



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