Workforce Recruitment Issue:** High cost of living combined with declining reimbursement makes it difficult to recruit and retain providers.

Impact:

- Provider shortages worsen
- Clinics cannot offer competitive wages
- Reduced access and longer wait times

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Proposed Solutions:

- Stabilize reimbursement to support sustainable wages
- Incentivize in-state practice through payment parity and predictability
- Align workforce policy with Alaska's real economic conditions

5. **Excessive Licensing Timelines Issue:** Professional licensing can take months, even when providers are fully licensed in another state.

Impact:

- Delayed workforce entry
- Financial hardship for new graduates and single parents
- Clinics cannot meet patient demand while waiting for licensing

Proposed Solutions:

- Streamline licensing timelines, especially between states
- Allow provisional or conditional licensure with supervision
- Require predictable processing deadlines

6. **Insurance Credentialing Delays (3–9 Months) Issue:** After licensing, insurers require an additional 3–9 months for credentialing before a provider can bill insurance.

Impact:

- Clinics lose revenue
- Providers cannot earn income
- Patients lose access to care

Proposed Solutions:

- Credential the business NPI/TIN, not just individual providers
- Allow providers already in-network to add locations

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immediately

- Permit provisional billing during credentialing review
- Require insurers to fully utilize CAQH data to shorten and standardize timelines

This is a unique barrier in health care that creates avoidable delays and harms patients, new graduates, and small clinics.

7. **Lack of Insurance Payment Transparency and Downcoding Practices**

Issue: Insurers (notably Aetna) are automatically downcoding visits (e.g., 99214–99215 to 99213) without notification.

Impact:

- Delayed and reduced payments
- Costly audits and appeals
- Clinics billing correctly under 2021 E/M guidelines are penalized without clear justification

Proposed Solutions:

- Require written notice of any downcoding or payment changes
- Mandate justification tied to published guidelines
- Impose penalties for systematic, undisclosed downcoding

8. **Premiums Rising While Reimbursement Declines**

The cost of health insurance in Alaska has risen to levels that no longer align with household income or health care utilization, while reimbursement to providers declines and administrative barriers increase. Insurance products are increasingly priced higher than the care they cover, lack transparency, and shift financial risk to patients, employers, and clinics—without

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corresponding improvements in access or outcomes.

Consequences: For Patients and Families:

- Premiums force families to choose between health care and basic needs
- Individuals pay more in premiums than they spend on care, yet still face high deductibles and delayed access
- Delayed care worsens chronic disease and increases downstream costs

For Employers and Small Businesses:

- Rising premiums make it difficult to offer health benefits
- Employers absorb higher costs while employees receive fewer usable benefits
- Businesses reduce coverage, shift costs to employees, or drop plans

For Clinics and the Workforce:

- Declining reimbursement plus administrative burden undermines sustainability
- Recruiting and retaining providers becomes harder in a high-cost state
- Access gaps widen as clinics limit insurance participation or close

For Alaska's Health Care System:

- Primary care shortages deepen despite being the most cost-effective level of care
- Increased reliance on ER and hospital care raises total system

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costs

- Rural and underserved communities are disproportionately impacted

Solutions:

- Require insurers to publicly disclose fee schedules, premium structures, and justification for rate increases
- Align premium cost with meaningful coverage and prioritize primary care access, prevention, and chronic disease management
- Implement consumer protections to prevent “standard plans” from functioning as catastrophic coverage in practice
- Reduce administrative barriers and recognize primary care as essential infrastructure deserving of protection

9. **Systemic Impact: A Workforce and Access Crisis**

Core Concern: Insurers are prioritizing cost savings at the expense of Alaska's health care infrastructure.

Consequences:

- Provider shortages
- Reduced mental health access
- Clinic closures
- Higher costs shifted to employers and patients

Call to Action: Without action, Alaska's health care shortage will deepen. We need protections that hold insurers accountable, ensure reimbursement parity, reduce administrative barriers,

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support workforce recruitment and retention, and preserve access to care across Alaska.

10. Downcoding and the Need for a “Fair Coding and Transparency Act”

Issue: Insurers downcode claims (for example, changing a Level 4 visit to a Level 2) as a blanket cost-saving policy, often without notifying providers of the specific criteria used to justify the change.

Proposed Solutions:

- Disclosure of Proprietary Coding Logic: Require insurers to file internal coding methodologies—including automated rules and NLP keyword logic—with the Alaska Division of Insurance to prevent undisclosed downcoding practices.
- Ban on Percent-Based Downcoding: Prohibit automated systems programmed to downcode a fixed percentage of claims regardless of clinical merit or documentation.
- Standardized Fast-Track Appeal: Establish a state-mandated fast-track appeals process. If documentation meets national CMS standards for the billed level, the insurer must reverse the downcode within 30 days or pay penalty interest at 15%.

10. AI-Driven “Clinical Validation” Denials

Issue: Insurers are using AI and NLP to review clinical notes before payment, flagging claims based on narrative phrasing rather than the actual complexity and risk involved in care. These are often labeled “clinical validation” denials.

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Impact: These determinations are frequently full denials requiring manual appeals to prove medical necessity, delaying payment for months and disrupting clinic operations—especially for small and rural practices.

Proposed Solutions:

- **Mandatory Human Review:** No claim should be denied or downcoded based on medical necessity or clinical validation by an automated system alone. Any adverse determination must be reviewed and signed by a human clinician licensed in Alaska with relevant specialty expertise.
- **Explainability Requirement:** Insurers must provide a specific, plain-language clinical rationale referencing the patient's actual medical record, not a generic "failed AI validation" statement.
- **Deemed Approved Timeline:** If an insurer flags a claim for clinical validation, a human review must be completed within 14 days. If not completed within that window, the claim is deemed approved and must be paid at the original level.

Thank you for your time, consideration, and commitment to the health of Alaskans. I welcome the opportunity to discuss these issues further and to help develop solutions that protect patients, stabilize Alaska's workforce, and ensure fair and transparent insurance practices.

Respectfully,

Christine Sagan, MSN, APRN, FNP-BC
Founder & Medical Director

Re: Senate bill 121

4/29/2025

Dear Members of the L&C Committee:

As a medical oncology physician practicing in Alaska, I am writing in support of SB 121. This bill would protect Alaskans from the effects of increasing costs and decreasing availability of quality medical services in our state.

Since the repeal in January, 2024 of the 80th percentile regulation, our practice has seen declining rates of reimbursement for the care we provide patients. At the same time, our costs to provide that care continue to increase.

The care of patients with cancer is complex and expensive. With increasing frequency, insurers are refusing to pay for even standard care. Services such as blood tests and xrays are often denied. Yet these services are critical elements of providing appropriate patient care. Appealing these denials requires even more of my time away from seeing patients, thus reducing the number of people I can see in a day. Yet insurers are demanding even lower rates from us, and often refusing to negotiate in good faith without the safeguards a 75th percentile rule would provide.

We who live in Alaska know everything is more expensive in our state. Medical care is also more costly. Yet insurers have used undisclosed and, I believe, unrealistic metrics to justify reducing physician reimbursement rates. Critical practices have closed, including the Senior clinic at Alaska Regional hospital, as the reimbursement rates were insufficient to keep the doors open for this increasing, vulnerable segment of our citizenry.

It is a challenge to attract highly qualified physicians to move to and practice in our state. Many of my colleagues in other specialties, especially in primary care, have closed their doors to Medicare and Medicaid patients. My practice, Katmai Oncology, is committed to continue providing comprehensive, evidence-based care to any patient. Lower reimbursement rates will make that even more difficult, and possibly impossible if the current trend of declining reimbursement continues.

I welcome any opportunity to discuss the implications of this bill in more detail. I welcome you to contact me to discuss these issues further.

Alaskans need the protections of SB 121. Please support our ability to provide care to the people of Alaska!

Sincerely,

Mary M. Klix, MD, FACP

From: Nick Sarrimanolis, MD <nicksarrimanolismd@gmail.com>

Sent: Thursday, April 24, 2025 8:53 AM

To: Sen. Forrest Dunbar <Sen.Forrest.Dunbar@akleg.gov>

Cc: Sen. Cathy Giessel <Sen.Cathy.Giessel@akleg.gov>; Sen. Matt Claman <Sen.Matt.Claman@akleg.gov>; Sen. Löki Tobin <Sen.Loki.Tobin@akleg.gov>; Sen. Shelley Hughes <sen.shelley.hughes@akleg.gov>

Subject: Senate Bill 121

Dear Senator,

I am writing in support of Senate Bill 121, 80th percentile replacement. My practice has seen declining contract reimbursement rates from insurers since January 2019. At the same time, my practice expenses have risen over the same period. I have also experienced declining personal take home income. In light of the difficulties of recruiting physicians to Alaska, I emphasize the importance of addressing the adverse impacts the repeal of the bill can have on medical care in Alaska. Alaskan medical practices run the danger of closing due to financial stress since the repeal. Kindly devote your prompt attention to this very important matter in the interest of continued healthcare in Alaska.

Sincerely,

Nick Sarrimanolis, M.D.

Fairbanks, Alaska

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From: Giulia Tortora <gtortora@sphosp.org>

Sent: Monday, April 21, 2025 2:20:30 PM

To: Sen. Forrest Dunbar <Sen.Forrest.Dunbar@akleg.gov>; Sen. Kelly Merrick <Sen.Kelly.Merrick@akleg.gov>; Sen. Elvi Gray-Jackson <Sen.Elvi.Gray-Jackson@akleg.gov>; Sen. Robert Yundt <Sen.Robert.Yundt@akleg.gov>; Sen. Cathy Giessel <Sen.Cathy.Giessel@akleg.gov>; Sen. Matt Claman <Sen.Matt.Claman@akleg.gov>; Sen. Löki Tobin <Sen.Loki.Tobin@akleg.gov>; Sen. Shelley Hughes <sen.shelley.hughes@akleg.gov>

Cc: Sen. Jesse Bjorkman <Sen.Jesse.Bjorkman@akleg.gov>

Subject: Senate bill 121

I am a family physician in a practice in Homer, Alaska. I support Senate Bill 121. I ask that you also support it.

We have experienced a raise in practice expenses, and cuts in reimbursement in the last 2 years. We see a large number of Medicare patients (we do not believe in stopping care when patients go on Medicare, unlike many clinics in Anchorage.). We need to be able to keep reimbursement at appropriate levels.

Having further loss of revenue can be very problematic for small rural clinics, and I request that you do what is needed to keep health care available in all of your communities.

Thank you

Giulia Tortora MD
Homer Medical Center
Homer, AK

Friday 1/30/2026

**Testimony on Senate Bill 121
Alaska State Legislature**

Senator Bjorkman and Members of the Senate Committee,

Thank you for allowing me to testify on Senate Bill 121. My name is **Debbie Ryan**.

I am a co-owner of a chiropractic clinic with a **70+-year legacy** of serving Alaskans. For transparency, I also serve as the **CEO of the Alaska Chiropractic Society**, representing chiropractic physicians statewide and working to protect patient access to conservative care.

In that role, I hear far too often from providers who are retiring early, leaving Alaska, or unable to repay student loans (which can be as much as \$250,000) or support their families because they simply cannot make a living practicing health care in this state anymore. Nor are we attracting new younger providers to Alaska.

Today, I am here to speak about **how insurance affects health care**, not only for providers, but for patients. When you look at the full picture, both sides of the health-care equation are under serious strain.

Let me share a few real-world facts directly from my office.

First, **deductibles are extremely high**. The highest deductible I have seen is **\$6,350**, with coverage at 80 percent only *after* that deductible is met. For conservative care like chiropractic services, this often means patients pay **100 percent out of pocket**, despite paying significant monthly premiums. For patients with a straight co-pay, some of these co-pays are \$85 and the insurer pays nothing.

Second, Alaska has a **dominant health insurer that functions as a monopoly**. Over ten years ago, that insurer implemented major fee schedule reductions—some services were reduced by as much as **60 percent**—while premiums have remained strong. Providers today are being paid **less than they were 20 years ago**.

When I reviewed my **2025 billings**, that insurer paid only **36 percent** of all claims submitted by my office. Patients paid **35 percent** of the charges, in addition to their premiums. As an **in-network provider**, my office was required to write off **29 percent** of all charges submitted, nearly one-third of the care we provided, because of contractual obligations.

Let me be clear: our services are **not expensive and not excessive**.

You may ask why we remain in network. The answer is simple: many insurance plans in Alaska provide **no coverage at all** if a patient sees an out-of-network provider. Providers are effectively forced to stay in network just to serve their patients.

Let me give you one concrete example of what “insured” care looks like today.

For a common chiropractic service **CPT code 98940**, our office charges **\$78**. The insurance company allows **\$45.10**. We are required to write off **\$32.90**. The patient pays a **\$35 copay**, and the insurance company pays **\$10.10**.

The patient paid most of the cost, plus their monthly premiums. From my perspective, **that is not meaningful insurance coverage**.

Years ago, the State recognized these issues and implemented **percentage-based safeguards** for out-of-network reimbursement. That system allowed providers to assess whether staying in network was sustainable or whether they needed to go out of network to survive.

When that safeguard was removed, **control shifted entirely back to the insurer**. Reimbursement is now dictated solely by internal fee schedules and payment policies. The result has been predictable: providers retiring early, closing practices, or leaving Alaska.

Health care is a business, like any other. Providers face rising costs for labor, rent, supplies, taxes, and compliance. Small practices must compete with hospitals and large systems for the same workforce. We often train staff only to lose them to larger organizations that can offer better wages and benefits. Because the cost of doing business has grown and reimbursements have diminished, I currently operate with half the support staff I once had.

This is why **SB 121 matters**.

If SB 121 passes, it will:

- **Protect patient choice** by making Alaska a more viable place for health-care providers to practice and remain.
- Allow providers to make informed decisions about whether being in network with strict fee limitations or operating out of network with predictable reimbursement which is sustainable; and
- Use **Medicare as a benchmark**, adjusted by a reasonable percentage, which is a fair and transparent reference since Medicare evaluates costs annually.

Members of the Committee, SB 121 addresses a real and urgent problem in Alaska’s healthcare system. I urge you to ensure the final policy is **data-driven, reasonable, and sustainable**, so we can protect patients, retain providers, and preserve access to care.

Thank you for your time and for your service to the State of Alaska.

Additional Remarks for the Record

During my testimony, I was asked how chiropractic physicians operated prior to the widespread use of insurance. When my father began treating patients in 1970 over 55 years ago, his practice was entirely cash-based. A chiropractic adjustment averaged approximately \$7.00, with slightly higher fees for examinations, X-rays, and related services. I would like to outline how dramatically the cost of operating a chiropractic practice has changed since that time.

First, licensure costs were minimal. An Alaska chiropractic license costs approximately \$50 every two years. Over time, this has increased substantially. By 2022, the two-year licensing fee had risen to \$600. In 2025, it increased again to \$1,000, and we have recently learned that renewal in 2026 will cost \$1,300. In addition, chiropractors must complete 32 credit hours of continuing education to renew their license, at a cost ranging from approximately \$25 to \$100 per credit hour, depending on the provider.

Second, insurance requirements were once minimal or nonexistent. Today, chiropractic practices are required to carry malpractice insurance, cyber insurance, umbrella policies, workers' compensation, disability insurance, and insurance coverage for expensive clinical equipment. We are also required to maintain a notary on-site for business purposes, which itself involves registration and insurance costs.

Third, documentation and billing were once done entirely on paper. There were no electronic health record systems, no cloud storage, no firewalls, no IT service contracts, and no requirement for digital patient intake or electronic billing. When insurance entered the picture, we purchased one of the earliest computer systems, System 32 and later the System 34, which occupied nearly an entire room and cost tens of thousands of dollars. By 1981, desktop computers became available, but they still cost approximately \$1,500 per unit. Since then, the cost of hardware, software, IT support, system upgrades, maintenance, backups, storage, internet service, and cybersecurity have grown exponentially. At the end of 2024, my clinic was required to replace or upgrade all ten of our computers to comply with Windows 11 requirements, an enormous and unplanned financial burden.

Fourth, X-rays were once taken using large cassettes that were manually processed and hung to dry, and the machines were not licensed by the state. Today, most chiropractic offices use digital X-ray systems, which require computers, data storage, backups, technical support, and trained staff. In addition, state registration is now required. Last year, the registration fee for a simple single tube x-ray machine was \$80; this year it increased to \$250, more than tripling in a single year. We are also required to monitor all personnel who take X-rays using dosimetry badges, which are mailed out, tracked, and archived in the event of an exposure incident. This monitoring adds yet another ongoing expense.

Fifth, there was no need for highly trained insurance coders or billers in the early years. Today, certified chiropractic assistants and insurance billing specialists are essential and appropriately compensated. Labor costs have increased dramatically, particularly with the addition of mandated sick leave. Last year my employee payroll costs were 73% of my overall gross profit. Small, independent clinics cannot compete with state government, large corporations, or hospital systems for staffing.

Sixth, patient payments were once handled entirely by cash or check. The widespread use of credit and debit cards has added processing fees, terminal costs, and service contracts to the cost of doing business.

Seventh, there were no fax machines, postage machines, or electronic communication systems. Today, these devices are expensive to purchase or lease. In addition, postage costs have increased significantly, making the mailing of bills to patients, insurers, and other entities a major expense associated with collecting payment for services rendered.

Eighth, modern chiropractic practices must purchase and maintain a wide range of additional products and services simply to operate: electronic documentation software, clearing house fees, collections services, advertising, website hosting and security, shredding services, cleaning supplies, telephone systems, and numerous other ongoing expenses that did not exist decades ago.

In short, the cost of doing business and the cost of living was far simpler and significantly lower in earlier decades.

Insurance expanded rapidly in the late 1970s and 1980s, and chiropractic care was incorporated relatively quickly into most insurance policies, including Workers' Compensation. As insurance became more prevalent, so did increasingly aggressive controls designed to reduce payments for care already delivered.

Over time, insurance companies became highly profitable enterprises with limited regulation governing how they treat providers. They implemented provider networks, fee schedules, and payment policies that unilaterally dictate compensation. These payment policies are essentially mechanisms for preserving corporate profit by reducing what providers are paid, even though providers still incur the full cost of delivery, documenting, and staffing care.

Providers who choose to participate in insurance networks effectively relinquish control over compensation and are often contractually locked in for 90 days before they may terminate participation. Since the repeal of the 80 percent rule, insurance companies also control what they pay out-of-network providers and how much their insured patients must pay when seeking care outside a network. In practical terms, insurance companies now hold nearly all leverage in the system.

This imbalance must be addressed if Alaska hopes to remain competitive in retaining healthcare providers and preserving patient choice. We are already losing providers and failing to attract new ones. As access to care becomes more limited, treatment delays increase, ultimately driving higher healthcare costs.

Because my clinic has used the same billing and documentation system since 2012, I am submitting a spreadsheet that documents the steady growth of insurance-mandated write-offs imposed by the primary insurance company with which we are in-network. Any small business owner will recognize that this model is not sustainable. I have already reduced my support staff and personally absorbed additional administrative and clinical responsibilities with little to no compensation. I cannot continue to operate at a loss, despite having served this community for decades.

If the proposed statewide sales tax is implemented in addition to the taxes currently being proposed by the Municipality of Anchorage, offices will have the additional burden of collecting and paying these taxes to the government which will add additional costs to providers, I believe all providers will evaluate their ability to sustain their offices and we will see a significant exodus from Alaska. As seniors, my

husband and I would no longer be able to afford to live in the state where our children and grandchildren reside. Alaska has been my home for most of my life, and the prospect of leaving it is deeply saddening.

Thank you again for the opportunity to provide testimony. I would be happy to answer any additional questions or provide further information upon request. Please see attachments.

Debbie Ryan
debbieryan@gci.net
907-317-4486

YEAR	BC PAID %	PATIENT PAID %	PROVIDER W/O %	YEARLY CHGS +/-
2012	68%	31%	1%	overall chgs
2013	59%	40%	1%	-4%
2014	62%	37%	1%	-12%
2015	64%	34%	2%	8%
2016	59%	38%	3%	-4%
2017	61%	35%	4%	2%
2018	62%	32%	6%	-9%
2019	47%	33%	20%	-2%
2020	45%	34%	21%	-5%
2021	40%	35%	25%	11%
2022	39%	32%	29%	-14%
2023	38%	32%	30%	-1%
2024	41%	32%	27%	5%
2025	37%	36%	27%	-5%

Chart info taken directly from stats in my office.

2012 is the year we implemented this program.

%'s are based on what BC/Patient paid and Provider write-off burden.

Premera was 32% of all insurance payors in 2025.



**BlueCross
BlueShield.**
Federal Employee Program,
Professional Claims



**Federal Employee Program
Demittance Report**

Premera Blue Cross Blue Shield of Alaska
Federal Employee Program
P.O. Box 33932
Seattle, WA 98133-0932
425-774-3994/1-800-562-1011

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Patient Name:
Subscriber ID:

Patient Account Number:
Claim Number:

Claim Trans. ID:

Place of Service	Procedure Code	Service From	Service To	Provider Charges	Non Covered Charges	Coinsurance CoPay	Deductible	COB	Negotiated Savings	Previous Amt. Paid	Sub Liability	Amount Paid	Reason Code
11	97140			\$260.00	\$81.80	\$30.00	\$0.00	\$0.00	\$178.20	\$0.00	\$30.00	\$148.20	610
11	98941			\$93.00	\$28.10	\$0.00	\$0.00	\$0.00	\$64.90	\$0.00	\$0.00	\$64.90	610
Claim Trans ID Totals				\$353.00	\$109.90	\$30.00	\$0.00	\$0.00	\$243.10	\$0.00	\$30.00	\$213.10	

Patient Name:
Subscriber ID:

Patient Account Number:
Claim Number:

Claim Trans. II:

Place of Service	Procedure Code	Service From	Service To	Provider Charges	Non Covered Charges	Coinsurance CoPay	Deductible	COB	Negotiated Savings	Previous Amt. Paid	Sub Liability	Amount Paid	Reason Code
11	98940	1/6/2026	1/6/2026	\$78.00	\$32.90	\$35.00	\$0.00	\$0.00	\$45.10	\$0.00	\$35.00	\$10.10	610
Claim Trans ID Totals				\$78.00	\$32.90	\$35.00	\$0.00	\$0.00	\$45.10	\$0.00	\$35.00	\$10.10	

Patient Name:
Subscriber ID:

Patient Account Number:
Claim Number:

Claim Trans. I:

Place of Service	Procedure Code	Service From	Service To	Provider Charges	Non Covered Charges	Coinsurance CoPay	Deductible	COB	Negotiated Savings	Previous Amt. Paid	Sub Liability	Amount Paid	Reason Code
11	98941			\$93.00	\$28.10	\$35.00	\$0.00	\$0.00	\$64.90	\$0.00	\$35.00	\$29.90	610
Claim Trans ID Totals				\$93.00	\$28.10	\$35.00	\$0.00	\$0.00	\$64.90	\$0.00	\$35.00	\$29.90	

actual charge

↓
provider write-off

↓
Patient pays

↓
Ins. Paid



From: [Wayne Todd](#)
To: [Senate Health and Social Services](#)
Subject: Equitable pay for ANP
Date: Monday, March 24, 2025 6:47:37 AM

Dear Committee members

Thank you for hearing SB 121: *“An Act relating to settlement of health insurance claims; relating to allowable charges for health care services or supplies; and providing for an effective date.”*

Advanced Practice Registered Nurses are vital members of the health care system in Alaska, particularly in the practice of primary care. APRN’s include Family Nurse Practitioners, Psychiatric Mental Health Nurse Practitioners, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists, they are the backbone of our healthcare system. APRNs are licensed to practice independently in rural and remote communities across the state as well as in urban centers. Many have their own practices or work in group practices with physician colleagues and/or physician assistants.

Current reimbursement rates for primary care providers, especially APRNs are not sufficient to remain in business and thus health care practices are being forced to close. With reimbursement rates significantly less than physicians, the effect on APRN practices is particularly acute resulting in fewer available providers to care for those patients with primary health care needs. This is contributing to a growing crisis in accessing primary care. **Ensuring consistency of reimbursement and equal pay for equal work is critical to assuring that APRNs can continue to provide care in Alaska.**

I thank you for hearing this bill and I stand in support of uniform reimbursement standards and equal application of those standards for all health care providers. I encourage you to pass this bill out of committee in its current form.

I have seen numerous APRN's over recent years and had very good interactions.

Respectfully,

Wayne L Todd