

ALASKA STATE LEGISLATURE
SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

March 11, 2025

3:30 p.m.

MEMBERS PRESENT

Senator Forrest Dunbar, Chair
Senator Cathy Giessel, Vice Chair
Senator Matt Claman
Senator Shelley Hughes

MEMBERS ABSENT

Senator Löki Tobin

COMMITTEE CALENDAR

SENATE BILL NO. 121

"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."

- HEARD & HELD

SENATE BILL NO. 122

"An Act relating to insurance; establishing standards for health insurance provider networks; and providing for an effective date."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: SB 121

SHORT TITLE: HEALTH INSURANCE ALLOWABLE CHARGES

SPONSOR(s): SENATOR(s) GIESSEL BY REQUEST

03/05/25	(S)	READ THE FIRST TIME - REFERRALS
03/05/25	(S)	HSS, L&C
03/11/25	(S)	HSS AT 3:30 PM BUTROVICH 205

BILL: SB 122

SHORT TITLE: HEALTH INSURANCE NETWORK STANDARDS

SPONSOR(s): SENATOR(s) GIESSEL BY REQUEST

03/05/25 (S) READ THE FIRST TIME - REFERRALS
03/05/25 (S) HSS, L&C
03/11/25 (S) HSS AT 3:30 PM BUTROVICH 205

WITNESS REGISTER

JANE CONWAY, Staff
Senator Cathy Giessel
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Provided the sectional analysis for SB 121.

JEFFREY DAVIS, Principal
Weston Group Consulting LLC
Wenatchee, Washington

POSITION STATEMENT: Provided a presentation on SB 121, 80th Percentile Replacement.

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

POSITION STATEMENT: Answered questions on SB 121.

JANE CONWAY, Staff
Senator Cathy Giessel
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Provided the sectional analysis for SB 122.

JEFFREY DAVIS, Principal
Weston Group Consulting LLC
Wenatchee, Washington

POSITION STATEMENT: Provided a presentation on SB 122, Provider Network Minimum Standards for Health Insurers.

ACTION NARRATIVE

3:30:30 PM

CHAIR DUNBAR called the Senate Health and Social Services Standing Committee meeting to order at 3:30 p.m. Present at the call to order were Senators Giessel, Hughes, Claman, and Chair Dunbar.

SB 121-HEALTH INSURANCE ALLOWABLE CHARGES

[3:31:17 PM](#)

CHAIR DUNBAR announced the consideration of SENATE BILL NO. 121 "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."

[3:31:33 PM](#)

SENATOR GIESSEL speaking as sponsor introduced SB 121. She said the bill establishes minimum reimbursement rates for healthcare services. The repeal of the 80th percentile rule that was originally removed because it incentivized inflated charges, left no reimbursement floor in place. As a result, insurers now control reimbursement levels, and providers have little to no leverage in negotiations, which is causing significant strain on healthcare practices.

[3:33:59 PM](#)

SENATOR GIESSEL stated that providers report insurers are lowering reimbursement rates, refusing to renew contracts, or offering flat or declining payments that threaten the viability of clinical practices. SB 121 aims to fix this by establishing consistent, fair reimbursement standards to protect access to care and stabilize providers and patients financially. Falling reimbursement rates lead to balance billing or "surprise bills"—and higher out-of-pocket costs, further reducing access to care. Practice costs are rising sharply, including a 47 percent increase in support-staff expenses since 2016, while Medicare's physician fee schedule has fallen 33 percent over 20 years. She said insurers use low out-of-network rates to push down contract rates, forcing some clinicians to close their practices.

SENATOR GIESSEL said SB 121 directs the insurance director to set statistically credible, market-based standards using the most current 12 months of Alaska charge data. Reimbursements must meet at least the statewide 75th percentile of charges or a minimum of 450 percent of the Medicare fee schedule. These standards will be audited periodically, and insurers must update rates every three to five years. The 450 percent floor is based on prior consulting analysis indicating that level is necessary to keep primary care practices viable.

[3:39:04 PM](#)

SENATOR GIESSEL stated that the full repeal of the 80th percentile rule was a positive step, but policymakers failed to set a reimbursement floor to keep clinicians financially viable. She stated that its clear adjustments are needed after four

years without that safeguard. Clinicians are struggling, and establishing a minimum reimbursement standard is now an urgent policy correction.

[3:40:07 PM](#)

CHAIR DUNBAR asked whether the 80th percentile rule was repealed one year ago or four years ago.

[3:40:14 PM](#)

SENATOR GIESSEL stated her belief that the repeal occurred more than one year ago.

[3:40:26 PM](#)

SENATOR CLAMAN said his recollection was unclear but stated his belief that a lawsuit was filed over the repeal of the 80th percentile rule. He asked for an update on the status.

[3:40:46 PM](#)

SENATOR GIESSEL replied that a hearing on that lawsuit was held about two weeks ago. She said she has an invited testifier who can speak to the lawsuit status in more detail.

[3:41:10 PM](#)

SENATOR HUGHES noted that the sponsor statement references reimbursements set at the statewide 75th percentile or 450 percent of Centers of Medicaid/Medicare Services (CMS) rates and asked whether this applies only to primary care or to all charges.

[3:41:31 PM](#)

SENATOR GIESSEL replied that 450 percent of Medicare (CMS) minimum applies to all charges. She added that, while primary care costs are lower than specialties like orthopedics, primary care is the entry point to the healthcare system and the group she is most concerned about supporting.

[3:42:12 PM](#)

SENATOR HUGHES asked whether the 450 percent floor is based on Medicaid rates or Medicare rates.

[3:42:23 PM](#)

SENATOR GIESSEL replied that the 450 percent floor is for Medicare.

[3:42:33 PM](#)

SENATOR HUGHES said she has followed Alaska's high healthcare costs and supported repealing the 80th percentile rule because

it contributed to rising prices. Historically, Alaska's costs were only slightly above the Lower 48, but once the 80th percentile rule took effect, charges steadily increased as providers collectively raised their rates to stay in the top tier. She is worried that setting reimbursement at the 75th percentile could create similar upward pressure, causing charges to rise again. While she understands the need for a 450 percent Medicare floor to keep primary care practices viable, she prefers allowing the free market to rebalance costs and is concerned SB 121 would recreate the same problems the 80th percentile rule caused. She asked why the 75th percentile would avoid those issues.

[3:45:30 PM](#)

SENATOR GIESSEL replied that some questions are better addressed by the invited testifier but clarified that the 75th percentile refers to the level at which the 75th highest charges fall, not what 75 percent of clinicians charge. Unlike the old 80th percentile rule, which used geographic regions, this standard applies statewide. She noted the prior system might have worked better if Washington State data had been included, as many patients already traveled out of state for lower-cost care. She explained that large specialty groups, like cardiology and orthopedics, merged and collectively set high charges under the 80th percentile model. She emphasized that SB 121 covers all clinicians, not just physicians. She said while she supports free-market principles, she argued that true market conditions do not exist in healthcare because insurers also exert significant power and often refuse to reimburse clinicians at sustainable levels or fail to renew contracts, pushing providers out of network and forcing patients to pay cash. A minimum reimbursement standard is needed to correct this imbalance.

[3:49:08 PM](#)

JANE CONWAY, Staff, Senator Cathy Giessel, Alaska State Legislature, Juneau, Alaska, provided the sectional analysis for SB 121:

[Original punctuation provided.]

Sectional Analysis (vsn N)

"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."

**Section 1. Amends AS 21.36 Trade Practices and Fraud
Adds new section 21.36.497 that outlines the
following:**

- For an out-of-network provider the director of the Division of Insurance shall set in regulation the standards an insurer must use in considering an allowable charge
- The director will require the insurer to use statistically credible methodology to set the allowable charge.
- The charges must be based on current data of provider charges over a 12-month period and cannot vary for different parts of the state.
- The allowable charge may not be less than the 75th percentile of the charges as defined by the CPT code; however, the director may set an allowable charge at a higher percentile.
- For primary care providers, the allowable charge must be the greater of the allowable charge or 450 percent of the current CMS fee schedule at the time of delivery.
- The director shall periodically audit the methodology used by the insurer in setting the allowable charge and should do this at least every 5 years, but not more often than every 3 years.
- An insurer must uniformly and equally apply reimbursement rates to any provider practicing within the scope of their license for same services under the same CPT code adopted by the AMA.

[3:51:13 PM](#)

CHAIR DUNBAR asked for clarification on SB 121, Section 1(c), wanting to know whether its requirement for uniformly applied reimbursement rates applies to in-network, out-of-network, or something else. He asked whether this language would effectively eliminate in-network and out-of-network distinctions in Alaska or whether he was misinterpreting it.

[3:51:44 PM](#)

SENATOR GIESSEL replied that the provision requires equal reimbursement for the same service regardless of whether it is provided by a physician, physician assistant, or nurse practitioner. As long as they are practicing within their licensed scope and billing under the appropriate current procedural technology (CPT) code, they must be reimbursed at the same rate.

CHAIR DUNBAR noted this language is similar to an earlier amendment and would prevent insurers from differentiating reimbursement based on a provider's license type. However, it would not stop insurers from setting different in-network and out-of-network rates.

[3:52:46 PM](#)

SENATOR GIESSEL replied in the affirmative.

[3:52:53 PM](#)

MS. CONWAY resumed the sectional analysis for SB 121:

[Original punctuation provided.]

Section 2. Adds a new section that allows for a transition period

In this section the insurer would set allowable charges based on current data from provider charges over a 12-month period beginning in 2023 or earlier. In 2029 the allowable charges must be based on current data of provider charges for services/supplies over the previous 12-month period.

Section 3. Sets an effective date for January 1, 2026.

[3:53:34 PM](#)

CHAIR DUNBAR announced the presentation on SB 121.

[3:54:03 PM](#)

JEFFREY DAVIS, Principal, Weston Group Consulting LLC, Wenatchee, Washington, provided a presentation on SB 121. He stated that [health care] is a complex subject.

[3:56:10 PM](#)

MR. DAVIS moved to slide 2, History, and explained the history of the 80th percentile in the following order:

[Original punctuation provided.]

-The 80th percentile regulation was established 20 years ago to protect Alaskans from "balance billing"

•Balance billing = difference between insurance payment and provider charge

-Insurers don't base payments on actual charges - base them on "allowable charges"

-When the regulation was implemented, insurers' definition of allowable charges were much lower than actual prices/costs in Alaska

-As a result, Alaskans were stuck paying the difference between the insurance payment and the provider's charges - the balance bill

-At the time, very few providers were "in-network" where the contract defines allowable charges through negotiation

-The regulation worked - Alaskans were protected as insurers adjusted allowable to Alaska market levels at the "80th percentile"

[3:57:59 PM](#)

MR. DAVIS moved to slide 3, Intended and Unintended Consequences of the Regulation, and explained that the 80th percentile rule produced both intended and unintended effects. It successfully reduced balance billing, as insurers aligned their allowable charges with the 80th percentile, protecting Alaskans from large, unexpected bills. However, providers with significant market share could push the percentile upward by raising their own charges, creating an unintended inflationary effect. He said on the positive side, the rule stabilized reimbursement and reflected Alaska's higher operating costs, which encouraged provider growth and expanded access to care. A surge in new practices, roughly a 40 percent increase over a short period, helped meet long-standing unmet demand. He said the rule also created a common benchmark for contract negotiations.

[4:00:30 PM](#)

MR. DAVIS moved to slide 4, Market Changes Since the Rule's Inception, and explained that after the 2004 regulation took effect, the market shifted significantly. Between 2014 and 2017, providers moved from mostly out-of-network to mostly in-network.

By 2023, only about 400 providers remained out of network. He said because the 80th percentile applied only when no contract existed, its role diminished as providers signed network agreements. However, it still shaped negotiations: a provider knew that if they stayed out of network, reimbursements would track the 80th percentile. So, when insurers offered contract rates close to that level, providers usually accepted—sometimes even slightly lower—because being in network meant better benefits for patients and easier payment. He said this dynamic made the 80th percentile the de facto benchmark that drew most providers into network during that period.

[4:02:44 PM](#)

MR. DAVIS moved to slide 5, Where is the Money Going, and explained that the horizontal lines on the graph represent insurer reimbursements to providers. He said because competitors cannot share actual rates, each provider normalized their 2018 reimbursement level to 1.0 and tracked percentage changes over time. The data show insurer reimbursements staying flat or declining, while insurance premiums continued to rise. This disproves the idea that higher provider payments were driving premium increases. He said instead, provider payments were stable under contracts, and rising insurance rates were likely driven by other factors.

[4:04:15 PM](#)

MR. DAVIS moved to slide 6, Repeal of the 80th Percentile Regulation, and stated that the 80th percentile rule was repealed on January 1, 2024, without a replacement, allowing insurers to set their own standards for allowable charges. This returned the system to a 2004-style model where payers determine allowable, often far below previous levels. He said as a result, providers have significantly less bargaining power, with insurers offering lower contract rates because going out of network now yields much smaller reimbursements. Providers report that insurers are using this leverage to push rates down even further, despite flat reimbursements over six years and rising practice costs, about a 47 percent increase, creating substantial financial strain.

[4:06:47 PM](#)

MR. DAVIS moved to slide 7, Bargaining Dynamics—Power Shift to Insurers, and stated as reimbursement dynamics shift, providers have few options: leave the state, go out of network and balance bill patients, or close their practices. Significant changes haven't appeared yet because insurers agreed not to adjust contract rates until 2025, but many providers are forecasting

closures, and some have already shut down. He said these outcomes are harmful for Alaskans, especially given existing provider shortages.

[4:07:34 PM](#)

MR. DAVIS moved to slide 8, The Solution- State Defined Replacement.

[4:07:40 PM](#)

CHAIR DUNBAR interjected calling on Senator Claman for a question.

[4:07:52 PM](#)

SENATOR CLAMAN stated that an insurer paying 185 percent of Medicare for in-network services appears far below typical reimbursement and seems unfair. He asked whether, in cases where a provider's negotiated in-network rate is close to the Medicare rate, a 450 percent cap could result in out-of-network payments that are higher than in-network rates.

[4:08:40 PM](#)

MR. DAVIS responded that, in theory, out-of-network payments could exceed in-network rates, but he is not aware of any practices where that occurs. He said he would move ahead to slide 10 to help address the question.

[4:08:58 PM](#)

MR. DAVIS moved to slide 10, Myth Busting-Alaska Providers Highest Paid in the Country-WRONG, and explained that many discussions assume Alaska providers are among the highest paid because Alaska's medical charges are high. However, new data from the Medical Group of Management Association's (MGMA) 2024 compensation study-based on 211,000 responses and used by the federal government for fair-market-value assessments-shows otherwise. He said according to the study, Alaska family physicians and non-surgical specialists are actually in the bottom five states for take-home compensation, and surgical specialists fall in the middle. He stated that high charges reflect high operating costs, not high provider pay, especially given years of flat reimbursement.

[4:11:21 PM](#)

MR. DAVIS moved back to slide 7 and noted that Alaska's high charges stem from high operating costs, not high compensation. He stated his belief that, due to high operating costs, Alaska does not have practices operating anywhere near 185 percent of Medicare rates.

[4:11:49 PM](#)

SENATOR CLAMAN said he is convinced that 185 percent of Medicare is an unreasonably low out-of-network rate, noting that double of nothing is still nothing. He stated his concern is balancing competing market pressures: insurers want to reduce healthcare costs, providers need fair compensation to maintain high-quality care, and consumers want good access without large out-of-pocket bills. He asked how market forces could operate effectively while still encouraging providers to remain in-network, noting that when out-of-network rates are too similar to in-network rates, providers have little incentive to participate.

[4:13:58 PM](#)

MR. DAVIS replied that from 2014 to 2017, most providers moved in-network at rates near the 80th percentile because it created a balanced negotiating environment. Patients received better benefits, providers preferred insurer payments over patient collections, and both sides rejected rates that were too far from that benchmark. He said removing the 80th percentile without a replacement disrupted that balance, giving insurers significantly more leverage, especially in a market with few carriers. With years of flat or declining reimbursement, low provider compensation, and now no meaningful floor, Alaska is seeing provider practices fail.

[4:15:51 PM](#)

MR. DAVIS moved back to slide 8, Solution-State Defined Replacement, and stated that the solution is to reestablish a state-determined, market-based floor for allowable reimbursements. The key is that the state, not insurers, sets the standard, and that it reflects Alaska's own cost structure rather than fee schedules from other markets that create winners and losers. He said previously he opposed repealing the 80th percentile without a replacement because it would destabilize the medical community. After evaluating alternatives, he concluded that a statewide, market-based percentile, such as the 75th, updated every few years, would best restore balance, limit excessive market power, and avoid cost-inflation problems seen under past regulations.

[4:18:50 PM](#)

MR. DAVIS moved to slide 9, Summary, and concluded that, based on publicly available filings insurance rate increases in the individual market did not slow from 2023 to 2025 after the repeal. He said the repeal has had significant negative effects on providers, and those impacts are beginning to accelerate.

Losing providers in Alaska, which is an already federally designated healthcare professional shortage area, creates long-term problems, as they are difficult to replace. He emphasized that the market is now out of balance, and that restoring balance is essential to prevent worsening shortages and protect access to care.

[4:21:06 PM](#)

SENATOR HUGHES agreed that free-market principles don't function well in the current healthcare system, but argued that policymakers should let the self-insured, private, and self-pay markets drive pricing, rather than allowing Center for Medicaid and Medicare Services (CMS) to dictate pricing. She noted concerns about moving from four regions to one and updating rates every three to five years, but questioned whether a 75th-percentile floor would still allow charges to rise unchecked. She argued that providers could collectively raise charges, causing the percentile to increase regardless of market share, and asked for an explanation of why that wouldn't lead to the same problems as before.

[4:22:46 PM](#)

MR. DAVIS replied that the data did not show providers clustering at a single charge level before contracting. After most providers moved in-network between 2014 and 2017, contract rates, not the 80th percentile, set reimbursement levels. The percentile only applied to out-of-network claims but remained important as a benchmark during contract negotiations. He said because of that, the dynamic is different when providers are in network and negotiating rates rather than all operating out of network.

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SENATOR HUGHES said she still doesn't understand how the proposal avoids incentivizing providers to go out of network. She shared the concern that out-of-network care is worse for consumers and asked how this approach meaningfully changes bargaining dynamics.

MR. DAVIS replied that when the 80th percentile was in place, providers moved in network because it served as a fair benchmark for contract negotiations. Insurers could offer rates near the 80th percentile, and providers often accepted slightly less since it benefited patients and simplified collections. He said based on that experience, a new, improved replacement modeled on the 80th percentile should encourage similar in-network participation while avoiding the earlier problems.

[4:25:07 PM](#)

SENATOR CLAMAN asked Mr. Davis whether he would choose the 450th or 75th percentile floor and why.

MR. DAVIS responded that he would choose the 75th percentile because it is market-based and adjusts with business costs. He noted rising expenses, such as a 47 percent increase in support-staff costs over eight years, while Medicare reimbursement continues to decline. He emphasized the need to keep Alaska providers viable, noting they are among the least compensated, and argued that years of stagnant rates followed by proposed cuts will not sustain a functional market.

[4:26:31 PM](#)

CHAIR DUNBAR asked Ms. Wing-Heier to answer questions pertaining to SB 121.

[4:26:54 PM](#)

LORI WING-HEIER, Director, Division of Insurance, Alaska Department of Commerce, Community and Economic Development, Juneau, Alaska, answered questions on SB 121. She put herself on the record.

[4:27:03 PM](#)

CHAIR DUNBAR noted that the 80th percentile was repealed in January 2024 and that last year there wasn't enough data to know the impact. He asked whether insurers have actually lowered rates, as expected, and expressed surprise that insurers can set allowable charges without regulatory guardrails. He inquired about any guidelines that limit how they set those charges.

[4:28:20 PM](#)

MS. WING-HEIER replied that most insurers determine allowable charges using Fair Health, a national database that collects over 2 billion claims annually to identify usual, customary, and reasonable charges.

[4:28:46 PM](#)

CHAIR DUNBAR asked if it's a reasonable charge nationwide.

MS. WING-HEIER replied no, the division looks at Alaskan charges. The division follows statute and regulation that require providers to reimburse at a reasonable rate, preventing a return to pre-2004 levels before the 80th percentile.

CHAIR DUNBAR opined that the requirement to reimburse at a reasonable rate partly undermines the argument that there is a need for a 75th or 80th percentile floor. He asked whether the repeal has changed insurer-provider negotiation dynamics and whether insurers are now lowering their charges now that the 80th percentile is gone.

[4:30:05 PM](#)

MS. WING-HEIER replied that she is aware as of April 1, Primera sent some providers letters reducing certain charges while increasing others. Filings showed a 4 percent decrease in 2025 and about 2.5 percent in 2024, expected to accumulate overtime. She said although the 80th percentile portion decreased; other factors drove overall rates up. She noted that without the repeal consumers' 15 percent rate increase would have been 4 percent higher.

[4:31:08 PM](#)

SENATOR HUGHES asked how many providers the percentile impacts and what claim trends are being noticed in-network versus out-of-network.

MS. WING-HEIER replied that one concern the department has with SB 121 is that it places the sole burden on the 118,000 Alaskans that are in the insured market. SB 121 does not include AlaskaCare unions and large self-insured employers. It places disproportionate burden on roughly 15 percent of the population.

[4:32:11 PM](#)

SENATOR HUGHES asked what movement trends the department has observed in claims submitted for in-network and out-of-network services.

MS. WING-HEIER replied that in 2023, AlaskaCare repealed the 90th percentile and adopted 185 percent. Since then, 1,100 providers have moved in-network, benefiting both consumers and the broader healthcare industry.

[4:33:10 PM](#)

CHAIR DUNBAR held SB 121 in committee.

SB 122-HEALTH INSURANCE NETWORK STANDARDS

[4:33:30 PM](#)

CHAIR DUNBAR announced the consideration of SENATE BILL NO. 122 "An Act relating to insurance; establishing standards for health

insurance provider networks; and providing for an effective date."

[4:33:44 PM](#)

SENATOR GIESSEL speaking as the sponsor introduced SB 122 and read the sponsor statement:

[Original punctuation provided.]

Sponsor Statement (vsn N)

"An Act relating to insurance; establishing standards for health insurance provider networks; and providing for an effective date."

Senate Bill 122 will establish state-defined minimum standards for health insurer provider networks tailored to Alaska. Standards are necessary to ensure Alaska patients have access to a network of providers sufficient to meet their healthcare needs. Thirty-eight states and territories have adopted provider network minimum standards. The National Association of Insurance Commissioners has stated that provider network minimum standards are the most important mechanisms to ensure a well-functioning healthcare and health insurance market. In many states, insurers often establish and market products with a limited subset of the providers available in the area, or a "narrow network". Because all of Alaska is a federally designated provider shortage area, narrow networks would be detrimental to Alaskans' health by hindering access to needed providers. Narrow networks can also result in barriers to care by creating long waiting times for appointments. This bill would establish simple standards tailored to the geography and distribution of population and providers in Alaska. It makes provision for a phase-in period to avoid insurance market disruption and a process for insurers to request exceptions when standards can't be met. Standards are designed to ensure that the full range of specialties in a community are represented in the network. Senate Bill 122 would proactively protect Alaskans from the access issues that have arisen with narrow networks elsewhere in the country. Please join me in supporting this commonsense bill to protect Alaska patients' access to needed health care while supporting local providers in the community.

[4:36:02 PM](#)

JANE CONWAY, Staff, Senator Cathy Giessel, Alaska State Legislature, Juneau, Alaska, provided the sectional analysis for SB 122. She read the following portion of the sectional analysis:

[Original punctuation provided.]

- (d) Divides Alaska into 6 contracting (network) regions:

-Municipality of Anchorage Network must include 85 percent of total active physicians, PAs and APRNs in each specialty and at least 85 percent of each provider groups in each specialty.

-Mat-Su Borough Network must include at least 9 percent of active physicians, PAs and APRNs in each specialty and at least 90 percent of the provider groups in each specialty.

-Fairbanks North Star Borough and Southeast Fairbanks Census Area 90 percent same as Matsu

-Kenai Peninsula Borough Network must include at least 95 percent of active physicians, PAs and APRNs in each specialty and at least 95 percent of the provider groups in each specialty.

-City and Borough of Juneau, Ketchikan Gateway Borough and City and Borough of Sitka 95 percent - same as Kenai Peninsula Borough

-Remaining areas of the state

[4:38:04 PM](#)

MS. CONWAY moved to section 1 of the sectional analysis for SB 122:

[Original punctuation provided.]

Section 1. Amends AS 21.07 Patient Protections Under Health Care Insurance Policies

Adds new section 21.07.035 Minimum provider network standards.

In this section a health care insurer

- Must take into account the network requirements set out in this new section when calculating the benefits or contractual requirements of the covered person.

[4:38:22 PM](#)

MS. CONWAY continued with the sectional analysis for SB 122:

- (b) A health care insurer's provider network must include each hospital, skilled nursing facility or mental health/substance abuse facility in the state and each physician, PA and APRN employed by them. This would be the same for any tribal health organization.
- However, the physicians, PAs and APRNs are 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, PAs and APRNs in each region to meet the minimum standards set out in (d). The provider network may include physicians, PAs and APRNs who are not contracted network health care providers, but they must be shown as in-network providers in the insurer's directory of network providers and treated as in-network when determining benefits for a covered person.
- In (e) a health care insurer may request to the director an exception to the minimum provider network standard for up to 36 months. The process for an exemption will be set in regulation by the director. The insurer must submit a plan to comply and also submit annual progress reports to the director.
- In (f) a health care insurer must attest or prove they meet the minimum provider network standards and provide supporting documentation to the director as part of their required rate filings. If standards are not met, the insurer must submit a plan of corrective action.
- In (g) allows the director to adopt regulations to implement this section and may also require that a

contracting region exceed the minimum network standards

Section 2. Repeals AS 21.07.020(3):

Sec. 21.07.020. Required contract provisions for health care insurance policy. A health care insurance policy must contain a provision

(3) that covered medical care services be reasonably available in the community in which a covered person resides or that, if referrals are required by the policy, adequate referrals outside the community be available if the medical care service is not available in the community;

Section 3. Sets an effective date for January 1, 2026

[4:41:44 PM](#)

At ease.

[4:42:08 PM](#)

CHAIR DUNBAR reconvened the meeting and invited Mr. Davis to testify.

[4:42:18 PM](#)

JEFFREY DAVIS, Principal, Weston Group Consulting LLC, Wenatchee, Washington, began his presentation, Provider Network Minimum Standards for Health Insurers. He said SB 122 purpose is to create provider network minimum standards and is a way to ensure health care for all Alaskans.

[4:42:51 PM](#)

MR. DAVIS moved to slide 2, What is a Narrow Provider Network, and stated that narrow network limits, which providers are included, is a common tactic in the Lower 48 where some markets exclude up to 80 percent of providers. He said out-of-network benefits are typically minimal, though Alaska currently requires them, something some payers want to change. he said insurers use narrow networks to gain market leverage by offering lower rates to one provider group while excluding another, which can reduce costs but also makes patient access to care more difficult.

[4:43:56 PM](#)

MR. DAVIS moved to slide 3, Why Does Alaska Need Minimum Network Standards, and stated that Alaska is already a federally designated healthcare provider shortage area, and allowing plans with even fewer providers could create networks too narrow to meet patient needs. The National Association of Insurance

Commissioners—considered the gold standard—states that the most important step a state can take is establishing minimum provider standards for a functioning healthcare and insurance market. By 2019, 38 states and territories had such standards, but Alaska does not. Without state-defined criteria, it's difficult to judge whether a network is adequate. This proposal would establish those standards, and some insurers have publicly expressed interest in offering these narrow-network products in Alaska.

[4:45:31 PM](#)

MR. DAVIS moved to slide 4, Impact of Narrow Networks, and stated that Narrow networks can limit access by excluding key specialty groups, creating longer wait times or forcing patients to seek care outside Alaska. He said consumers often judge plans simply by checking whether their current doctors are included, but they may not realize the network lacks needed specialists, something they only discover after developing a serious condition. He said narrow networks with little or no out-of-network coverage leave patients without needed care and also financially harm excluded providers, especially in markets like Alaska with only a few major insurers and already fragile practices.

[4:47:24 PM](#)

MR. DAVIS moved to slide 5, Solution and stated that the proposed solution is for the state to adopt Alaska-specific minimum network standards. Other states' models don't work well due to Alaska's unique geography and provider distribution, so a simpler, percentage-based approach is recommended. He said the plan includes a phased-in process, applies across specialties, and requires insurers to include a broad share of both providers and practices—for example, 85 percent of cardiologists and 85 percent of cardiology practices, not just one dominant group. This approach helps ensure adequate access and restores balance in insurer-provider negotiations. SB 122 would establish these Alaska-tailored standards.

[4:49:21 PM](#)

SENATOR CLAMAN opined that narrow networks are a bigger issue in large population centers like Seattle or San Francisco, where insurers can significantly limit access by excluding many providers. He said Alaska already functions like a narrow network simply because there are so few providers and few insurance carriers. He asked how Alaska achieves reasonable provider rates when the system already lacks both provider numbers and insurer competition.

[4:50:20 PM](#)

MR. DAVIS replied that the concern is that narrow networks function in large markets with many carriers and ample providers without destabilizing the system. He said Alaska is already in a provider-shortage area with a naturally narrow network. Further narrowing would strain the system and harm both patients and providers. Without state protections that limit how narrow a network can be, these products could negatively affect Alaskans and the provider community.

[4:51:32 PM](#)

SENATOR CLAMAN asked whether adopting SB 122 would create a state regulated price structure, and if not why not.

[4:51:40 PM](#)

MR. DAVIS replied that it is his belief that this isn't creating a state-regulated price structure because it addresses network adequacy, not prices. He said while insurers may claim narrow networks help lower costs, they also risk harming patients by limiting access and harming providers in an already small market. Minimum standards simply prevent networks from becoming too limited. Thirty-eight states and the NAIC consider such standards essential, and the goal is to put protections in place before narrow-network products enter Alaska and cause harm.

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CHAIR DUNBAR noted that he personally has a narrow-network plan through TRICARE and is often surprised by how few providers accept it. At times, no specialist in the entire state will take his insurance.

[4:53:11 PM](#)

SENATOR HUGHES noted that SB 122 won't fix Tricare. She asked what the insurance providers think of the proposal and whether they're likely to oppose it. She asked how current networks compare to the proposed 85-95 percent standards in the communities affected, and whether insurers might push back in a way that could limit the availability of insurance products in Alaska.

[4:54:28 PM](#)

MR. DAVIS said he can't speak for insurers, but he's confident they will push back. He said he doesn't know the current percentage of provider participation.

[4:54:52 PM](#)

SENATOR HUGHES reminded Mr. Davis of her second question about the 85-95 percent range.

MR. DAVIS replied that that narrow-network products haven't reached Alaska yet but are well established in the Lower 48. Since Alaska is already a provider-shortage area. He said the goal is to proactively set state-defined standards to prevent insurers from offering networks that include too few providers, which could limit access to care when patients need it.

[4:56:06 PM](#)

SENATOR HUGHES viewed SB 121 and 122 being in tandem. Between 2014 and 2017, some providers remained outside the network, driving higher prices and influencing the 80th-percentile standard. While SB 121 allows some providers to stay out of networks, SB 122 seeks to require broader inclusion. She asked if SB 122 is intended to prevent providers from opting out under SB 121 and is that why the two bills are paired.

[4:57:07 PM](#)

MR. DAVIS replied that the two bills work in tandem but have different purposes. SB 122 aims to prevent insurers from pushing providers out of networks to pit groups against each other and suppress rates. He noted that after most providers moved in-network, reimbursement levels were flat or declining under the 80th percentile, suggesting mainstream providers were not the ones driving costs up—only a few outliers outside the network were. He stated his belief that the price increases came from those outliers, not the broader provider community.

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CHAIR DUNBAR held SB 122 in committee.

[4:59:48 PM](#)

There being no further business to come before the committee, Chair Dunbar adjourned the Senate Health and Social Services Standing Committee meeting at 4:49 p.m.