ALASKA HOSPITAL & HEALTHCARE ASSOCIATION

April 23, 2026

Senator Jesse Bjorkman, Chair
Senate Labor and Commerce Committee
Juneau AK, 99801
Senate.Labor.And.Commerce@akleg.gov

RE: AHHA Opposes SB 283 - Staffing Ratios for Registered Nurses

Dear Chair Bjorkman and Committee Members,

For over 70 years, the Alaska Hospital & Healthcare Association (AHHA) has served as a non-profit trade association representing Alaska's hospitals, nursing homes, and a growing number of healthcare partners across the continuum of care. AHHA members play an invaluable role as community providers and essential employers in cities, towns, and villages across Alaska.

We are writing to share AHHA's strong opposition to SB 283 and our concerns with its effort to establish fixed staffing ratios for registered nurses working in Alaska hospitals. We agree that safe working conditions for our caregivers are of paramount importance. We also believe the cost of healthcare in Alaska is far too high and unsustainable for Alaskans and even our healthcare system.

However, SB 283 is extraordinarily problematic as it relies on archaic methods to restrict how care is provided in diverse clinical environments, and it is well documented that these methods do not in any way increase the workforce or improve quality outcomes. In fact, following SB 283 will require hospitals to incur substantially higher costs to secure more traveling nurses. In turn, this will put hospitals in the position of needing to close other services and lay off nonclinical employees to offset intense cost pressure on operations. This is not viable for any of our hospitals, especially those in rural and isolated communities.

These assertions are not dramatic. Only 5 states have laws requiring fixed staffing ratios, and only California and Oregon use the level of staffing ratios called for in SB 283. The reason 45 other states do not require fixed staffing ratios is because peer reviewed research shows these laws correlate with longer emergency room wait times and increased instances of delayed care.[1]

Looking at California, which currently has the strictest fixed staffing ratio laws in the U.S. (and aligns with the approach taken in SB 283), we see that 17% to 20% of California's rural community hospitals have stopped offering obstetrics services within the last decade, and the closure rate of services is three times faster than the national average.[2] Additionally, a wage study found ancillary healthcare staff were eliminated in hospitals across California to shift

[1] *Society for Academic Emergency Medicine* (Chan et al. 2010)
[2] *Maternity Care in California: An Environmental Scan* (2025); *CalMatters*.

funds toward mandatory compliance with the staffing ratio laws.[3] Lastly, there is no evidence of or correlation with improved patient outcomes from the mandated staffing ratios in California or elsewhere.[4]

After carefully considering SB 283 with our large urban hospitals, rural midsize hospitals, and remote critical access hospitals, we all find that compliance with this proposed legislation can only be achieved through a combination of hiring more temporary travel nurses and reducing services. It is well documented that Alaska produces only a fraction of the nurse workforce needed in our industry, and we have been unable to recruit permanent nurses from out of state to fill the gap.[5]

Permanent nurses are far more stable and economical compared to using temporary traveling nurses, and every hospital in our state would choose permanent placements over travelers every single time. If we are unable to recruit more permanent registered nurses (which we continue to pursue to no avail) and if we cannot sustain the increased costs of traveling nurses, then the only option for complying with SB 283 is eliminating beds and services to reduce the number of patients in our facilities. This is why Massachusetts chose not to expand its ratio laws in 2018—the *Massachusetts Health Policy Commission* found that full hospital mandated ratios would result in $676 to $949 million in new, annual increased healthcare costs for the Massachusetts healthcare system.

Furthermore, how can rural facilities possibly comply with SB 283? Many of our critical access hospitals have small clinical teams that ebb and flow into different roles to address low, fluctuating volumes. There is no way they can recruit and retain or even bear the expense of essentially having more permanent nurses on-call for when they have a busy day.

Working conditions and employee burnout are important issues that deserve serious contemplation and strategies. Every hospital department and operation is unique because the populations served and conditions experienced are different—just as the community of Petersburg does not represent what it is like to live in Fairbanks, nor do Alaska Native patients in Alaska Native Medical Center have the same needs or experiences as the patients in Mat-Su Regional Medical Center.

The Legislature cannot understand the complexities of a clinical environment, much less the unique clinical environments in over 20 hospitals. This is why the Legislative body and SB 283 are not a suitable approach for managing healthcare delivery in this vein. These decisions are best left to professionally trained administrators and clinical regulators, and it is the whole reason the collective bargaining process exists in many hospitals and why hospitals are exhaustively surveyed by the Centers for Medicare & Medicaid Services and the Joint Commission.

AHHA is not rejecting the call for dialogue and consideration of improving working conditions in our hospitals. We are showing why SB 283 is an ineffective way of doing so, especially with

[3] *California's Minimum-Nurse-Staffing Legislation and Nurses' Wages* (Mark, Harless, and Spetz 2009).
[4] *National Bureau of Economic Research* (Cook, Gaynor, Stephens Jr., Taylor 2010).
[5] *Alaska Department of Labor Occupational Employment Statistics; DOL Alaska Occupational Forecast 2020 to 2030*; See *2025 Alaska Healthcare Workforce Analysis* at 21.

other recent updates to compliance standards. More specifically, the Joint Commission is a national accrediting body that surveys, evaluates, and accredits hospitals to ensure they meet rigorous quality and safety standards from the Centers for Medicare & Medicaid Services. Accreditation, which is set through unannounced, weeklong onsite compliance surveys, is required to receive federal payments through Medicare and Medicaid.

Effective January 1, 2026, consistent with the requirements set by the Centers for Medicare & Medicaid Services, the Joint Commission announced new nurse staffing safety standards. National Performance Goal #12 (as the mandatory standard is known) requires hospitals to be staffed to meet the needs of the patients it serves, and that the staff is competent to provide safe, quality care. With 6 defined subparts and 29 requirements of performance, this rule is measurable and has fines for failure to comply. "Compliance with NPG 12 requires data-driven staffing methodologies beyond static nurse-to-patient ratios." *American Institute of Healthcare Compliance*. We need to give this and other substantive workforce strategies time to work.

In closing, we welcome discussions about safe, quality staffing strategies and workforce recruitment and retention efforts. However, we strongly recommend that new requirements like the Joint Commission's NPG #12 and workforce investment strategies be given time to develop and work. Credible studies show mandated staffing requirements like those in SB 283 do not enhance quality or service delivery. In Alaska, they will bring more travel nurses, close services, generate layoffs for non-clinical employees, and unquestionably increase healthcare costs for the entire population, including individuals and businesses. This is why only 5 states in the U.S. have laws akin to SB 283, and we urge this committee to reject this legislation.

Thank you for your time and consideration of this matter.

Sincerely,

Jared C. Kosin, JD, MBA
President & CEO