

**ALASKA STATE LEGISLATURE**  
**SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE**

February 11, 2025

3:33 p.m.

**MEMBERS PRESENT**

Senator Forrest Dunbar, Chair  
Senator Matt Claman  
Senator Löki Tobin  
Senator Shelley Hughes

**MEMBERS ABSENT**

Senator Cathy Giessel, Vice Chair

**COMMITTEE CALENDAR**

SENATE BILL NO. 60

"An Act establishing May 12 as Myalgic Encephalomyelitis/Chronic Fatigue Syndrome Day of Recognition."

- HEARD & HELD

SENATE BILL NO. 83

"An Act relating to health care insurance; relating to insurance reimbursement for health care services provided through telehealth; and providing for an effective date."

- HEARD & HELD

**PREVIOUS COMMITTEE ACTION**

BILL: SB 83

SHORT TITLE: TELEHEALTH REIMBURSEMENT RATES

SPONSOR(S): SENATOR(S) CLAMAN

01/31/25	(S)	READ THE FIRST TIME - REFERRALS
01/31/25	(S)	HSS, FIN
02/11/25	(S)	HSS AT 3:30 PM BUTROVICH 205

BILL: SB 60

SHORT TITLE: ESTABLISH ME/CHRONIC FATIGUE SYNDROME DAY

SPONSOR(S): SENATOR(S) TOBIN

01/24/25	(S)	READ THE FIRST TIME - REFERRALS
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01/24/25 (S) HSS  
02/11/25 (S) HSS AT 3:30 PM BUTROVICH 205

**WITNESS REGISTER**

LOUIE FLORA, Staff  
Senator Löki Tobin  
Alaska State Legislature  
Juneau, Alaska

**POSITION STATEMENT:** Provided the sectional analysis for SB 60.

DAVID PENN, MD  
Anchorage, Alaska

**POSITION STATEMENT:** Invited testimony on SB 60.

HOLLIS MICKEY, representing self  
Anchorage, Alaska

**POSITION STATEMENT:** Invited testimony on SB 60.

SALLIE REDISKE, representing self  
Homer, Alaska

**POSITION STATEMENT:** Invited testimony on SB 60.

DONNA WAYNE ADERHOLD, Member  
Homer City Council  
Homer, Alaska

**POSITION STATEMENT:** Invited testimony on SB 60.

SIMONETTA MIGNANO, representing self  
Anchorage, Alaska

**POSITION STATEMENT:** Invited testimony on SB 60.

MICHAEL DICKERSON, representing self  
Anchorage, Alaska

**POSITION STATEMENT:** Invited testimony on SB 60.

FRANCESCA DUBROCK, representing self  
Anchorage, Alaska

**POSITION STATEMENT:** Invited testimony on SB 60.

MERCEDES HARNESS, representing self  
Homer, Alaska

**POSITION STATEMENT:** Invited testimony on SB 60.

SARA TABBERT, representing self  
Fairbanks, Alaska

**POSITION STATEMENT:** Invited testimony on SB 60.

SARENA HACKENMILLER, Staff  
Senator Matt Claman  
Alaska State Legislature  
Juneau, Alaska

**POSITION STATEMENT:** Provided the sectional analysis for SB 83.

JAMES REBITZER, Economist  
Boston University  
Boston, Massachusetts

**POSITION STATEMENT:** Invited testimony on SB 83.

SAMMY MACK, Co-owner  
Alaska Telepsychology  
Anchorage, Alaska

**POSITION STATEMENT:** Invited testimony for SB 83.

CHRISTINE SAGAN, Owner  
Vitae Integrative Medical Center  
Anchorage, Alaska

**POSITION STATEMENT:** Invited testimony on SB 83.

LORI WING-HEIER, Director  
Division of Insurance  
Department of Commerce, Community, and Economic Development  
Juneau, Alaska

**POSITION STATEMENT:** Answered questions on SB 83.

#### **ACTION NARRATIVE**

[3:33:11 PM](#)

CHAIR DUNBAR called the Senate Health and Social Services Standing Committee meeting to order at 3:33 p.m. Present at the call to order were Senators Hughes, Claman, Tobin and Chair Dunbar.

#### **SB 60-ESTABLISH ME/CHRONIC FATIGUE SYNDROME DAY**

[3:34:47 PM](#)

CHAIR DUNBAR announced the consideration of SENATE BILL NO. 60 "An Act establishing May 12 as Myalgic Encephalomyelitis/Chronic Fatigue Syndrome Day of Recognition."

[3:35:01 PM](#)

SENATOR LÖKI TOBIN, District I, speaking as sponsor of SB 60 began introducing the bill.

[3:35:14 PM](#)

LOUIE FLORA, Staff, Senator Löki Tobin, Alaska State Legislature, Juneau, Alaska, introduced himself.

[3:35:21 PM](#)

CHAIR TOBIN paraphrased the following sponsor statement for SB 60:

[Original punctuation provided.]

### **Sponsor Statement**

#### **SB 60**

Senate Bill 60 establishes May 12 as Myalgic Encephalomyelitis (ME) Awareness Day to help spread knowledge of the disease, the need for research and appropriate medical care, and to support individuals and their families living with Myalgic Encephalomyelitis.

Myalgic Encephalomyelitis, also known as chronic fatigue syndrome (CFS) or ME/CFS, is a serious, chronic, neurologic disease affecting as many as nine million Americans of all ages, including children. ME/CFS causes dysfunction across all body systems that severely impacts quality of life and ability to work.

ME/CFS often causes a lifetime of disability, with 75 percent of people unable to work or attend school and 25 percent of people housebound or bedbound. As many as 90 percent of people with ME/CFS are undiagnosed. Covid has increased the prevalence of ME/CFS three to five times since 2020 with 50 percent of Long Covid cases meeting the diagnostic criteria for ME/CFS. Long Covid is affecting as many as 56 million Americans with an estimated economic impact of \$3.7 trillion dollars.

ME/CFS is underfunded relative to disease burden and has no known treatments or cures. Experts and advocates for years have been requesting increased funding, research, medical education, and multidisciplinary collaboration. Medical education pertaining to ME/CFS is lacking. According to the U.S. Center for Disease Control and Prevention most medical schools in the United States do not have ME/CFS as part of their physician training. This leaves the

average medical practitioner untrained and unprepared to treat people with ME/CFS & associated diseases.

Establishing May 12 as Myalgic Encephalomyelitis Awareness Day in Alaska mirrors the international designation, chosen to memorialize the birth date of Florence Nightingale, the English army nurse who inspired the founding of the International Red Cross, and who was believed to have contracted a chronic immunological and neurological illness in her mid-thirties and spent the last 50 years of her life virtually bedridden.

This day of recognition will lead to increased awareness of ME/CFS in Alaska. It is our hope that this recognition will lead to increased funding for research by the federal government and private entities, directed clinical education of the disease, and development of diagnostic testing and appropriate treatments, resulting in better medical care for those living with ME/CFS.

[3:38:29 PM](#)

MR. FLORA provided the sectional analysis for SB 60:

[Original punctuation provided.]

***Sectional Analysis***  
***SB 60***

***Section 1 (Page 1, lines 4-9) Establishes Myalgic Encephalomyelitis/Chronic Fatigue Syndrome Day of Recognition as Alaska Statute 44.12.167.***

[3:39:12 PM](#)

DAVID PENN, MD, Anchorage, Alaska, invited testimony on SB 60, moved to slide 1, ME/CFS myalgic Encephalomyelitis, and stated he is not an expert; there are very few experts in the US or world. He stated that myalgic encephalomyelitis is a chronic, complex neuro-immune disease that severely impacts the health and productivity of affected individuals. He explained that while the exact cause and physiology are not fully understood, it is often triggered by viral infections. He emphasized that there is no diagnostic test, cure, or FDA-approved treatment. He noted that most patients live with the disease for life, and only about 5 percent are estimated to recover.

[3:40:21 PM](#)

DR. PENN moved to slide 2, a picture of listed symptoms pointing to the area of the body they affect. He stated that the symptoms of myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) are numerous and impact all body systems. He explained that symptoms include fatigue, brain fog, orthostatic intolerance (worsening symptoms with upright posture), pain in muscles, joints, and nerves, sensory sensitivity, flu-like symptoms, chest pain, palpitations, shortness of breath, gastrointestinal issues, loss of appetite, nausea, and bowel and bladder dysfunction. He emphasized the profound and widespread effect of the disease on patients.

[3:41:04 PM](#)

DR. PENN moved to slide 3, Diagnostic Criteria for ME/CFS, and explained that due to the absence of diagnostic tests for ME/CFS, clinicians rely on criteria established by the Institute of Medicine in 2015. He stated that diagnosis requires a substantial reduction or impairment in the ability to function at pre-illness levels across multiple domains for more than six months, accompanied by profound fatigue of new or definite onset. He clarified that the fatigue is not lifelong from birth but typically becomes lifelong, is not caused by excessive exertion, and is not significantly relieved by rest. He emphasized that post-exertional malaise is a pathognomonic feature of the disease, along with unrefreshing sleep and either cognitive impairment (brain fog) or orthostatic intolerance.

[3:42:04 PM](#)

DR. PENN moved to slide 4, Post Exertional Malaise (PEM), and elaborated that post-exertional malaise, the hallmark symptom, involves a worsening of symptoms or even the onset of new symptoms following exertion. He noted that this can occur 24 to 72 hours after physical, cognitive, or emotional exertion. He added that patients often describe the experience as feeling poisoned, hungover, drained like a low battery, or as if they are moving through wet cement. He stressed that this is distinct from normal post-exercise fatigue, is not relieved by sleep, is not due to deconditioning, and is not simply being unusually tired after activity. He concluded that this symptom significantly reduces quality of life.

[3:43:05 PM](#)

DR. PENN moved to slide 5, Health-Related Quality of Life by Disease, and presented data showing that individuals with ME/CFS report a lower quality of life than those with many other serious conditions, including cancer, stroke, and multiple

sclerosis. He attributed part of this impact to the widespread lack of awareness about the disease, both among the general public and within the medical community.

[3:43:31 PM](#)

DR. PENN moved to slide 6, a graph showing the average time in years from symptom onset to ME/CFS diagnosis by diagnosis year. He shared his personal experience as a physician, stating that he was unfamiliar with ME/CFS when his partner's condition began to worsen. It took several years to reach a diagnosis, which he did not make himself. His partner went from a successful professional career to being fully disabled and unable to work. He said a 2022 survey reported an average delay of 16.2 years from symptom onset to diagnosis. He emphasized that this long diagnostic delay reflects the broader lack of knowledge surrounding the disease.

[3:44:44 PM](#)

DR. PENN moved to slide 7, a picture of Florence Nightingale, and stated that the proposed recognition of International myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) Awareness Day in Alaska aims to raise public and medical awareness, enabling earlier recognition and diagnosis. He emphasized that early identification is critical, especially when treatment is limited to symptom management, as preventing post-exertional malaise is essential to avoid long-term deterioration. He noted that avoiding these episodes requires awareness, making education the most effective tool for preserving function and improving lives. He explained that May 12 was chosen by an American advocate in the early 1990s to honor Florence Nightingale, founder of modern nursing, who became bedridden later in life with what historians believe was likely ME/CFS.

[3:46:19 PM](#)

DR. PENN moved to slide 8, International ME/CFS Awareness Day, and expressed appreciation to the committee for their consideration of the condition and efforts to raise awareness. He stated his belief that this initiative has the potential to significantly improve the health of Alaskans.

[3:47:44 PM](#)

CHAIR DUNBAR continued invited testimony on SB 60.

[3:47:58 PM](#)

HOLLIS MICKEY, representing self, Anchorage, Alaska, invited testimony on SB 60 and stated that she has severe myalgic

encephalomyelitis (ME) and is among the 25 percent of patients who are fully housebound and mostly bedridden. She shared that she lost her active professional and personal life in Alaska, where she had worked as an educator, arts administrator, artist, and professor at the University of Alaska Anchorage. She explained that even minor cognitive efforts now trigger symptom escalation lasting hours to weeks, and she struggles daily with basic self-care. She emphasized that due to widespread lack of awareness in both the medical field and general public, patients are often left to manage their healthcare alone and experience social isolation. She urged support for the SB 60 as a meaningful gesture to recognize ME patients, help them feel seen, and promote more informed and compassionate care.

[3:50:32 PM](#)

SALLIE REDISKE, representing self, Homer, Alaska, invited testimony on SB 60 and stated that she is a medically retired physical therapist who developed ME/CFS as a child following a severe fever after a hypothermic event. She described lifelong cycles of appearing outwardly healthy while internally struggling, followed by prolonged infections and debilitating fatigue throughout her youth and into adulthood. She was not diagnosed until age 32 in the year 2000.

MS. REDISKE explained that she lost her physical therapy business, which had been designed around her healthcare needs and served others with complex chronic conditions. At its peak, the clinic employed 13 people who received strong benefits and wages, contributing to the local economy. As her illness progressed, she became fully disabled in 2016, closed the business, and many employees left the community. She experienced social isolation, losing friends who did not understand or believe her condition.

MS. REDISKE shared that she spent three years bedridden, is now mostly housebound, uses a power wheelchair, cannot drive, and requires a live-in caregiver. She noted severe cognitive challenges, including difficulty reading and following multi-step instructions. In nearly 50 years of living with ME/CFS, she has encountered only three healthcare providers in Alaska who recognized the name of the disease—none of whom knew how to treat it. She urged support for the SB 60, emphasizing that ME/CFS is not rare but rarely diagnosed, and stated that this is a critical opportunity to improve care and access to management strategies for Alaskans living with the disease.

[3:53:52 PM](#)

DONNA WAYNE ADERHOLD, Homer City Council Member, Homer, Alaska, invited testimony on SB 60 and shared her experience with ME/CFS, emphasizing the importance of recognizing the condition and advocating for further research to ease the path for future patients. She stated that her symptoms began in the late 1990s with sudden fatigue and cognitive impairment, followed by years of being dismissed by doctors. After multiple consultations, she was eventually diagnosed with Epstein-Barr Virus, though it took even longer to find a physician who could manage her condition. She explained that after more than a decade of gradual improvement, she contracted COVID-19 in August 2022, which developed into long COVID and reactivated the Epstein-Barr Virus. Her health significantly declined again, and despite supportive doctors and years of effort, she continues to experience severe energy crashes if she overexerts. She noted that although she appears well in public, she often hides the days when she cannot get off the couch or complete basic tasks. She concluded that each ME/CFS journey is different, often triggered by various infections, and that a day of recognition would validate the condition as real and deeply impactful. She urged support to raise awareness and help those living with ME/CFS feel seen and understood.

[3:56:36 PM](#)

SIMONETTA MIGNANO, representing self, Anchorage, Alaska, invited testimony on SB 60 and expressed support for the proposed day of recognition to raise awareness of myalgic encephalomyelitis (ME) and long COVID. She urged the medical community to take the condition seriously, describing the experience of a close friend—a high-functioning professional—who was forced to completely withdraw from her life due to the severity of the illness. She stated that witnessing her friend's physical and emotional decline was heartbreaking and prompted her to learn more about the disease. She emphasized that her friend's experience is not unique and that many others are enduring similarly devastating outcomes. She concluded that ME is more than a collection of symptoms; it is a daily struggle that demands validation and understanding.

[3:58:58 PM](#)

MICHAEL DICKERSON, representing self, Anchorage, Alaska, invited testimony on SB 60 and stated that he has witnessed the impact of myalgic encephalomyelitis (ME) on Hollis Mickey, who contributed significantly to Alaska's arts and education communities but can no longer engage with the creative work for which she was known. He described her suffering as both acute and chronic, and noted the broader loss of her leadership,

artistic voice, and friendship. He emphasized that the societal cost of ME reaches beyond one individual and affects millions worldwide. He expressed support for designating a day of recognition as a meaningful step toward raising awareness, which can lead to increased resources, better understanding, and progress toward effective treatment or a cure.

4:00:27 PM

FRANCESCA DUBROCK, representing self, Anchorage, Alaska, invited testimony on SB 60 and shared a personal account of witnessing the impact of ME/CFS through her friend and former colleague, Hollis. She described Hollis as operating at the highest level—intellectually, creatively, professionally, and physically—when they worked together at the museum. She recalled Hollis’s vibrant lifestyle, including athletic activities and hosting elaborate dinner parties. She explained that beginning in the summer of 2022, Hollis’s health visibly declined, leading to short-term and then long-term disability. Since a brief driveway visit in the summer of 2023, they have not seen each other in person. She described witnessing Hollis endure painful treatments that worsened her condition and caused immense suffering, leaving loved ones feeling helpless due to the lack of research and treatment options. She expressed deep admiration for Hollis’s strength and ongoing advocacy despite the devastating nature of the illness. She concluded by stating that recognizing May 12 as ME/CFS Awareness Day is the bare minimum the community can do to raise awareness and help improve health outcomes.

4:02:33 PM

MERCEDES HARNESS, representing self, Homer, Alaska, invited testimony on SB 60 and stated that she is the parent of a medically complex child receiving treatment for long COVID, which has manifested as ME/CFS and autonomic nervous system dysfunction. She shared that as her child’s condition worsened over the past year—after two years of illness—efforts to seek care in Alaska were repeatedly dismissed, with providers minimizing her concerns and attributing the symptoms to frequent childhood illness. She explained that her 10-year-old daughter has effectively lost her childhood, having been hospitalized twice at age nine, including one episode where her fatigue was so severe she could not walk. Due to the lack of awareness and diagnostic resources in Alaska, they traveled out of state to seek answers. They eventually found support through a local primary care provider working with out-of-state specialists, but her daughter remains unable to attend school or maintain regular social activities. She emphasized that her child’s ongoing

health struggles are not the life any parent would hope for and noted the devastating limitations ME/CFS places on both the patient and the family. She urged that formal recognition of ME/CFS is a vital step toward improving treatment, raising awareness, and supporting affected individuals and their caregivers.

[4:05:24 PM](#)

SARA TABBERT, representing self, Fairbanks, Alaska, invited testimony on SB 60 and stated that she became aware of ME through Hollis's work at the Anchorage Museum and her advocacy, which came at significant personal cost. She shared that she now knows two other individuals with ME—of different ages and in different regions—who both face varying levels of severity and lack the support they need. She reflected on having witnessed many serious illnesses among friends and family, including cancer, severe mental illness, and AIDS, and stated that watching someone live with severe ME has been the most difficult. She emphasized the lack of relief, minimal public understanding, and the painful reality that even well-intentioned gestures of support can worsen symptoms. She urged support for SB 60 to raise awareness in Alaska and contribute to research that could lead to better treatment and a cure.

[4:07:01 PM](#)

SENATOR HUGHES described the testimonies as powerful and helpful in providing a foundational understanding of myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS). She asked whether the condition is more prevalent among females than males.

[4:07:44 PM](#)

DR. PENN responded that ME/CFS is diagnosed two to four times more frequently in women than in men. He noted that the reasons for this disparity are not fully understood, though some speculative explanations exist. He added that it may also reflect underreporting by men or under recognition by providers. He emphasized that ME/CFS affects people of all ages, from children to elders, and spans all racial, ethnic, and socioeconomic groups.

[4:08:34 PM](#)

SENATOR HUGHES asked how many states have recognized a day for myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) awareness. She acknowledged that raising awareness is an important step toward securing research funding and ultimately improving treatment and finding a cure.

[4:09:04 PM](#)

MR. FLORA suggested Dr. Penn might know the answer.

[4:09:27 PM](#)

MS. HOLLIS responded that she did not know the exact number of states that have recognized a day for myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) awareness. She noted, however, that May 12 is an internationally recognized day, with organizations around the world observing it to raise awareness.

CHAIR DUNBAR recognized the committee had received many letter from doctors.

[4:10:13 PM](#)

SENATOR HUGHES stated that even if Alaska is among the first to formally recognize ME/CFS Awareness Day, it is a necessary and important step. She asked whether ME/CFS is considered a disability under Medicare and the Veterans Administration (VA), and whether it is a recognized diagnosis by Medicare, Medicaid, and private insurance.

[4:10:42 PM](#)

DR. PENN stated that myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) has a recognized diagnosis code under ICD-10. He confirmed that it can qualify as a disability but acknowledged that the lack of awareness among medical and administrative systems often makes the process of obtaining disability recognition challenging.

[4:11:07 PM](#)

SENATOR HUGHES asked whether fibromyalgia is a subset of myalgic encephalomyelitis (ME), related to it, or a separate condition. She noted some similarities between the two based on her observations of a friend with fibromyalgia and wondered if her friend may have actually had ME, given the overlap in symptoms.

[4:11:28 PM](#)

DR. PENN stated that some researchers believe fibromyalgia and myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) may exist on a spectrum, though the underlying pathophysiology of both conditions remains unclear. He explained that it is common for individuals to be diagnosed with both, especially given the significant pain experienced by many ME/CFS patients. He added that due to limited awareness of ME/CFS, more familiar diagnoses

like fibromyalgia are often applied, even when they may not fully match the patient's condition.

[4:12:25 PM](#)

SENATOR HUGHES referenced the legislature's support for the WWAMI program (Washington, Wyoming, Alaska, Montana, and Idaho regional medical education) and noted that Senator Tobin's sponsor statement mentioned most medical schools do not include instruction on myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS). She asked whether WWAMI students currently receive any education or training on this condition.

SENATOR TOBIN responded she didn't know but would find out.

[4:13:03 PM](#)

CHAIR DUNBAR concluded invited testimony and opened public testimony on SB 60; finding none, he closed public testimony.

[4:13:34 PM](#)

CHAIR DUNBAR held SB 60 in committee.

[4:13:39 PM](#)

SENATOR TOBIN stated that many legislative efforts are deeply personal and shared that this SB 60 holds personal significance for her. She recalled working with Hollis at the Anchorage Museum and emphasized the importance of elevating Alaskan voices. She expressed that SB 60 could provide hope and solace by affirming individuals' presence in the community, even when they are not physically present.

[4:14:08 PM](#)

At ease.

### **SB 83-TELEHEALTH REIMBURSEMENT RATES**

[4:14:49 PM](#)

CHAIR DUNBAR reconvened the meeting and announced the consideration of SENATE BILL NO. 83 "An Act relating to health care insurance; relating to insurance reimbursement for health care services provided through telehealth; and providing for an effective date."

[4:15:08 PM](#)

SENATOR MATT CLAMAN, District H, speaking as sponsor of SB 83 introduced the legislation:

[Original punctuation provided.]

Thank you Chair Dunbar and members of the Senate Health & Social Services Committee. For the record this is Matt Claman, Senator for District H in West Anchorage.

Senate Bill 83 was brought forward by health care providers in my district who provide both in-person and telehealth services to Alaskans across the state. SB 83 will ensure pay parity for telehealth, requiring health care insurers to reimburse at the same payment rate for telehealth services as in-person care.

Telehealth reduces barriers to care and allows patients to receive timely and convenient care from the comfort of their own homes. In Alaska, barriers to care affect individuals in rural areas, those with disabilities, and those with limited transportation options. Telehealth is especially important for chronic disease management, mental health services, and preventative care.

The COVID-19 pandemic highlighted the critical need for telehealth access, prompting the Centers for Medicare & Medicaid Services (CMS) to temporarily implement telehealth parity. While this federal mandate has expired, some telehealth provisions remain in place. What was once a temporary need is now standard practice, and many states have made efforts to solidify permanent access to these services. Over 33 states have enacted similar legislation to SB 83 to ensure fair reimbursement for telehealth services.

Alaska's Medicaid program already has telehealth pay parity. This legislation builds upon that existing framework to require the same parity by private insurers. Passage of this legislation will expand access to care, improve and maintain quality of care, and incentivize continued telehealth utilization.

[4:16:50 PM](#)

SARENA HACKENMILLER, Staff, Senator Matt Claman, Alaska State Legislature, Juneau, Alaska, Provided the sectional analysis for SB 83.

### **Senate Bill 83**

## Sectional Analysis - Version N

Section 1 AS 21.42.450. Coverage for telehealth. Establishes a new section requiring health care insurers to reimburse health care providers for telehealth services at the same rate as for in-person services.

Section 2 AS 21.42.599. Definitions. Adds new paragraph (9) for the definition of "telehealth" as given in AS 47.05.270.

Section 3 AS 29.10.200. Limitation of home rule powers. Adds new paragraph (68) "AS 29.20.420 (health care insurance plans)" to the list of provisions which apply to home rule municipalities.

Section 4 AS 29.20.420. Health care insurance plans. Establishes a new section requiring a home rule or general law municipality offering a group health care insurance plan to meet the requirements of AS 21.42.450 (Section 1). Provides the definition of "health care insurance plan" as given in AS 21.52.500.

Section 5 AS 39.30.090(a). Adds a new subsection (13) requiring a policy or policies of group insurance covering state employees and other specific employee groups under the Department of Administration to meet to the requirements of AS 21.42.450 (Section 1).

Section 6 AS 39.30.091. Authorization for self-insurance and excess loss insurance. Amends this statute to require those employers with a self-insured group health insurance plan covering active state employees to meet the requirements of AS 21.42.450 (Section 1).

Section 7 AS 21.42.422(b)(2). Coverage for telehealth. Subsection (b), paragraph (2) is repealed.

Section 8 Establishes an effective date of July 1, 2025.

[4:19:09 PM](#)

SENATOR TOBIN asked what SB 83 repeals on page 5, line 2.

[4:19:36 PM](#)

MS. HACKENMILLER replied that Section 7 updates a definition and in Section 2 points to a different statute.

SENATOR TOBIN asked for the definition.

MS. HACKENMILLER provided the definition of AS 47.05.270(e), "In this section, "telehealth" means the practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of health care data through audio, visual, or data communications, performed over two or more locations between providers who are physically separated from the recipient or from each other or between a provider and a recipient who are physically separated from each other."

[4:21:02 PM](#)

SENATOR HUGHES recalled that during the COVID-19 pandemic, legislation addressed telemedicine by allowing its use and possibly establishing payment parity. She expressed uncertainty about whether the change long-term. She asked if anyone could clarify what was ultimately decided.

SENATOR CLAMAN stated that he did not specifically recall what was decided regarding telehealth under COVID-19 regulations but offered to follow up. He noted that a telehealth bill sponsored by Representative Spohnholz passed recently and described it as the first significant telehealth legislation from the last session. He mentioned that his office had introduced a related bill focused on specialized care through coordinated care teams for individuals with amyotrophic lateral sclerosis (ALS) and similar disabilities. He characterized SB 83 as a follow-up or adjustment to earlier telehealth legislation and part of broader efforts to promote medical innovation and cost savings.

SENATOR HUGHES expressed concern about the cost structure of telehealth services. She stated that while telehealth was a valuable innovation during COVID-19—providing convenience, access, and the hope of affordability—she is disappointed it has not lowered healthcare costs as expected. She emphasized that, unlike in-person visits with higher overhead costs such as staff, facilities, and maintenance, telehealth appointments require fewer resources. She questioned why telehealth services are being reimbursed at the same rate as in-person care and urged further explanation to help her understand the justification for payment parity.

[4:24:47 PM](#)

SENATOR CLAMAN stated that invited testimony would be provided by economist Dr. Rebitzer who authored the book "Why Not Better and Cheaper?" He said Dr. Roberts is better qualified to address the question.

[4:25:10 PM](#)

CHAIR DUNBAR announced invited testimony on SB 83 and asked that testifiers keep in mind the question regarding telemedicine costs. He said he would also like to know which states have addressed telehealth similar to SB 83.

[4:25:55 PM](#)

JAMES REBITZER, Professor of Economics, Management and Public Policy, Boston University, Boston, Massachusetts, testified by invitation on SB 83 and said:

[Original punctuation provided.]

My name is James Rebitzer and I am the Peter and Deborah Wexler Professor of Economics, Management and Public Policy at the Questrom School of Business, Boston University. I am also a Research Associate at the National Bureau of Economic Research.

My area of research and teaching is primarily in the area of health economics. In addition to teaching university classes in applied microeconomics, managerial economics and health economics, I have published many academic papers about the economics of the U.S. healthcare system. I also recently published a book on innovation in healthcare published by Oxford University Press. It is called *Why Not Better and Cheaper? Healthcare and Innovation*.

I am here to testify about a new piece of legislation regarding reimbursement for telehealth services. The bill requires a health insurer to reimburse for telehealth services on the same basis and at least at the same rate as comparable healthcare services provided in person.

Let me begin with my conclusion: This is a reasonable piece of legislation worthy of your support. However, my reasoning may be of more interest to the committee than my conclusion.

As an economist who studies management, I normally don't think that a state legislature should determine how much private insurers contract to pay for services. As a rule, legislatures lack key information and incentives and move too slowly to set relative reimbursement rates. Better to leave that to negotiations between insurers and providers. However, telehealth may be the exception that proves the rule. Mandating equal payment can help solve an economic problem that private parties can't solve on their own.

Like every new treatment modality, telehealth requires providers to develop new capabilities to deliver distant care. Payers may be willing to pay something to induce providers to make these costly investments, but will they pay enough on their own? Maybe not. In our fragmented payment system, each provider treats patients from many different payers: Medicare, Medicaid, The State of Alaska, Private Insurers, Private Employers. And this diversity of payers creates the opportunity for free-riding.

[4:28:41 PM](#)

MR. REBITZER continued his testimony:

Suppose a provider deals with 10 different payers, each paying \$50 for a telehealth visit. Suppose providers are happy to invest adequately in telehealth capacity at this price. What would happen if one payer decided to pay \$40 for a telehealth visit? Providers might still be willing to deliver telehealth care to this payer because they have already borne the upfront cost of developing the telehealth capacity. The insurer who pays \$40 would, in effect, be "free-riding" on the other payers' generosity. That would be annoying to the other payers. If the rest followed suit, the result would be an inadequate investment in telehealth capacity or, in the extreme case, no investment at all.

You can see where this is going. The proposed bill can help because it makes it harder for a single insurer to free-ride on other payers because it makes it more costly to cut rates on telehealth. There is no guarantee that the "parity" required by the bill gets relative telehealth reimbursements exactly right, but it makes free-riding less likely. Since the cost of

delivering telehealth care is partly determined by what else providers could do with their time, parity also has the advantage of not making telehealth more expensive relative to in-person care.

[4:30:10 PM](#)

MR. REBITZER continued his testimony:

Although I am not an Alaskan, I am impressed by the vast distances healthcare providers must travel to reach all Alaskans. The cost of underinvestment in and under provision of telehealth is especially severe for Alaska, so the proposed legislation's value is likely to be high.

[4:30:40 PM](#)

SENATOR HUGHES questioned the claim that providers must make costly investments in telehealth capacity. She stated that most clinics already have broadband and secure systems, which are not comparable to purchasing expensive medical or surgical equipment. She argued that parity concerns should focus on consistency among telemedicine payers rather than equating telemedicine with in-person visits, since the two have different costs and overhead. She concluded that she remained unconvinced by the reasoning for payment parity between telemedicine and in-person care, as the modalities differ significantly.

[4:33:26 PM](#)

MR. REBITZER explained that the true cost of telehealth is not only the setup, training, and maintenance of systems but also the opportunity cost of what providers are not doing while delivering telehealth. He stated that if compensation for telehealth falls too far below that of other services, providers may stop investing attention and resources, leading to infrastructure decline. He warned that this free-riding problem could reduce telehealth capacity in Alaska. He emphasized that, given Alaska's large distances and the high value of telehealth, reducing capacity would be a serious mistake.

[4:35:15 PM](#)

SAMMY MACK, Co-owner, Alaska Telepsychology, Anchorage, Alaska, testified by invitation on SB 83. She said she is a clinical psychologist and supports SB 83:

[Original punctuation provided.]

In 2018, our company became the first private Alaskan mental health practice to offer mental health services through HIPAA encrypted videoconferencing. Over the past 7 years we have provided psychotherapy, psychological testing, and psychiatric care via Telehealth and also maintain an in-person office space for patients if they come to town. Our practice includes clinical psychologists, social workers, professional counselors, marriage and family therapists, and a psychiatric nurse practitioner.

We are in-network with most major insurance providers, and nearly all of our providers have a waitlist-- the demand for our services is great. For many, Teletherapy is their only option for accessing timely, high-quality mental health care. For most, paying out-of-pocket is a financial impossibility, and therefore insurance billing is a must.

Unfortunately, many Alaskan mental health providers are requiring payment in full at the time of service because negotiated insurance reimbursement rates have failed to keep up with the rising cost of living and inflation.

A further complication is a lack of parity between Telepsychology and in-person services. Providers are disinclined to provide Telehealth services when these are reimbursed at lower rates than in-person care. Inadequate Telehealth coverage drives patients toward large, nationwide online therapy platforms, where they experience inconsistent care and a revolving door of therapists unfamiliar with the unique challenges of life in Alaska.

[4:37:22 PM](#)

MS. MACK added that this relates to what Senator Hughes' mentioned regarding seeing more patients on telehealth. Many national platforms crank out many sessions in a day and provide inadequate care because they are overburdened.

[4:37:44 PM](#)

MS. MACK continued reading her testimony:

[Original punctuation provided.]

Pay parity will allow providers to offer high-quality, accessible mental health services without financial disincentives. Without pay parity, we risk losing providers to cash-pay models or losing them altogether - a particularly acute problem in rural Alaska where rates of suicide and abuse are among the highest in the nation. As a lifelong Alaskan, I am proud to own Alaska Telepsychology and to provide services to Alaskans across our state. Please support pay parity so that Alaskans from Savoonga to Dillingham to Sitka, Alaskans regardless of location, can access high-quality mental health care moving forward. Thank you for your time and consideration. Please let me know if you have any questions.

[4:38:45 PM](#)

CHRISTINE SAGAN, Nurse Practitioner, Vitae Integrative Medical Center, Anchorage, Alaska, testified by invitation on SB 83. She said she is in strong support of the bill and commented that her experience as a nurse practitioner since 2007 and in private practice since 2015 showed the importance of telemedicine, especially during COVID-19. She explained that reimbursement parity matters because, while care quality and effort remain the same, insurers such as Blue Cross paid 40 percent less for telemedicine visits, which forced her clinic to bring patients back in person despite ongoing pandemic concerns. She noted that telemedicine improved compliance, reduced no-shows, increased access, and lowered indirect costs for patients by saving travel time and expenses. She emphasized that clinics still carry overhead costs such as staff, electronic medical records, billing, and facilities, and argued that paying 40 percent less for telemedicine undermines continuity of care in Alaska, where distance makes access difficult.

[4:44:48 PM](#)

CHAIR DUNBAR thanked the testifiers, acknowledging the time and cost burdens for medical providers. He noted that he had answered his own earlier question regarding other states' practices. He stated that a document provided in the bill packet showed 21 other states required payment parity for telehealth services on a permanent basis, according to the American Medical Association. He clarified that this information was from 2023 and may have changed. He invited Ms. Wing-Heier to come forward to answer questions.

[4:45:24 PM](#)

LORI WING-HEIER, Director, Division of Insurance, Department of Commerce, Community, and Economic Development, Juneau, Alaska, answered questions on SB 83. She put herself on the record.

CHAIR DUNBAR stated that he did not see any statements from the division, aside from a possible zero fiscal note. He asked what the anticipated impact on rates would be from a bill like SB 83.

[4:45:53 PM](#)

MS. WING-HEIER stated that conversations with insurers revealed a disconnect between providers and payers. She explained that the insurers the division spoke to believe they are paying at parity for telehealth and in-office visits, with only minor exceptions. She acknowledged that Senator Claman had received constituent concerns about a lack of parity but said she had not been able to find exactly where it is. She added that both commercial insurers affirmed parity and neither submitted a letter of opposition to the bill.

CHAIR DUNBAR observed that if the bill had a significant financial impact, insurers would likely have submitted comments, but they had not. He noted this could also suggest the bill simply codifies existing practice. He then asked whether there could be any unintended consequences from passing the bill.

[4:47:06 PM](#)

MS. WING-HEIER stated she could not predict future actions by insurers but emphasized the state's ongoing effort to reduce health care costs. She noted that parity is not currently in statute and acknowledged uncertainty about the source of the reported disconnect. She referenced a testifier's claim of a 40 percent difference in payment and expressed interest in reviewing the billing code used to investigate the discrepancy further. She reiterated the difficulty in forecasting how insurers might respond when negotiating future rates with providers.

[4:47:46 PM](#)

CHAIR DUNBAR noted that at least 21 states had adopted payment parity legislation as of 2023. He asked if there were any known trends or impacts on rates in those states following the adoption of similar legislation.

[4:48:00 PM](#)

MS. WING-HEIER stated that parity for telehealth and behavioral health is an ongoing issue in many states. She confirmed awareness that several states have adopted similar legislation.

She added that there have been no reports of negative impacts from states that have already passed such laws.

[4:48:16 PM](#)

CHAIR DUNBAR asked whether the concern mentioned referred to a lack of payment parity or to the payment parity laws themselves.

[4:48:22 PM](#)

MS. WING-HEIER clarified that the concern is about a lack of payment parity, which is being addressed in various states.

[4:48:35 PM](#)

SENATOR TOBIN stated that her main question was what problem SB 83 aims to fix, a question more appropriate for the bill sponsor than the division. She noted that both the Division of Insurance and the Department of Retirement and Benefits submitted zero fiscal notes. She sought clarification that the SB 83 would have no impact on AlaskaCare and no fiscal impact to the state unless renegotiation occurs.

[4:49:06 PM](#)

MS. WING-HEIER stated she could not speak officially for the Department of Retirement and Benefits but, based on her conversations with them, they indicated they are currently paying at parity. She acknowledged the possibility of some losses within the plan but said the Department believes it is meeting the intent of the statute.

[4:49:37 PM](#)

SENATOR HUGHES asked whether there was a rough estimate of the percentage of appointments conducted via telehealth versus in person. She suggested that if telehealth visits were reimbursed even 10 percent less than in-person visits, AlaskaCare could potentially reduce health care costs. She noted this could lead to savings for both consumers and the State of Alaska. She asked if such a percentage is known and whether it is reasonable to assume that lower telehealth reimbursement could help reduce overall costs.

[4:50:44 PM](#)

MS. WING-HEIER responded that she did not currently have data on the percentage of telehealth visits compared to in-person visits but would work to gather that information. She emphasized that the division is actively seeking ways to reduce health care costs without harming the overall system. She stated that any opportunity to save money is being considered for inclusion not only in plans regulated under Title 21 and the Division of

Insurance but also in AlaskaCare and other plans across the state. She acknowledged that Alaska's health care costs are high and that employers are struggling to manage them.

[4:51:31 PM](#)

SENATOR HUGHES posed a hypothetical policy scenario in which telehealth visits are reimbursed at 90 percent of in-person visit rates. She asked whether, if private insurers and AlaskaCare adopted this approach, it would result in reduced health care costs for Alaskans.

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MS. WING-HEIER stated her belief that such a policy would have to result in reduced health care costs.

[4:52:15 PM](#)

CHAIR DUNBAR concluded invited testimony on SB 83.

[4:52:37 PM](#)

SENATOR CLAMAN responded to questions raised by Senator Hughes and offered a perspective that differed from Ms. Wing-Heier's. He stated that while paying telehealth at 90 percent of in-person rates might appear to save money if focusing solely on per-visit costs, this view overlooks the broader economic impact. He referenced testimony from Alaska providers who emphasized that telehealth improves access and consistency of care, which can reduce costly emergency and complex care. He argued that paying parity enables preventive care that lowers total health care spending, and that analyzing costs per visit without considering overall patient outcomes and system-wide expenses presents a flawed understanding.

[4:54:31 PM](#)

CHAIR DUNBAR stated that affordability is a key priority for both the committee and the administration regarding health care costs, but noted that quality, effectiveness, and availability are equally important. He emphasized that the testimony from the second provider highlighted availability as a critical benefit of telehealth. He shared that delays in accessing care can negatively affect both physical and psychological health.

[4:55:16 PM](#)

SENATOR HUGHES emphasized the value of preventive care, noting that early intervention reduces long-term health care costs. She acknowledged that parity in telehealth increases patient compliance, particularly in remote areas, but pointed out that this also increases provider income, as more visits are

completed and reimbursed at full rate. She expressed concern that this dynamic may unintentionally increase overall health care spending in Alaska. She underscored the financial burden on businesses, school districts, and families, and urged the committee to prioritize consumer affordability. She advocated for a compromise—such as reimbursing telehealth at 90 or 95 percent—to maintain access while achieving some cost savings.

[4:58:27 PM](#)

CHAIR DUNBAR held SB 83 in committee.

[4:59:49 PM](#)

There being no further business to come before the committee, Chair Dunbar adjourned the Senate Health and Social Services Standing Committee meeting at 4:59 p.m.