

ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

March 17, 2016

3:06 p.m.

MEMBERS PRESENT

Representative Paul Seaton, Chair
Representative Liz Vazquez, Vice Chair
Representative Louise Stutes
Representative David Talerico
Representative Geran Tarr
Representative Adam Wool

MEMBERS ABSENT

Representative Neal Foster

COMMITTEE CALENDAR

HOUSE BILL NO. 234

"An Act relating to insurance coverage for mental health benefits provided through telemedicine."

- MOVED HB 234 OUT OF COMMITTEE

HOUSE BILL NO. 237

"An Act relating to an interstate compact on medical licensure; amending the duties of the State Medical Board; and relating to the Department of Public Safety's authority to conduct national criminal history record checks of physicians."

- MOVED HB 237 OUT OF COMMITTEE

HOUSE BILL NO. 344

"An Act relating to the controlled substance prescription database; and providing for an effective date."

- SCHEDULED BUT NOT HEARD

PREVIOUS COMMITTEE ACTION

BILL: HB 234

SHORT TITLE: INSURANCE COVERAGE FOR TELEMEDICINE

SPONSOR(S): REPRESENTATIVE(S) VAZQUEZ

01/19/16 (H) PREFILE RELEASED 1/8/16
 01/19/16 (H) READ THE FIRST TIME - REFERRALS
 01/19/16 (H) HSS, L&C
 03/15/16 (H) HSS AT 3:00 PM CAPITOL 106
 03/15/16 (H) Heard & Held
 03/15/16 (H) MINUTE(HSS)
 03/17/16 (H) HSS AT 3:00 PM CAPITOL 106

BILL: HB 237

SHORT TITLE: INTERSTATE MEDICAL LICENSURE COMPACT
 SPONSOR(S): REPRESENTATIVE(S) SEATON

01/19/16 (H) PREFILE RELEASED 1/15/16
 01/19/16 (H) READ THE FIRST TIME - REFERRALS
 01/19/16 (H) HSS, FIN
 01/26/16 (H) HSS AT 3:00 PM CAPITOL 106
 01/26/16 (H) Scheduled but Not Heard
 01/28/16 (H) HSS AT 3:00 PM CAPITOL 106
 01/28/16 (H) Heard & Held
 01/28/16 (H) MINUTE(HSS)
 03/15/16 (H) HSS AT 3:00 PM CAPITOL 106
 03/15/16 (H) Scheduled but Not Heard
 03/17/16 (H) HSS AT 3:00 PM CAPITOL 106

WITNESS REGISTER

ANITA HALTERMAN, Staff
 Representative Liz Vazquez
 Alaska State Legislature
 Juneau, Alaska

POSITION STATEMENT: Presented HB 234 on behalf of the bill sponsor, Representative Vazquez.

LYN FREEMAN, MD
 Mind Matters Research
 Anchorage, Alaska

POSITION STATEMENT: Testified during discussion of HB 234.

MICHAEL SOBOCINSKI
 Alaska Psychological Association
 Anchorage, Alaska

POSITION STATEMENT: Testified in support of HB 234.

ROBERT LANE, MD
 Alaska Pacific University
 Alaska Psychological Association
 Anchorage, Alaska

POSITION STATEMENT: Testified in support of HB 234.

DIANE INGLE
Anchorage, Alaska

POSITION STATEMENT: Testified in support of HB 234.

ROBIN MINARD, Director
Public Affairs
Mat-Su Health Foundation
Wasilla, Alaska

POSITION STATEMENT: Testified in support of HB 234.

MARGARET BRODIE, Director
Director's Office
Division of Health Care Services
Department of Health and Social Services
Juneau, Alaska

POSITION STATEMENT: Answered questions during discussion of HB 234.

RANDALL BURNS, Director
Central Office
Division of Behavioral Health
Department of Health and Social Services
Juneau, Alaska

POSITION STATEMENT: Testified during discussion of HB 234.

KATE BURKHART, Executive Director
Advisory Board on Alcoholism & Drug Abuse
Division of Behavioral Health
Department of Health and Social Services
Juneau, Alaska

POSITION STATEMENT: Testified during discussion of HB 234.

TANEEKA HANSEN, Staff
Representative Paul Seaton
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Presented HB 237 on behalf of the bill sponsor, Representative Seaton.

JAY BUTLER, MD, Chief Medical Officer/ DPH Director
Central Office
Division of Public Health
Department of Health and Social Services
Anchorage, Alaska

POSITION STATEMENT: Answered questions during discussion of HB 237.

KEVIN LUPPEN
Alaska State Medical Board
Anchorage, Alaska

POSITION STATEMENT: Testified in support of HB 237.

ACTION NARRATIVE

[3:06:37 PM](#)

CHAIR PAUL SEATON called the House Health and Social Services Standing Committee meeting to order at 3:06 p.m. Representatives Seaton, Stutes, Vazquez, Tarr, and Talerico were present at the call to order. Representative Wool arrived as the meeting was in progress.

HB 234-INSURANCE COVERAGE FOR TELEMEDICINE

[3:07:14 PM](#)

CHAIR SEATON announced that the first order of business would be HOUSE BILL NO. 234, "An Act relating to insurance coverage for mental health benefits provided through telemedicine."

[3:08:09 PM](#)

ANITA HALTERMAN, Staff, Representative Liz Vazquez, Alaska State Legislature, paraphrased from the Sponsor Statement [included in members' packets], which read:

This bill seeks to require health care insurers that offer, issue, or renew insurance plans in Alaska to reimburse mental health professionals for medically necessary services delivered using telemedicine via secure phone or internet video applications. This legislation would not require an initial face to face visit but requires providers be licensed in Alaska.

There is no law in Alaska requiring private insurance companies that provide mental health benefits to reimburse for services provided through telemedicine. There are thousands of Alaskans across the state that have private health insurance but have little or no access or choice of professional mental health

providers because some private insurers do not reimburse for telephonic or video mental health counseling. Currently, mental health providers and individuals must demonstrate to some insurance companies that the individual has a severe mobility issue and cannot obtain counseling where they live, or that an emergency exists. In many cases individuals are still often refused reimbursement for mental health services furnished through telemedicine.

Alaska's Medicaid program funds most mental health services for individuals with severe or chronic mental illness. Medicaid regulations clearly allows payment for telemedicine delivery, and do not require face-to-face visits. Thus, there is currently a double standard in Alaska between public and private health care reimbursement for services furnished through telemedicine. The national trend is to allow for reimbursement for mental health services provided through telemedicine. According to the Center for Connected Health Policy, State Telehealth Laws and Medicaid Programs Policies, 32 states and the District of Columbia currently have telehealth parity laws, some of which will go into effect by 2016 and 2017. An interactive map from the Center for Connected Health Policy can be retrieved online at <http://cchpca.org/state-laws-and-reimbursement-policies>.

Historically, there was a reluctance to reimburse for services delivered through telemedicine because there was no established code of ethics regarding electronic counseling and no secure video or telephonic resources. However, today the mental health counseling profession has to comply with the national Telemedicine Codes of Ethics addressing internet services. In addition, there are free encrypted, HIPAA compliant telephone and video conferencing applications that work with low broadband internet. Thus, with the current available technology and code of ethics regulating the professional use of this technology, there are numerous advantages to both patients and Alaskan mental health providers.

Advantages of Telemedicine:

- Provides for better access/privacy in rural and remote as well as urban areas of Alaska
- Early intervention is key to prevention, which saves money
- Often individuals will seek counseling earlier in distress if they aren't seen entering an office
- Alaskans with mild to moderate needs may seek help that is more convenient/accessible
- It saves time and money for many patients if they do not have to leave home or office
- Greater access for referrals to providers who specialize in treating specific issues
- Better access means a potential reduction in suicides, domestic violence and more serious crises
- Costs are expected to be the same to insurance companies as face to face counseling
- Zero impact on state budget

In summary, this proposed legislation is very limited in scope. First, it does not require insurers to provide or cover mental health benefits. It only requires insurers that presently offer mental health benefits to reimburse for these benefits delivered through telemedicine. In addition, this bill requires that the mental health service be provided "by a health care provider licensed in this state".

In conformance with the mental health profession, this bill uses the term "mental health" versus "behavioral health". Research has shown that both terms are used interchangeably by those in the mental health profession and that the term "behavioral health" is not defined within Alaska Statute or regulation.

MS. HALTERMAN explained that the bill sponsor had included in members' packets a definition of telemedicine, which read:

7 AAC 12.449. Definitions. "Telemedicine" means the practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of medical data, audio, visual, or data communications that are performed over two or more locations between providers who are physically separated from the recipient or from each other.

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MS. HALTERMAN stated that it was necessary for a review of the definition for behavioral health to be included in statute. She relayed that it was necessary to address the concerns for the potential shortage of providers for substance abuse needs and she spoke about the possibilities of treatment for substance abuse through telemedicine. She acknowledged the obligation for licensing of the provider, and that some people felt that a face to face encounter was necessary prior to engagement in telemedicine. She expressed a preference to leave the decisions for best practices to the medical professionals rather than dictate through public policy. She stated that she was not supporting this change, but would prefer to keep the proposed bill simple, as it ensured parity and was consistent with the work in most other states. She relayed that telemedicine was reimbursed in more than 32 states, and she gave Alaska an A+ for its Medicaid reimbursement for telemedicine, but an F for its private sector reimbursement. She declared that it was time for that [private sector reimbursement for telemedicine] to change.

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CHAIR SEATON directed attention to the sponsor statement which stated that mental health and behavioral health definitions were used interchangeably, yet the definition for behavioral health in the proposed bill, which included substance abuse and counseling, would not be covered in the proposed bill. He suggested the need to look at that more carefully. He expressed his understanding that there may not be enough providers for substance abuse, alcohol treatment, and other similar issues. He surmised that should telehealth be eliminated as a mechanism for providing that counseling, there would not be any expansion of the provider pool because it was not legal for reimbursement. He reported that this was concern voiced by the Alaska Mental Health Board Advisory Board on Alcoholism and Drug Abuse and may be addressed further.

REPRESENTATIVE VAZQUEZ relayed that the sponsor did not want to mandate what constituted mental health services to the insurance companies. The bill simply stated that mental health services which were offered, also needed to be available via telemedicine. She declared that this was not expanding or mandating anything further to the insurance companies. She pointed to the shortage of providers, with individuals in need of services, and many outlying villages not very accessible.

CHAIR SEATON offered his belief that this was not a discussion for expansion of the definition to include other things, but

that coverage of substance abuse, alcoholism, and counseling should also be offered through telemedicine. He declared that he was not advocating expansion of the bill or the requirements. He opined that the bill stated that if those services were already offered, then they should also be provided by telemedicine. He pointed out that the current definition specifically excluded alcoholism or drug abuse counseling, and he was unclear if that was the intent.

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MS. HALTERMAN pointed out that neither Alaska's statute nor regulation currently defined behavioral health, although she discovered that behavioral health was defined in 7 AAC 70.996 as "the outpatient evaluation or treatment of an individual's mental health or substance use." In 7 AAC 160.990.87, it was defined as a behavioral health clinic service; and in 7 AAC 135.010(c), behavioral health rehabilitation services was identified. She stated that mental health benefits were defined as the following in state statute, AS 21.54.500, under definitions (22), she read:

benefits provided for mental health services as defined under the terms of a health care insurance plan but does not include benefits for treatment of substance abuse or chemical dependency.

MS. HALTERMAN reiterated that behavioral health had not been defined in the insurance statute, hence the lack for a consistent definition. She reported that a general term definition for behavioral health had been found in the federal agency, Substance Abuse and Mental Health Services Administration (SAMHSA) which encompassed the promotion of emotional health, the prevention of mental illness and substance abuse use disorders, and treatment and services for mental and/or substance use disorders. She relayed that the lack of definition in state statute had road blocked them.

CHAIR SEATON asked whether this bill would require coverage through telemedicine for a private insurance company currently covering substance abuse or behavioral health. He asked if this was the intention of the bill.

REPRESENTATIVE TARR shared that she had not yet fully resolved her comfort level regarding the requirement for the in-person contact, as there could be an emergency circumstance, and she would not want that to preclude the delivery of telehealth

services. She added that a lot of the experience with mental health services and its indicators related to demeanor, behavior, and overall appearance. She suggested a search for the sweet spot where things were not limited unnecessarily, but to also encourage the initial in-person assessment.

MS. HALTERMAN offered to share an analysis which addressed the states' positioning on telemedicine. She stated that there were also national standards provided for telemedicine. [Included in members' packets.] She declared that the proposed bill did not change the provider responsibility to determine its own best practice, it left the decision in the hands of the provider and not the insurance company.

REPRESENTATIVE TARR directed attention to page 1, line 9, of the proposed bill, and read: "and may not require that prior in-person contact occur..." She questioned whether this language could be made less restrictive, as her interpretation was the opposite of that from Ms. Halterman. She asked that the Legislative Legal Services "help sort that out." She directed attention to the 288 page Best Practices document.

MS. HALTERMAN replied that the bill addressed an obligation of the insurance industry, not the medical professional, as it imposed the requirement that the insurance company not enact the face to face requirement. She relayed that, if the provider determined that the face to face encounter was the best practice, they had the right to make that medical decision when dealing with the patient.

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CHAIR SEATON directed attention to page 1, line 5, of the proposed bill, and clarified that nothing precluded a health care insurer from offering mental health and substance abuse counseling through telemedicine, although nothing required the insurer to offer this through telemedicine.

MS. HALTERMAN expressed her agreement.

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CHAIR SEATON opened public testimony.

[3:32:00 PM](#)

LYN FREEMAN, MD, Mind Matters Research, reported that she was a clinical researcher, as well as a private provider for chronic diseases, mental illness, and mental stress. She mentioned the issue of provider determination for appropriate treatment by telemedicine, and assured the committee that even the first contact through telemedicine was good. She encouraged the committee not to limit this contact. She reported that she had created a mental health intervention, through a grant from the National Institutes of Health, to overcome the long term and late term side effects of cancer and its treatments. She noted that this intervention had been clinically designed, tested, and delivered in Alaska. She stated that it was delivered "first and foremost" to improve the quality of life and the medical outcomes of Alaskans. She added that this had also been delivered in the State of Washington as "a multi trial effect." She delivered this mental health support to patients in Alaska, as it had been found to be highly effective in reducing and reversing symptoms. She relayed that she had been treating patients in her office, but had recognized that access for face to face treatment was too expensive for many areas of the state. She declared that, although she would prefer to have a face to face delivery, the telemedicine delivery was "every bit as efficacious and beneficial to the patients it served as the ones that I treated in person." She directed attention to nationwide research on telemedicine for similar results. She acknowledged that there were situations when it was necessary to have the patient in person, and that professionals were aware of the need to identify these situations. She stated her support of the proposed bill.

REPRESENTATIVE VAZQUEZ asked for an example to the lack of telemedicine becoming a barrier to access for treatment.

DR. FREEMAN declared that there were five people just this week who she had not been able to schedule for weekly visits for a variety of reasons.

REPRESENTATIVE VAZQUEZ asked how many patients had been affected so far this year due to the lack of telemedicine.

DR. FREEMAN opined that there were about 40 patients, although she had severely limited her treatment schedule to those whom she could personally treat. She stated that passage of the proposed bill would allow her to make this treatment more available.

REPRESENTATIVE TARR asked for a description regarding the face to face meetings and whether they were a necessity.

DR. FREEMAN explained that she used HIPAA compliant programs for phone calls which allowed for the ability to visualize the patient and interact live in real time. She pointed out that telemedicine was defined in some states as face to face, per the ability to see someone's face, although that definition did vary from state to state. She declared that often a phone call could offer plenty of evidence for whether there should be a treatment in-person. She said that she was able, almost every time, to have a first meeting with a patient with a visual form of telemedicine. She reported that the patient only needed a computer with a screen, and a quiet, private place. She declared that the purpose and intent was to serve people in the least stressful and most convenient way as these populations were already overwhelmed and did not need additional stressors and barriers in their way.

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MICHAEL SOBOCINSKI, Alaska Psychological Association, declared support of the proposed bill by the association. They believed that the use of technology, such as telemedicine, was critical in Alaska in order to provide access to needed health care services, especially in the provision of mental health services. He affirmed that there had been many obstacles to access, and he opined that the proposed bill would help advance health care.

CHAIR SEATON asked if there was any problem with the various definitions for mental health when billing the insurance companies for care provision to mental health or substance abuse issues.

MR. SOBOCINSKI replied that he worked in the community mental health center, and he was not as familiar with insurance in the private sector. He stated that very often people with mental health issues had co-occurring substance use problems, and that most providers would see people with both issues. He offered his belief that the definitions would be determined by the private insurance providers.

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ROBERT LANE, MD, Alaska Pacific University, Alaska Psychological Association, expressed his support for the proposed bill, as it put private providers on equal footing with those in the

Medicaid system. He reported that, as part of the training facility, they were teaching students to be well-practiced with the ability to do telemedicine. He added that, as a psychologist in private practice he had focused almost entirely on substance abuse, and that there had never been a problem with his billing for treatment under his psychologist license. He pointed out that a letter for support had been sent. [Included in members' packets.]

[3:46:59 PM](#)

DIANE INGLE reported that she had sent a letter in support of the proposed bill from a patient perspective [included in members' packets]. She shared that she had long term challenges with mental health, and that she had been fortunate enough to always receive treatment for services, which allowed her to have a successful educational experience, earning a graduate degree in public health. She reported that she had served the Municipality of Anchorage as the Director of the Department of Health and Human Services. She shared that she had found that mental health counseling in conjunction with any medical management was the best way to deal with the issue. She pointed out that many people in Alaska were socially isolated for a variety of reasons including sexual and physical abuse, and were not given the opportunity to easily leave their home to seek counseling. She noted that there were times when it was not possible to go to the provider, which were often the times when she was most in need to talk with her provider. She shared that she felt compelled to share her story because she believed that mental health had all too often been pushed out of sight, and it was necessary to "bring good quality services and help people who can be successful, be successful."

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ROBIN MINARD, Director, Public Affairs, Mat-Su Health Foundation, reported that the Mat-Su Health Foundation shared ownership in the Mat-Su Regional Medical Center and invested its profits from this partnership back into the community in order to improve the health and wellness of Alaskans living in the area. She declared support for HB 234, as it increased the access to needed mental health services provided by telemedicine. She asked that there be inclusion for substance abuse disorders along with mental health in the proposed bill, as it would encourage more providers to do the necessary work to "get into telemedicine." She reported that a 2013 community health needs assessment from more than 500 Mat-Su residents had

identified that the top five health and wellness goals for the community were all related directly to access to behavioral health care. She stated that this assessment data made clear that the residents did not have access to vital care for mental health and substance abuse disorder needs. She shared that, without this access, many people could not seek needed care until the situation became a crisis, with a visit to the emergency room of a hospital. She reported that, in 2013, alcohol related disorders for behavioral health care were the number one reason for emergency room visits to the Mat-Su Regional Medical Center, at a cost of \$23 million not including the doctor, emergency medical service (EMS), or police costs. She declared that telemedicine was a proven way to increase access to health care, pointing out that recruiting and retaining an effective behavioral health workforce was difficult in states with large rural populations, similar to Alaska. She stated that, statewide, Alaska had significantly lower rates of psychiatrists, psychologists, substance abuse counselors, and marriage and family counselors compared to the national average, with both Alaska and the Mat-Su designated as federal mental health shortage areas. She reported that data had shown that there were several behavioral health providers who had not been able to find psychiatrists to work on-site, hence the need for telemedicine to get access to medication management services for the clients. She reported that there was a tremendous need in the Matanuska-Susitna Borough for infant and early childhood mental health specialists. She emphasized that the cost for travel to receive and provide mental health and substance abuse care was tremendous, and ultimately lead to the treatment of problems at a crisis level, instead of earlier when care was less expensive. She shared the experiences of a local provider now offering telemedicine, stating that the provider had "seen no significant difference in the effectiveness of the service provided via telemedicine versus traditional in-office visits." She reported that 86 percent of those telehealth clients had evidenced a reduction in substance use, while 100 percent reported being treated with respect, and 85 percent evidenced an increase in their quality of life as a result of participation in the program.

MS. MINARD shared a University of Maryland study from 2003 which examined the distance travelled for out-patient substance abuse treatment and its impact of client retention. This report stated that clients who travelled less than one mile were 50 percent more likely to complete treatment than those who travelled more than one mile, with everything else consistent. She noted that clients in the local telehealth program, with no

distance to travel, had a 33 percent lower no-show rate than clients in traditional treatment groups.

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MARGARET BRODIE, Director, Division of Health Care Services, Department of Health and Social Services, said that the department fully supported telemedicine and that it was a really good way for the state to save money.

3:59:32 PM

RANDALL BURNS, Director, Central Office, Division of Behavioral Health, Department of Health and Social Services, reiterated that the department was fully in support of telehealth and believed that parity was a very important issue.

CHAIR SEATON asked if the department had any further comments on parity, and if they dealt with any private insurance.

MR. BURNS said that the department did not deal with private insurance.

MS. BRODIE said that this would affect the Medicaid program as many services it currently paid for would be billed back to the insurance companies, thereby recovering the money for the state.

CHAIR SEATON mused that a private insurance company which paid for counseling for chemical dependency was not required to offer this through telemedicine. He asked, if the proposed bill required that private insurance which offered substance abuse services must also offer counseling through telemedicine, what effect this would have on Medicaid.

MS. BRODIE replied that this would increase the collectable amount from insurance companies, as the services would increase.

REPRESENTATIVE VAZQUEZ asked for a specific example for how the proposed bill would benefit the Medicaid program.

MS. BRODIE explained that for the use of telehealth with chemical dependency counseling, if an individual had insurance and Medicaid for these services, the Medicaid program would bill the insurance companies for those costs, and would save money in other areas by reducing the utilization of emergency rooms and primary care. Patients would receive the proper care and treatment in the appropriate setting.

MR. BURNS added that there were occasions when the provision of tele-behavior health services for consultation to an individual awaiting transfer to Alaska Psychiatric Institute (API), thereby avoiding the necessity for transfer, would allow for the private insurance to be billed.

REPRESENTATIVE VAZQUEZ asked how much this would have saved in FY15.

MR. BURNS replied that it did not happen that often as it was currently difficult to connect a patient with a psychiatrist in an emergent situation, although it had been possible upon occasion.

REPRESENTATIVE WOOL asked for clarification about a patient with private insurance and Medicaid.

MS. BRODIE explained that Medicaid was the payer of last resort, so any other health care insurer was billed for any covered services.

REPRESENTATIVE WOOL mused that, as Medicaid was the safety net for covering costs that private insurance did not cover, it was important for the State of Alaska to have private insurance pay for telemedicine. He asked if insurance covered substance abuse with telemedicine if it was not the primary issue.

MS. BRODIE, in response to Chair Seaton, explained that, if insurance does not cover a service through telemedicine, and an individual has Medicaid, then the state would pay for this through Medicaid because Medicaid does cover that service. However, if the insurance company did cover this service and it was also offered through telemedicine, it would be possible to bill them.

REPRESENTATIVE WOOL asked about the travel expenses for treatment paid by Medicaid, and offered his belief that there would be savings with telemedicine.

MS. BRODIE said that was correct, that there would be savings for travel and lodging, as well.

REPRESENTATIVE VAZQUEZ asked for the amount of savings from travel and lodging.

MS. BRODIE said that she did not have a figure available, and that she was unsure for finding them.

4:12:19 PM

CHAIR SEATON closed public testimony after ascertaining that no one further wished to testify.

4:12:26 PM

REPRESENTATIVE VAZQUEZ said that the Medicaid program had model regulations for telemedicine legislation, touted as best practices nationally.

CHAIR SEATON questioned whether behavioral health and substance abuse should also be required for coverage by telemedicine, if it was already covered in an insurance plan. He relayed that testimony had indicated telemedicine was much more effective for consistency and follow up, and that improvement to the success rate for substance abuse would go up. He acknowledged that the House Health and Social Services Standing Committee did not "do too much with private insurance," although the bill would next be heard in the House Labor and Commerce Standing Committee which specifically worked with these definitions. He offered his belief that the committee should arrive at a correct definition to ensure that the behavioral health services covered by private insurance should also be covered by telemedicine. He stated that this would not be an expansion of private insurance coverage. He expressed concern for forwarding his own conceptual amendment, and asked that the sponsor of the proposed bill write an amendment to be included with the bill during its hearing in the House Labor and Commerce Standing Committee. He offered his belief that:

it's a good bill and has a lot of issues that it's covering, but I think that substance abuse is so profound and prolific here in our state that if we could address that and make treatment of substance abuse more effective, I think that that's something that we should seriously consider in the offering of telemedicine.

4:15:46 PM

REPRESENTATIVE TARR expressed her concern for a circumstance with co-occurring disorders when the provider states that it can only help with part of the problem. She acknowledged that the

proposed bill only dealt with one specific component, mental health services.

CHAIR SEATON asked if substance abuse was defined in state statute, suggesting that this definition could be cited.

MS. HALTERMAN offered her belief that the definition was not included in state statute. She shared that there had been a change within the Department of Health and Social Services that integrated behavioral health, mental health issues, and substance abuse, and these all used the same standard set of billing codes for these services. She pointed out that there was the potential side effect that individuals had to lose their employment in order to gain Medicaid coverage for the necessary treatment.

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MR. BURNS opined that there were still some issues around the coding for the services that these were not as integrated as preferred.

MS. BRODIE reported that the Department of Health and Social Services was working to make headway on the coding to make it work for the providers in Alaska. She noted that there had been substantial changes to the medical billing and the diagnosis codes.

REPRESENTATIVE TARR asked whether the accessibility to a computer and internet service for an individual who could not afford these would be considered a part of the service so the insurance provider would assist with availability.

MS. BRODIE explained that telemedicine was not limited to video, that it could be telephonic, as well.

REPRESENTATIVE TARR asked if a telephone was the only technological necessity.

MS. BRODIE expressed her agreement.

[4:22:16 PM](#)

CHAIR SEATON re-opened public testimony.

[4:22:28 PM](#)

KATE BURKHART, Executive Director, Advisory Board on Alcoholism & Drug Abuse, Division of Behavioral Health, Department of Health and Social Services, offered a definition of substance abuse treatment, as defined in statute, AS 47.37.270(15), which she read:

a broad range of emergency, outpatient, intermediate, and in-patient services and care that may be extended to alcoholics, intoxicated persons, or drug abusers, including diagnostic evaluation, medical, psychiatric, psychological and social service care, vocational rehabilitation, and career counseling.

MS. BURKHART stated that this was a different definition than that definition for treatment for mental illness or mental health in the community mental health act.

[4:24:01 PM](#)

CHAIR SEATON closed public testimony on HB 234.

[4:24:18 PM](#)

REPRESENTATIVE TARR said that she was supportive of the intentions of the proposed bill, although she had some concerns with the substance abuse issues.

REPRESENTATIVE VAZQUEZ opined that, as the bill was being referred to the House Labor and Commerce Standing Committee, they were well versed in insurance issues. She suggested that some of these issues may be moot per mandates of the Patient Protection and Affordable Care Act, although, she admitted to being not versed on these requirements.

CHAIR SEATON stated that the focus was only for the telemedicine portion, and that it was either [PP]ACA compliant or offered by private insurance. He pointed out that if coverage was offered, it had to be extended to include telemedicine.

REPRESENTATIVE WOOL asked about a limitation to the availability of providers, as well as considerations for the coding issues and co-occurrence with other mental illness.

MS. HALTERMAN expressed her agreement that there were some outstanding questions that still needed to be addressed, including a clear definition in state statute for behavioral health, and the shortage of providers to serve these

populations. She stated that she would like to move forward with the requirement for mental health coverage, with a promise to explore these other issues.

REPRESENTATIVE VAZQUEZ reported that there was a definition of mental illness in AS 47.30.915(c)(14), and she stated:

mental illness means an organic mental or emotional impairment that has substantial adverse effects on an individual's ability to exercise conscious control of the individual's actions or ability to perceive reality or to reason or understand; intellectual disability, developmental disability, or both; epilepsy, drug addiction, and alcoholism do not per se constitute mental illness, although person's suffering from these conditions may also be suffering from mental illness.

REPRESENTATIVE VAZQUEZ pointed out that the current definition excluded drug addiction and alcoholism.

CHAIR SEATON clarified that this was not an attempt to expand the definition of mental health. If coverage for substance abuse treatment was offered, then this should also be offered through telemedicine. He said that he was comfortable moving forward with the proposed bill.

REPRESENTATIVE VAZQUEZ expressed her agreement that she would prefer to move the bill forward to the next committee of referral.

CHAIR SEATON suggested having an amendment written.

REPRESENTATIVE TARR said that she would not object to moving the proposed bill, and expressed her desire that the House Labor and Commerce Standing Committee could resolve the issue.

[4:31:43 PM](#)

REPRESENTATIVE VAZQUEZ moved to report HB 234, Version 29-LS1251\A, out of committee with individual recommendations and the accompanying fiscal notes. There being no objection, HB 234 was moved from the House Health and Social Services Standing Committee.

[4:32:25 PM](#)

The committee took an at-ease from 4:32 p.m. to 4:35 p.m.

HB 237-INTERSTATE MEDICAL LICENSURE COMPACT

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CHAIR SEATON announced that the final order of business would be HOUSE BILL NO. 237, "An Act relating to an interstate compact on medical licensure; amending the duties of the State Medical Board; and relating to the Department of Public Safety's authority to conduct national criminal history record checks of physicians."

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TANEEKA HANSEN, Staff, Representative Paul Seaton, Alaska State Legislature, stated that this was model legislation, and that there were currently 12 states in the Compact, with 14 other states, including Alaska, considering this legislation. She paraphrased from the FAQ [included in members' packets], which read:

The Interstate Medical Licensure Compact would create a new pathway to expedite the licensing of physicians seeking to practice medicine in multiple states. The proposal could increase access to health care for individuals in underserved or rural areas and allow patients to more easily consult medical experts through the use of telemedicine technologies. The Compact would make it easier for physicians to obtain licenses to practice in multiple states and would strengthen public protection because it would help states share investigative and disciplinary information that they cannot share now.

MS. HANSEN reviewed the proposed bill, and stated that the first six Sections were conforming language and applied to existing state statute of the medical board. These sections directed the board to implement the Compact. She directed attention to Section 2, which added to the board requirement that a physician shall submit their fingerprints along with their application and fees for an expedited license and a national criminal history record check. She noted that the medical board did not currently do background checks for applicants, and were not currently authorized to do so. She pointed out that a background check was required for this expedited license.

CHAIR SEATON clarified that an expedited license through the Compact would have a more thorough background check than someone solely applying for a license in Alaska.

MS. HANSEN expressed agreement, specifically for the criminal background check connected with fingerprints. She surmised that unless a background check was specifically noticed in statute, it was not allowed.

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MS. HANSEN moved on to page 5 of the proposed bill, and addressed the definition for an eligible physician to this expedited license, which included graduation from an accredited medical school, passing each component of a licensing examination, successfully completing graduate medical education, a specialty certification from the American Board of Medical Specialists, and a full and unrestricted license to engage in the practice of medicine. They would also never have been convicted of an offense by a court of appropriate jurisdiction, never held a license subject to discipline, and were not under active investigation.

MS. HANSEN stated that there were similar licensing requirements by the State of Alaska, which included graduation from a medical school and no encumbrance on your license. She relayed that the requirements under the Compact were more specific, noting that Alaska did not require the specialty certification. She reported that the idea behind the Compact was to allow any physician who qualified to pay the necessary fees and have license in another Compact state. They would be responsible for all medical and malpractice laws in each state they were licensed. She shared that there were concerns for the relinquishing of state authority to the federation of state medical boards; however, she pointed out that each of the voting members of the Commission were members of the state medical board from the member states.

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REPRESENTATIVE TARR referenced the aforementioned letter from Ms. Maureen Powers, dated February 11, 2016, [included in members' packets], which read: "There is no discretion to look at moral character, malpractice history, training irregularities, or other requirements." She asked what would happen in a circumstance related to any of those issues if one of the Compact states had a more restrictive statute than

another; which would take precedence, the more restrictive or the least restrictive.

MS. HANSEN explained that the qualifications for the expedited licenses were presented in the Compact. She stated that these were stricter than the Alaska statutes, as the Compact was drafted to be the strictest version of the licensure requirements; hence the reason for inclusion of the specialty certification. She relayed that an intention of the Compact was to hold those physicians applying for the expedited licensure to the highest level of requirements. She noted that a physician could apply using a normal procedure through the individual state medical boards if they did not qualify for the expedited license.

REPRESENTATIVE TARR asked about the cost of the recertification process mentioned in the aforementioned letter, and whether it was possible to "sync up" during the next natural recertification.

MS. HANSEN replied that the Compact had no effect on current licensees unless they desired to get an expedited license for automatic licensing in other Compact states.

REPRESENTATIVE TARR mused that the physician could then continue their scope of practice and not engage in activities outside the state.

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CHAIR SEATON reminded the committee that the proposed bill was being considered because it took so long for many doctors to get licensed in Alaska, and that this was an attempt to make the system work better to more easily get physicians into the state. He stated that, as the state did not want to lose doctors because of delays in the state's system, a doctor already having a license in a Compact state could more easily get the expedited license. He emphasized that all the fees still had to be paid.

REPRESENTATIVE WOOL asked if this would affect a newly licensed medical professional coming to Alaska to practice for the first time.

MS. HANSEN replied that, as a requirement to receive the expedited license was to already possess a license, they would have to go through the examination process.

CHAIR SEATON pointed out that someone with a specialty license, as well as licenses in other states, who was still waiting for an Alaska license under the current system, could apply through the Compact if they met all the other criteria. He clarified that a specialty license included family practice and preventative medicine, and was not limited to brain surgery.

MS. HANSEN explained that any disciplinary action or suspension in one state would result in notification to the other Compact states, each of which would then decide whether to maintain the action or reinstate the license.

REPRESENTATIVE WOOL asked if a practitioner in another state could come to Alaska and apply for a license through the current system, opting to not apply through the Compact because of a prior disciplinary action in a Compact state.

MS. HANSEN replied that the Alaska State Medical Board would also review disciplinary actions, but allowed for the possibility of more leniency should the board decide that action was not a concern. She opined that for a physician applying under the language of the Compact, the Alaska State Medical Board would not have this discretion.

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CHAIR SEATON opened public testimony.

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JAY BUTLER, MD, Chief Medical Officer/ DPH Director, Central Office, Division of Public Health, Department of Health and Social Services, listed some of the advantages for participation in the Compact which included increased ease in recruiting and faster "on-boarding" of providers when they arrived in Alaska. This allowed for providers and sub-specialty providers to begin service more quickly in underserved areas and facilities. He reported that this also streamlined the participation and availability by out of state providers in limited emergency and disaster responses, those events that were not big enough to lead to a state disaster declaration and the use of federal assets, such as a localized infectious disease outbreak.

REPRESENTATIVE WOOL asked if this would allow the inclusion of providers from another Compact state through telemedicine. This would allow medical personnel to have multiple licenses while residing in only one state.

DR. BUTLER replied that it would be included if the requirement for provision of telemedicine services included medical licensing in Alaska.

CHAIR SEATON shared that these requirements included those in the upper levels of the profession to receive the expedited license.

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KEVIN LUPPEN, Alaska State Medical Board, stated the support of the Alaska State Medical Board for the proposed bill, HB 237. He offered a personal anecdote for the loss of practitioners because of the current delays in licensing.

REPRESENTATIVE TARR asked if the Alaska State Medical Board were related to the Federation of State Medical Boards.

MR. LUPPEN replied no.

REPRESENTATIVE TARR asked if there was any mistrust with this national organization.

MR. LUPPEN replied that there had not been any concern from the state board with the national organization, and that some trends and expertise had been provided to the state board. He stated that he had not seen any potential threats from the national organization.

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CHAIR SEATON directed attention to page 7, line 8, of the proposed bill which stated the requirement that a formal license application had to be submitted, contrary to the claims of the aforementioned letter to the committee.

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CHAIR SEATON closed public testimony after ascertaining no one further wished to testify.

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REPRESENTATIVE VAZQUEZ directed attention to page 4, line 2, of the proposed bill, and she highlighted that the Compact did not

change the existing medical practice act of the state. She read from page 4, line 7, of the proposed bill:

State medical boards that participate in the Compact retain the jurisdiction to impose an adverse action against a license to practice medicine in that state issued to a physician through the procedures in the Compact.

REPRESENTATIVE VAZQUEZ pointed to page 6, lines 22-25, of the proposed bill, which clarified that the proposed bill did not usurp the current Alaska law.

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REPRESENTATIVE VAZQUEZ moved to report HB 237, labeled 29-LS1100\A, out of committee with individual recommendations and the accompanying indeterminate fiscal notes. There being no objection, HB 237 was moved from the House Health and Social Services Standing Committee.

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ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:04 p.m.