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Wallace
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CS FOR SENATE BILL NO. 121( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-FOURTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS GIESSEL BY REQUEST, Gray-Jackson

A BILL

FOR AN ACT ENTITLED

"An Act relating to insurance; establishing standards for health insurance provider networks; relating to settlement of health insurance claims; relating to allowable charges for health care services or supplies; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 21.07 is amended by adding a new section to read:

Sec. 21.07.035. Minimum provider network standards. (a) A health care insurer shall take the network requirements of this section into account when calculating the benefits of, or other contractual requirements applicable to, a covered person's health care insurance policy that, as determined by the director,

(1) requires the covered person to use a limited network of health care providers, as defined in regulation by the director; or

(2) creates a substantial financial or other incentive or disincentive for the covered person to use a limited network of health care providers.

(b) A health care insurer's provider network must include each hospital,

skilled nursing facility, or mental health or substance abuse facility licensed in the state and each physician, physician assistant, or advanced practice registered nurse licensed in this state who is employed or contracted by one of these hospitals or facilities to provide medical care at the hospital or facility. A health care insurer's provider network must include each health care facility operated by an Alaska tribal health organization and each physician, physician assistant, or advanced practice registered nurse employed or contracted by the organization to provide medical care at that location. A physician, physician assistant, or advanced practice registered nurse who is employed or contracted by a hospital, skilled nursing facility, mental health or substance abuse facility, or Alaska tribal health organization to provide medical care is not included when calculating the health care insurer's minimum network standards set out in (d) of this section.

(c) A health care insurer's provider network must include a sufficient number of physicians, physician assistants, and advanced practice registered nurses in each contracting region in which the insurer provides coverage to meet the minimum network standards set out in (d) of this section. Only a physician, physician assistant, or advanced practice registered nurse who is licensed in this state, meets the credentialling standards of the health care insurer, and whose principal practice location is physically located in the applicable contracting region may be included when determining whether a health care insurer meets the minimum network standards set out in (d) of this section. If an insurer treats the physician, physician assistant, or advanced practice registered nurse as contracted for the purposes of all insurance benefit determinations, a health care insurer may include in the provider network a physician, physician assistant, or advanced practice registered nurse who is not a contracted network health care provider to meet the standards set out in (d) of this section. Each physician, physician assistant, or advanced practice registered nurse included in the health care insurer's provider network, including a physician, physician assistant, or advanced practice registered nurse that is not a contracted network health care provider, must be shown as an in-network provider in the insurer's directory of network providers.

(d) For purposes of this section, the state is divided into six contracting

regions: the Municipality of Anchorage; the Matanuska-Susitna Borough; the Fairbanks North Star Borough and Southeast Fairbanks Census Area; the Kenai Peninsula Borough; the City and Borough of Juneau, Ketchikan Gateway Borough, and City and Borough of Sitka; and the remainder of the state. A health care insurer that provides coverage in the Municipality of Anchorage contracting region must include in the insurer's provider network at least 70 percent of the total number of actively practicing physicians, physician assistants, and advanced practice registered nurses in each specialty recognized for a Medicare advantage plan network adequacy requirement for the Centers for Medicare and Medicaid Services physically located in the region and at least 70 percent of the provider groups in each specialty. A health care insurer that provides coverage in the Matanuska-Susitna Borough contracting region or the Fairbanks North Star Borough and Southeast Fairbanks Census Area contracting region must include in the insurer's provider network at least 75 percent of the total number of actively practicing physicians, physician assistants, and advanced practice registered nurses in each specialty recognized for a Medicare advantage plan network adequacy requirement for the Centers for Medicare and Medicaid Services physically located in those regions and at least 75 percent of the provider groups in each specialty. A health care insurer that provides coverage in the Kenai Peninsula Borough contracting region, the City and Borough of Juneau, Ketchikan Gateway Borough, and City and Borough of Sitka contracting region, or the contracting region covering the remainder of the state must include in the insurer's provider network at least 80 percent of the total number of actively practicing physicians, physician assistants, and advanced practice registered nurses in each specialty recognized for a Medicare advantage plan network adequacy requirement for the Centers for Medicare and Medicaid Services physically located in those regions and at least 80 percent of the provider groups in each specialty.

(e) A health care insurer may make a written request to the director for an exception to the minimum provider network standards set out under this section. The director may grant an exception only for a specified limited period not to exceed 36 months. The director shall adopt regulations specifying the procedure for requesting an exception and the standards for granting an exception. The director shall require the

health care insurer to submit a plan to achieve the minimum network standards within the time frame of the exception granted by the director and submit annual progress reports to the director.

(f) A health care insurer shall annually attest whether the insurer meets or exceeds the minimum provider network standards in this section for each contracting region in which the insurer provides coverage and provide to the director supporting documentation to demonstrate compliance as part of the insurer's required rate filings. If a health care insurer does not meet a specific standard, the insurer shall submit a plan for corrective action for consideration by the director.

(g) The director may adopt regulations necessary to implement this section. The director may adopt in regulation minimum provider network standards by contracting region that exceed the minimum network standards set out in (d) of this section.

*** Sec. 2.** AS 21.36 is amended by adding a new section to read:

Sec. 21.36.497. Standards for settlement of health insurance claims. (a) In the absence of a contract between a health care insurer and a 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. The director shall require a health care insurer to use a statistically credible methodology to set allowable charges. 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, must be the same across the state, and must be at least 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.

(b) The director shall periodically audit and validate the methodology used by a health care insurer under (a) of this section to ensure that the insurer is setting allowable charges in accordance with this section. Unless otherwise required by the director, a health care insurer shall review and update allowable charges at least every five years, but not more often than every three years.

(c) A health care insurer shall uniformly and equally apply reimbursement rates for an allowable charge under (a) of this section for the same type of health care service or supply and for health care providers who are practicing within the scope of the provider's license and who are authorized to bill for health care services or supplies under the Current Procedural Terminology code adopted by the American Medical Association or other industry standard method of coding.

(d) In this section,

(1) "allowable charge" means the minimum amount that a health care insurer may use to set reimbursement rates for health care providers and to calculate benefits and pay health insurance claims on behalf of a covered person;

(2) "health care insurer" has the meaning given in AS 21.54.500;

(3) "health care provider" means a physician or other medical professional licensed in this state.

*** Sec. 3.** AS 21.07.020(3) is repealed.

*** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: CALCULATION OF ALLOWABLE CHARGES. Notwithstanding AS 21.36.497, added by sec. 2 of this Act, a health care insurer shall set allowable charges for services and supplies for calendar year 2027 based on the most current data available that shows the amounts charged by health care providers in the state for the services and supplies over a 12-month period beginning in 2024 or earlier. Beginning in calendar year 2030, allowable charges must be based on the most current data available at that time that shows the amounts charged by health care providers in the state for the services and supplies over a 12-month period.

*** Sec. 5.** This Act takes effect January 1, 2027.