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## Senator David Wilson

**Sectional Analysis**
**Senate Bill 45 v. D.A**
**"An act relating to insurance; relating to direct health care agreements; relating to the duties of the director of the division of insurance in the Department of Commerce, Community, and Economic Development; and providing for an effective date."**

**Section 1: Adds a new section (.025 Direct health care agreements) to AS 21 (Insurance) .03 (Scope of Code).**
**<u>Section (a), page 1, line 6 - 13:</u>** Allows a provider and a patient to enter into a direct health care agreement. Limits these agreements to primary care. This section also stipulates that Medicaid recipients under AS 47.47 and those receiving assistance for catastrophic illness and chronic or acute medical conditions under AS 47.08 are not eligible to enter a DHCA.

**<u>Section (b), page 1, line 14 – page 2, line 10:</u>** Requires providers entering into these agreements to accept new patients who are enrolled in Medicaid or Medicare or to maintain a practice were at least twenty percent of patients are Medicaid or Medicare recipients or uninsured.

**<u>Section (c), page 2, line 11 – page 3, line 3:</u>** Specifies what a DHCA must contain.

**(1)** It must describe the services a patient is entitled to for payment of a periodic fee.
**(2)** It must specify: the amount of the periodic fee, the length of period the fee covers, any additional fees the provider or business may charge.
**(3)** It must include contact information for a representative of the provider or business that is responsible for patient complaints and for patients request to amend the agreement.
**(4)** It must state that the agreement is not health insurance.

**<u>Section (d), page 3, line 4 - 5:</u>** Prohibits a provider from changing fees based on health care needs and patient sex.

**<u>Section (e), page 3, line 6 -11:</u>** Specifies that a provider may not decline to enter or terminate a DHCA solely based on a patient's status within a protected class.

**<u>Section (f), page 3, line 12 – 17:</u>** Specifies that a provider may decline to enter into an agreement if they are unable to provide the care the patient needs, or their practice is at capacity.

**Section (g), page 3, line 18 – 21:** Specifies that a provider may terminate a DHCA with a current patient based on their health status only if the provider is not able to provide the services the patient requires or in accordance with this section.

**Section (h), page 3, line 22 – 29:** Specifies that a patient may terminate an agreement within 30 days. Requires any fees and payments, less payments made for services the health care provider has already performed that are not included in the periodic fee.

**Section (i), page 3, line 30 – page 4, line 9:** Sets terms by which a health care provider may immediately terminate a DHCA.

**Section (j), page 4, line 10 - 12:** Specifies that a patient may terminate a DHCA immediately if a provider violates the terms of the agreement.

**Section (k), page 4, line 13 - 19:** Specifies that a provider may change the fee up to once a year, only with a written 45-day notice. A patient may cancel within those 45 days with no penalty.

**Section (l), page 4, line 20-22:** Specifies that a patient or provider can terminate an agreement with at least 30 days' notice.

**Section (m), page 4, line 23 - 26** Specifies that a provider may charge a termination fee if the patient cancels under (h).

**Section (n), page 4, line 27 – 31:** Specifies that a patient must pay the periodic fee, prorated through the date of termination if they cancel under (f) or (g).

**Section (o), page 5, line 1-3:** Specifies that the patient is billed by the provider at the end of the period covered by the fee.

**Section (p), page 5, line 4-9:** Allows an employer to pay the periodic fee on behalf of an employee. This does not mean the employer is a health insurance provider or business.

**Section (q), page 5, line 10 - 20:** Specifies that a DHCA is not insurance and is not regulated as such.

**Section (r), page 5, line 21, - page 6, line 2:** This is a "false advertising" clause. This section prohibits a provider from false advertising regarding a direct health care agreement. It specifically prohibits advertising these agreements as insurance or as an alternative to insurance.

**<u>Section (s), page 6, line 3 - 17:</u>** Requires the director of the Division of Insurance to adopt regulations regulating direct health care agreements in accordance with this act. Allows the director to impose civil penalties for violations of this act.

**<u>Section (t), page 6, line 18 - 20:</u>** Specifies the period in which the civil fees imposed by the director must be paid.

**<u>Section (u), page 6, line 21, - page 7, line 12:</u>** Defines: direct health care agreement, health care business, health care insurance, health care insurer, health care provider, health care service, health insurance, health maintenance organization, medical services corporation, and primary care provider.

**Section 2, page 7, line 13 – 18: Adds a transition language to uncodified law.** Allows the director of insurance to immediately begin adopting regulations necessary to implement this act.

**Section 3: Immediate effective date for section 2.**

**Section 4: Effective date of January 1, 2024, for the rest of the act.**