Senate Bill 121

Health Insurance Allowable Charges

- **ENSURING ACCESS FOR ALASKANS TO NEEDED HEALTH CARE PROVIDERS AND SERVICES**
- May 14, 2025

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- On behalf of the Alaska State Medical Association

SB 121: Restores State-defined, Alaska-based standard for health insurance allowable charges

Protects Alaskans from large balance bills

Restores balance at bargaining table

Addresses criticisms of the 80th percentile

Require insurers to:

- Set allowable charges, usual, customary & reasonable (UCR) at 75th percentile of Alaska charges (Reduced from 80th percentile)
- Entire state is one region, not 4 separate geographic regions
- Updated not more often than every three years
  - Instead of every six months, not less than every five years

Why does Alaska need a UCR replacement?

Insurers **don't** calculate benefits based on provider **charges**

Payments are based on "allowable" charges

For simplicity, "UCR", (Usual, Customary and Reasonable)

If UCR low, then payment is low

In 2004: Insurers used arbitrarily low UCR for Alaska

Division of Insurance was getting numerous complaints

Alaskans were not getting the coverage they were paying for

Regulation defined UCR as 80th percentile of Alaska charges

Benefit calculation examples:

Benefit with insurer-defined low UCR: Patient owes $60.

$100 charge for service

UCR set at $50

80% benefit = $40 covered by plan

Patient owes $60

UCR at hypothetical 80th percentile: Patient owes $28.

$100 charge for service

80th percentile = $90

80% benefit = $72 covered by plan

Patient owes $28

Effect of 80th percentile on provider contracts

80th percentile only applied when **no contract was in place**

Contract terms superseded the rule

In 2004, few providers were under contract

By 2017, almost all providers were under contract with the major insurers

80th no longer defined UCR, contract did

BUT 80th percentile was the alternative to a contract, so:

Insurers offered terms at 80th or less

Providers accepted terms less than 80th

In-network was better for patient and provider

Impact: Repeal with no “floor” replacement

No state-defined UCR method after repeal in January 2024

Insurers again used their own definition

Largest plans chose 185% of Medicare Physician fee schedule

185% is roughly 40% of the 80th percentile

With UCR defined as 185% of Medicare Insurers demanded steep reductions in contract rates!

Insurers began demanding steep reductions in existing contracts

Providers’ alternatives:

- Accept reduced terms – not financially sustainable, eventually close
- Go out-of-network and balance-bill patients

If terminate contract, large balance bills return

New insurers trying to establish network using low UCR – may cause large balance bills

Example: Impact on bargaining:

Bargaining table pre-repeal: Contract rate $80

$100 charge for service

80th percentile = $90

Offered and accepted contract rate = $80

Provider willing to take lower than 80th

• Benefits patients and practice

Bargaining table after repeal: Contract rate $65

$100 charge for service

185% of Medicare = $35

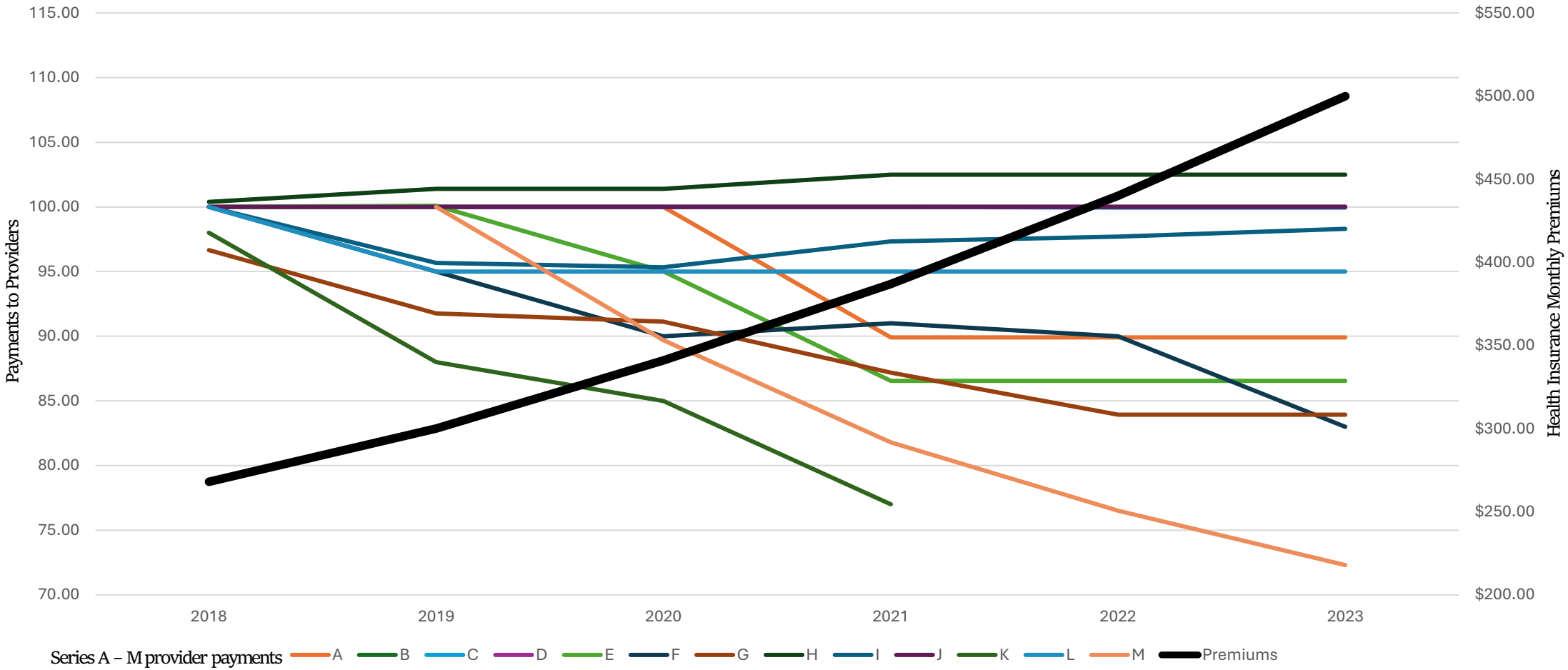
Offered contract rate =$65

Unsustainable cut after years of no increase

Leave network and balance bill patient

Provider costs flat for 5 years or longer!

Provider charge increases are clearly not the cause for rising premiums!



Series A through M are the fees paid by insurance for a unit of healthcare service. 13 different medical, chiropractic, physical therapy, or surgical practices in Alaska, for the first time ever, shared anonymized data on insurance reimbursement. Providers tabulated their historical contracted rates for a representative common procedure, made them proportional to the first year data was available, and shared them here anonymously.

Premiums indicates the monthly insurance premium paid by a local medical practice, an Alaskan small business owner.

Repeal created a “perfect storm” of financial pressures for providers

Contract payment terms flat or decreased for years

Attempts to negotiate unsuccessful

Operational costs skyrocket

AHHA study, non-provider labor costs up 47% since 2016

Alaska Family Practice and Non-Surgical Specialists lowest take home pay in nation for their specialties

- Medical Group Management Association 2024 compensation study based on 211k responses

Insurers now demanding deep reductions in contract rates

RESULT: Practices financially unsustainable are considering closing or going out-of-network

Sample comments excerpted from the dozens of letters in support of SB 121 from Alaskan Providers

- “My office is in danger of closing owing to shrinking reimbursement. While inflation has occurred every year and the cost of supplies like sutures, liquid nitrogen, gauze…and expenditures such as health insurance has grown exponentially (27% increase in health insurance rates, 2025-2026)…our reimbursement is CUT each year.” Matthew Cannava, MD, Soldotna

Provider letters in support continued

- “…I have tried to negotiate with insurance companies unsuccessfully. I am concerned that in the near future I may have to close my practice given the deteriorating financial situation for me in Alaska. Given the lower reimbursement, it will be more difficult for me to serve medicare and medicaid patients since my economic situation is declining…I am the only neurosurgeon in Fairbanks, Alaska and I want to stay in Fairbanks, Alaska but I do need to operate with positive margins. Please help me to continue to do this with passage of Senate Bill 121.” John A. Lopez, MD, Fairbanks

Provider letters of support continued

- "…Inflation has increased 30+ percent in the last 11 years. Reimbursements on average have **DECREASED by 30-40%.** It is not sustainable for medical practices in the state to continue to be able to pay the cost of doing business with the rates that Premera, who is setting in-network rates lower than 11 years ago, and out of network rates at 185% of Medicare. The ONLY leverage we had in negotiating any kind of fair reimbursements was to have a percentile rule in place that at the very least allowed providers to negotiate." Debbie Ryan, Business Manager, Community Chiropractic, Anchorage

Provider letters of support continued

- “…As a family physician practicing in Juneau for over 25 years, I have seen a tremendous change in the status of medical practices in Juneau. Patients have less selection and options, as a number of independent practices have closed (or merged into the local tribal health system). Declining reimbursement and decreasing income for physician practices are the factors causing physician practices to become nonviable.” Janice Sheufelt, MD, Juneau

Solution: SB 121 restores state-defined, Alaska-based standard

Requires insurers to:

- Set allowable charges, UCR, at 75th percentile of Alaska charges
  - Reduced from 80th percentile
- Uses one-region, statewide, rather than 4 regions
- Updated not more often than every three years
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SB 121 restores balance at bargaining table

Addresses criticisms of the repealed 80th percentile

Appendix: If not physician charges then why are costs so high?

High Medicare/Medicaid/Governmental Payer patient loads

Some practices as much as 70% of patients

- Large number of people spread over relatively few practices

Governmental payers roughly 40% of costs of delivering care

Result – requires high charges to private payers to be viable

See example on next slide

Shortages of professional staff

Results in high costs to hire and retain employees

Overall high cost of doing business in AK

Increasing insurer administrative burdens

Example: “Cost shift” resulting from governmental payers’ inadequate reimbursement

Assume 70% Visits Medicare/Medicaid/Other Govt Programs

100 visits, (70 Medicare/Medicaid, 30 Private Pay)

Average cost of visit, $25

Required revenue to sustain practice: 100 x $25 = $2500

Payments: Medicare/Medicaid pays $12 so all others must pay $55 which is equal to 450% of Medicare Fee Schedule

Medicare/Medicaid pay 40% of costs = $**12 paid per visit** x 70 visits = $840 total M/M revenue

$2500 needed - $840 paid by M/M = $1660 needed from private pay

$1660/30 visits = **$55** charge to private pay patients

- **Equal to 450% of Medicare rate**

Appendix: Why are costs/premiums rising?

For **Individual Market** – Affordable Care Act rules are primary driver of premium increases. The segment where headline grabbing increases are occurring.

- No pre-existing condition exclusions
- No waiting periods, few limits
- People enter and leave with few restrictions
- Many buy policy only when serious care is needed
- Plus same factors as general healthcare cost drivers

For healthcare in general, cost drivers are:

- New technologies
- New drugs
- Increased consumer demand
- Aging of the population

Appendix: Why not let the free market work?

Health care, particularly in Alaska, is not a free market

- No free flow of price information – only payers know what they are paying
- Healthcare providers cannot share price information – anti-trust regulations
- Market power concentrated in two or three major insurers
- Third-party payment insulates consumers from true costs
- Governmental programs/mandates skew market costs and payments

As a result, state action is required to:

- Regulate insurers, (Mission of Division of Insurance)
- Protect Alaska consumers, (Mission of Division of Insurance)
- Provide a viable economic environment for providers