Alaska State Legislature

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Room 121
Juneau, AK 99801

CS for Senate Bill 121(HSS)

Sponsor Statement (vsn I)

"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."

Senate Bill 121 addresses a pressing issue in Alaska: the lack of consistent and fair reimbursement rates for health care providers, which impacts access to care and the financial stability of both providers and patients. In the absence of contracts between health care insurers and providers, this bill establishes clear standards that insurers must follow to determine allowable charges, ensuring that Alaskans receive equitable and affordable healthcare services across the state.

Currently, low reimbursement rates create uncertainty for providers and can lead to higher out-of-pocket costs for patients (balance bills) or reduced access to care. This legislation aligns with Alaska's commitment to protecting public health and supporting our healthcare workforce. It responds to the growing need for transparency and fairness in health insurance practices, especially as healthcare costs continue to rise in our state.

A recent study by the Alaska Hospital and Healthcare Association (AHHA) reports non-practitioner staff costs have risen 47% since 2016. Over the past 20 years, the Medicare Physicians Fee Schedule has fallen by 33% adjusted for the cost of running a practice. Insurers are using the negotiating leverage produced by low out-of-network rates to drive contract rates down to unsustainable levels. Providers simply cannot remain viable at these low reimbursement levels.

Senate Bill 121 directs the Director of Insurance to set standards insurers must follow to determine allowable charges using a statistically credible market-based methodology based on the most current twelve months of data of provider charges in Alaska. It ensures that reimbursements are uniform, not less than the 75th percentile of charges statewide or 450 percent of the federal Centers for Medicare and Medicaid Services (CMS) fee schedule. The Director will audit these standards periodically, and insurers must update charges every three to five years.