

FALASKA STATE LEGISLATURE
HOUSE JUDICIARY STANDING COMMITTEE

March 29, 2017

1:02 p.m.

MEMBERS PRESENT

Representative Matt Claman, Chair
Representative Zach Fansler, Vice Chair
Representative Jonathan Kreiss-Tomkins
Representative Gabrielle LeDoux
Representative David Eastman
Representative Chuck Kopp
Representative Lora Reinbold

MEMBERS ABSENT

Representative Charisse Millett
Representative Louise Stutes

COMMITTEE CALENDAR

HOUSE BILL NO. 43

"An Act relating to prescribing, dispensing, and administering an investigational drug, biological product, or device by physicians for patients who are terminally ill; providing immunity related to manufacturing, distributing, or providing investigational drugs, biological products, or devices; and relating to licensed health care facility requirements."

- HEARD & HELD

HOUSE BILL NO. 108

"An Act adopting and relating to the Revised Uniform Fiduciary Access to Digital Assets Act."

- MOVED CSHB 108(JUD) OUT OF COMMITTEE

HOUSE BILL NO. 42

"An Act relating to seizure of property; relating to forfeiture to the state; relating to criminal law; amending Rules 3, 4, 11, 12, 16, 32, 32.2, 32.3, 39, 39.1, and 42, Alaska Rules of Criminal Procedure, Rules 501, 801, and 803, Alaska Rules of Evidence, and Rules 202, 209, and 217, Alaska Rules of Appellate Procedure; and providing for an effective date."

- MOVED CSHB 42(JUD) OUT OF COMMITTEE

HOUSE BILL NO. 123

"An Act relating to disclosure of health care services and price information; and providing for an effective date."

- MOVED CSHB 123(HSS) OUT OF COMMITTEE

PREVIOUS COMMITTEE ACTION

BILL: HB 43

SHORT TITLE: NEW DRUGS FOR THE TERMINALLY ILL

SPONSOR(s): REPRESENTATIVE(s) GRENN

01/18/17	(H)	PREFILE RELEASED 1/13/17
01/18/17	(H)	READ THE FIRST TIME - REFERRALS
01/18/17	(H)	HSS, JUD
02/28/17	(H)	HSS AT 3:00 PM CAPITOL 106
02/28/17	(H)	Heard & Held
02/28/17	(H)	MINUTE (HSS)
03/02/17	(H)	HSS AT 3:00 PM CAPITOL 106
03/02/17	(H)	Heard & Held
03/02/17	(H)	MINUTE (HSS)
03/07/17	(H)	HSS AT 3:00 PM CAPITOL 106
03/07/17	(H)	Moved HB 43 Out of Committee
03/07/17	(H)	MINUTE (HSS)
03/08/17	(H)	HSS RPT 5DP 1NR 1AM
03/08/17	(H)	DP: JOHNSTON, TARR, EDGMON, SULLIVAN- LEONARD, SPOHNHOLZ
03/08/17	(H)	NR: KITO
03/08/17	(H)	AM: EASTMAN
03/29/17	(H)	JUD AT 1:00 PM GRUENBERG 120

BILL: HB 108

SHORT TITLE: FIDUCIARY ACCESS TO DIGITAL ASSETS

SPONSOR(s): REPRESENTATIVE(s) CLAMAN

02/08/17	(H)	READ THE FIRST TIME - REFERRALS
02/08/17	(H)	L&C, JUD
03/08/17	(H)	L&C AT 3:15 PM BARNES 124
03/08/17	(H)	Heard & Held
03/08/17	(H)	MINUTE (L&C)
03/10/17	(H)	L&C AT 3:15 PM BARNES 124
03/10/17	(H)	Moved HB 108 Out of Committee
03/10/17	(H)	MINUTE (L&C)
03/13/17	(H)	L&C RPT 7DP

03/13/17 (H) DP: SULLIVAN-LEONARD, STUTES, WOOL,
JOSEPHSON, BIRCH, KNOPP, KITO
03/24/17 (H) JUD AT 1:00 PM GRUENBERG 120
03/24/17 (H) Heard & Held
03/24/17 (H) MINUTE (JUD)
03/29/17 (H) JUD AT 1:00 PM GRUENBERG 120

BILL: HB 42

SHORT TITLE: FORFEITURE & SEIZURE: PROCEDURE; LIMITS

SPONSOR(s): REPRESENTATIVE(s) WILSON

01/18/17 (H) PREFILE RELEASED 1/13/17
01/18/17 (H) READ THE FIRST TIME - REFERRALS
01/18/17 (H) JUD, FIN
01/23/17 (H) JUD AT 1:00 PM GRUENBERG 120
01/23/17 (H) Heard & Held
01/23/17 (H) MINUTE (JUD)
03/01/17 (H) JUD AT 1:00 PM GRUENBERG 120
03/01/17 (H) Heard & Held
03/01/17 (H) MINUTE (JUD)
03/13/17 (H) JUD AT 1:00 PM GRUENBERG 120
03/13/17 (H) Scheduled but Not Heard
03/22/17 (H) JUD AT 1:00 PM GRUENBERG 120
03/22/17 (H) Heard & Held
03/22/17 (H) MINUTE (JUD)
03/27/17 (H) JUD AT 1:00 PM GRUENBERG 120
03/27/17 (H) Heard & Held
03/27/17 (H) MINUTE (JUD)
03/29/17 (H) JUD AT 1:00 PM GRUENBERG 120

BILL: HB 123

SHORT TITLE: DISCLOSURE OF HEALTH CARE COSTS

SPONSOR(s): REPRESENTATIVE(s) SPOHNHOLZ

02/13/17 (H) READ THE FIRST TIME - REFERRALS
02/13/17 (H) HSS, JUD
03/02/17 (H) HSS AT 3:00 PM CAPITOL 106
03/02/17 (H) Heard & Held
03/02/17 (H) MINUTE (HSS)
03/09/17 (H) HSS AT 3:00 PM CAPITOL 106
03/09/17 (H) Moved CSHB 123(HSS) Out of Committee
03/09/17 (H) MINUTE (HSS)
03/10/17 (H) HSS RPT CS (HSS) 5DP 2NR
03/10/17 (H) DP: JOHNSTON, TARR, EDGMON, SULLIVAN-
LEONARD, SPOHNHOLZ
03/10/17 (H) NR: KITO, EASTMAN
03/24/17 (H) JUD AT 1:00 PM GRUENBERG 120

03/24/17 (H) Heard & Held
03/24/17 (H) MINUTE (JUD)
03/27/17 (H) JUD AT 1:00 PM GRUENBERG 120
03/27/17 (H) Heard & Held
03/27/17 (H) MINUTE (JUD)
03/29/17 (H) JUD AT 1:00 PM GRUENBERG 120

WITNESS REGISTER

REPRESENTATIVE JASON GRENN
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Presented HB 43 as prime sponsor, and read a letter written by Jason Norris into the record.

BROOKE IVY, Staff
Representative Jason Grenn
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: During the hearing of HB 43, offered a PowerPoint presentation.

JASON NORRIS
Unknown location

POSITION STATEMENT: During the hearing of HB 43, Representative Grenn read a letter from Mr. Norris.

ELIZABETH KROME
Wasilla, Alaska

POSITION STATEMENT: During the hearing of HB 43, offered support for the legislation.

MICHAEL MAHARREY
National Communications Director
Tenth Amendment Center
Lexington, Kentucky

POSITION STATEMENT: During the hearing of HB 43, offered support for the legislation.

KEN LANDFIELD
Homer, Alaska

POSITION STATEMENT: During the hearing of HB 43, offered support for the legislation.

STARLEE COLEMAN, Vice President of Communications
Goldwater Institute
Phoenix, Arizona

POSITION STATEMENT: During the hearing of HB 43, offered support for the legislation.

EBRAHIM DELPASSAND, M.D.
Excel Diagnostics & Nuclear Oncology Center
Houston, Texas

POSITION STATEMENT: During the hearing of HB 43, testified, answered questions, and offered support for the legislation.

DEBORAH BEHR, Member
Alaska Uniform Law Delegation
Juneau, Alaska

POSITION STATEMENT: During the hearing of HB 108, answered questions.

REPRESENTATIVE IVY SPONHOLTZ
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: During the hearing of HB 123, spoke to certain amendments, and answered questions.

ACTION NARRATIVE

[1:02:23 PM](#)

CHAIR MATT CLAMAN called the House Judiciary Standing Committee meeting to order at 1:02 p.m. Representatives Claman, Reinbold, Kopp, Fansler, and Eastman were present at the call to order. Representatives Kreiss-Tomkins and LeDoux arrived as the meeting was in progress.

HB 43-NEW DRUGS FOR THE TERMINALLY ILL

[1:02:59 PM](#)

CHAIR CLAMAN announced that the first order of business would be HOUSE BILL NO. 43, "An Act relating to prescribing, dispensing, and administering an investigational drug, biological product, or device by physicians for patients who are terminally ill; providing immunity related to manufacturing, distributing, or providing investigational drugs, biological products, or devices; and relating to licensed health care facility requirements."

[1:03:23 PM](#)

REPRESENTATIVE JASON GREEN, Alaska State Legislature, read his testimony as follows:

So, the goal of HB 43, or "Right to Try" is to create a legal climate in which a terminally ill patient, who has exhausted all FDA approved treatment options, may work with their doctor and drug manufactures to access investigational treatments that have passed Phase 1 of the FDA approval process, but are not yet widely available. The Right to Try laws have now been passed in 33 states, 15 additional states, including Alaska, are considering the law.

Each year it is estimated that over one million Americans die from terminally ill -- terminal illness. For those who have exhausted all FDA approved options, clinical trials become the next step. However, of those patients who attempt to gain entry into the clinical trial, it is found that fewer than 3 percent are accepted.

In recognition of the 97 percent of patients denied access to clinical trials, the FDA does have a program in place for accessing investigational drugs outside of clinical trials known as the "Compassionate Use Program." Nevertheless, it is estimated that only about 1,200 people make it through this arduous federal process each year.

Given this information, the goal of HB 43 is to provide the same access as the FDA's existing Compassionate Use Program, but on a shorter timeline. By ensuring -- by ensuring terminally ill patients have more timely access to safe, but experimental drugs in consultation with their doctor, HB 43 attempts to offer new hope when all FDA approved options have been exhausted.

[1:05:31 PM](#)

BROOKE IVY, Staff, Representative Jason Grenn, Alaska State Legislature, paraphrased from the sectional analysis as follows [original punctuation provided]:

Section 1: Prohibits disciplinary action of physicians by the State Medical Board for prescribing, dispensing or administering an investigational drug, biological

product or device to terminally ill patients that are ineligible or unable to participate in a current clinical trial, have considered all other treatment options approved by the FDA and have provided written consent.

Defines "investigational drugs, biological products and devices" as those that have successfully completed Phase 1 of the FDA drug review process and remain in ongoing Phase 2 or 3 clinical trials, but have not been approved for general use.

Defines "terminal illness" as a disease that will result in death in the near future or permanent state of unconsciousness from which recovery is unlikely.

Section 2: Establishes immunity for physicians, medical team members, manufacturers and distributors in the case of injury or death of a terminally ill patient from the use of an investigational drug, biological product or device, provided informed consent was obtained from the patient and notice of immunity was given in advance.

Establishes immunity for physicians and manufacturers who choose not to participate in the distribution of an investigational drug, biological product or device.

Section 3: Amends statute limiting the sale and distribution of new drugs (AS 17.20.110) so as not to apply to physicians prescribing or administering investigational drugs under the conditions established in Section 1.

Section 4: Prohibits the Department of Health and Social Services from requiring a licensed health care facility to increase its services solely to accommodate physicians prescribing, dispensing or administering investigational drugs to a patient.

[1:07:42 PM](#)

MS. IVY turned to the PowerPoint presentation titled "House Bill 43: The Right to Try," slide 3, "FDA Drug Review Process" and advised that it is helpful to be familiar with the different phases of the FDA drug review process. She explained that prior to Phase 1, sponsors of a drug are required to submit the form

"Investigational New Drug Application" or IND application, and through this application process the FDA reviews the applicant's pre-clinical testing results and determines whether the drug is reasonably safe for human testing. She then moved to slide 4, "Phase 1 - Safety" wherein Phase 1 studies occur after approval of the IND application. These studies may be conducted on healthy volunteer when testing Ibuprofen or an anti-inflammatory, or individuals with specific diseases or terminal illnesses. The goal of Phase 1 testing is to determine possible side effects and toxicity levels, wherein Phase 1 focuses on safety.

[1:08:43 PM](#)

MS. IVY turned to slide 5, "Phase 2- Efficacy" and advised that Phase 2 studies begin when a drug has passed Phase 1 and is considered relatively safe, with no unaccepted toxicity level, wherein Phase 2 focuses on the drug's effectiveness. She turned to slide 6, "Phase 3, and advised that if there was evidence the drug was effective, it would progress to Phase 3. During that phase, she explained, more information would be gained regarding safety and effectiveness, particularly, in varying populations or different dosages in combination with other medications.

[1:09:18 PM](#)

MS. IVY turned to slide 7, "Review Meeting & New Drug Application (NDA" and advised that after Phase 3, sponsors of the drug participate in a review meeting with the FDA, and the sponsors go on to complete a form titled "New Drug Application" (NDA). In the event the drug was approved, the sponsors could then market their drug in the United States. From that point, the FDA has 60 days to decide whether to officially file the application for review and, she explained, filed applications are generally processed within 10 months of filing. She turned to slide 8, and said that within HB 43, the term "investigational drug" discusses those drugs that passed the safety testing in Phase 1, and remain in ongoing clinical trials under Phase 2 or 3 of the FDA approval process.

[1:09:44 PM](#)

MS. IVY turned to slide 9, "Compassionate Use" and noted that the FDA has an existing Compassionate Use Program designed for terminally ill patients who do not have access to a clinical trial. Within this program, patients can still access those investigational treatments outside of the clinical trial. In

order to start this process, a patient must work with their doctor and apply to the FDA. She commented that for years, by the FDA's own estimate, the application form alone would take an estimated 100 hours for the doctor to complete. Although recently, she pointed out, the FDA made great efforts to streamline the application process, but it is only the first step in the process. Manufacturers must submit lengthy documentation, and once application paperwork is complete, it must then make its way through the FDA internal approval process, and then to a separate institutional review board for approval, which is often a lengthy process.

1:10:59 PM

MS. IVY turned to slide 10, "The Right to Try - A Nationwide Effort" and reiterated that 33 states signed The Right to Try into law, and most states have had overwhelming bipartisan and often unanimous support.

1:11:22 PM

MS. IVY referred the members to a document titled "Clinical Trials" included in the packets, and said that HB 43 focuses on terminally ill patients who do not qualify for clinical trials. The sponsor included these Alaskan stories to illustrate local experiences with terminal illness, as well as the benefit of simply having access to new treatment options, whether in a clinical trial or not.

CHAIR CLAMAN opened public testimony on HB 43.

1:12:40 PM

JASON NORRIS, was unavailable and Representative Grenn read Mr. Norris's letter into the record, as follows:

I write to you today in support of HB 43, with the short title "New Drugs for the Terminally Ill." I understand that your time is limited and; therefore, I'll make an effort to be as brief as possible.

In June of 2011, my father was diagnosed with ALS, sometimes known as Lou Gehrig's disease. For those unfamiliar, this disease slowly saps a person's ability to move, rendering them bedridden. Eventually it takes away their ability to breathe, at which point they die. It should be noted that this disease does

not affect a person's mind; therefore, they are acutely aware of their daily deterioration, and because of this the mind becomes a prisoner within the body. For my father, this began in June with a reduced range of motion in his left leg. At this point he had been working 12-hour days, 5-6 days a week, per week as a machinist. I feel this is important to point out because of the extended hours and physical nature of the job. He was, by all accounts, a very strong and healthy man at the time of diagnosis. But, by late fall he had completely lost his ability to walk, and at Thanksgiving he held our 5-month old son for the last time in his arms as he became too weak to trust him with such precious cargo. When he finally lost all movement in his limbs, he would hug our children by nuzzling his face against them. As we entered into the depths of winter, he and I carried on what conversations we could, trying to accelerate what should have been more years of passing knowledge and wisdom from father to son. These conversations became increasingly difficult as the disease made his breathing quite labored, even with the assistance of a BiPAP machine. While the painful and emotional moments are too many to list, the most painful came when I asked him a simple question: "Dad, are you angry?" He responded with uncommon grace and humility by uttering one word with every labored breath, "I'm not angry, I'm just sad that I won't see your kids grow up." And, in the early morning of February 1, 2012, he died at the all too young age of 58.

My father was a good man and my hero, he was a tireless worker, and a great role model, and an unparalleled family man. He took a chance on Alaska in 1996, when he moved his family from the only home he had only known to a place that we had no connections, no network, no family, and no friends. The gamble paid off for all of us. He saw the potential in this state, he fought like we all do to make a life here, and in the end I wish the state had afforded him the right to fight this disease with the same ferocity.

Recently, in the Washington Post there was an article detailing the experience of a man who had for all intents and purposes beaten ALS through advanced

therapies pioneered by doctors at the ALS Center, in Atlanta, Georgia. In reading about this man I became aware of the Right to Try movement. Soon thereafter, I became aware of the bill of which I write to you in support of today. I implore you to pass this bill and encourage your colleagues in the Senate to do the same. I cannot say that these advanced therapies would have helped save my father's life, but they may yet save someone else's father, mother, daughter, or son. Thank you for your consideration on this important legislation.

[1:15:56 PM](#)

ELIZABETH KROME said she supports HB 43, has been a licensed nurse since 1979, and practiced in a hospital setting for 30 years. Hope is one thing all humans require, she said, after being diagnosed with a terminal condition some patients hope for a peaceful death at home, for others their hope is to live to see the birth of a grandchild, or a child graduating from high school. Hope is so very important to individuals, she pointed out, and the Right to Try allows a treatment that may or may not prolong a life, and allows hope to continue. She said she would love to see Alaska give individuals the right to try, and to give them hope for the next stage of their life no matter what it might be.

[1:18:03 PM](#)

MICHAEL MAHARREY, National Communications Director, Tenth Amendment Center, said his organization has supported this legislation across the United States since its beginning, and he called it "our no brainer issue." Law and regulations are supposed to protect people, but the regulatory scheme tends to create bureaucracy and red tape that can cause harm. Even with the FDA's expanded use program, it does not begin to address the black hole between the end of clinical trials and the final approval of treatment. This process can take up to 10 months, leaving patients in limbo and between the end of clinical trials and the final approval, patients do not have any alternatives. He offered a situation wherein more than 70 Texas cancer patients and a doctor began clinical trials when the doctor found a successful treatment for a specific type of cancer, and when the clinical trials were close to the end, the FDA still hadn't given final approval for the drug. He remarked that the FDA basically told the doctor he had to stop treating his patients, except he was able to begin treating them under the

Right to Try new state law in Texas. Mr. Maharrey related that Right to Try has been so successful in the State of Texas that the Texas legislature is considering a bill to include chronically ill patients. This type of legislation illustrates the "beauty of our federated structure" wherein the American system was never to run based on a one-size fits all solutions imposed from Washington, D.C., he pointed out. In conclusion, he said, Right to Try is a specific example of states using their rightful authority to exercise control over local issues, and if Right to Try helps even one Alaskan patient, it is worth putting this legislation on the books.

[1:20:43 PM](#)

KEN LANDFIELD said he was not aware of any downside to enacting this legislation, and the idea of creating false hope appears disingenuous as terminal is terminal. This is an easy call and, he pointed out, within the Constitution of the United States there is a guarantee for the right to the pursuit of happiness and it appears making potentially lifesaving medications available would fall under that category, he said.

[1:22:18 PM](#)

STARLEE COLEMAN, Vice President of Communications, Goldwater Institute, advised that the Goldwater Institute crafted the model Right to Try law upon which this bill is based. She offered that it is important for Alaskans to understand that the organization reached out to doctors at major research facilities across the country as to why they don't use the FDA's existing Compassionate Use Program. She said that one of the best examples of why, was from a doctor who had previously run clinical trials for the Indy Anderson Cancer Center in Houston, Texas, and this doctor advised that she was possibly able to get one person each year through the FDA's expanded process. Ms. Colman said that if only one person a year, at the largest cancer trial center in the world, can get access to a drug through the FDA's process, imagine what it is like for a person in Alaska who has seen the community oncologist who has never run a clinical trial and doesn't know who to call at the FDA. The chances are not good that this patient would be helped through this program because the FDA program is actually for patients being treated at major research hospitals performing clinical trials all the time, they know who to call and how to navigate that system. She commented that it is not for regular people, although it is known that Right to Try is already working in Texas, Oregon, and Florida in accessing new treatment

options. These are real people with real families who need help. She said she had received updated information and Right to Try has now been adopted in 34 states due to the State of Kentucky. She remarked that "no one who is dying expects that an investigational treatment will cure them," but they want the right to try and the choice to take the same medication used in clinical trials. The Goldwater Institute believes that dying people and their families are owed that opportunity, she said.

[1:25:32 PM](#)

CHAIR CLAMAN, after ascertaining no one wished to testify, closed public testimony on HB 43.

[1:25:42 PM](#)

REPRESENTATIVE LEDOUX apologized for coming in late and asked how a person is able to receive the experimental drugs.

MS. IVY responded that the FDA has a Compassionate Use Program wherein a person can apply to for investigational drugs in conjunction with their doctor. Currently, she explained, it is an application process, and once the application has been turned in, the FDA has up to 30 days to review the application and, in the event a question comes up during the 30 day period, the 30 day clock can be reset. After that point, if the patient receives approval from the FDA, the patient and their doctor must seek out an external institutional review board (IRB), and "they have no requirements" when they have to get back to the person or approve the application. In the event the review board only meets every six months, the patient would have to wait for the review and approval of the request. She said that outside of a clinical trial, that is the only way a person could access those investigational drugs.

[1:27:12 PM](#)

REPRESENTATIVE LEDOUX noted her understanding that HB 43 would not subject a doctor to disciplinary action, and asked how would a person obtain the drugs and from what manufacturer.

MS. IVY explained that to be eligible, a patient must be diagnosed as terminally ill, their doctor has exhausted all other treatment options for whatever terminal illness they have, and they've attempted to access a clinical trial. After all of those steps have been taken, the person or doctor would contact the manufacturer and request its consent to providing that

medication, outside of the clinical trial, with the Compassionate Use Program. The person, their doctor, and the manufacturer would all have to consent to that relationship, she said.

[1:28:36 PM](#)

REPRESENTATIVE LEDOUX asked whether this type of legislation was law in other states, and inquired as to how cooperative the drug companies are to dispensing the drugs under the circumstances in which these types of laws have been enacted.

MS. IVY responded that similar Right to Try laws have passed in 34 states, and are pending in 14 states, including Alaska. She acknowledged that no action could be taken to force a drug manufacturer to provide access to the medication. Interestingly, she offered, due to a new federal law, drug manufacturers are required to list drug on their websites to make the drug more accessible if the drug manufacturer participates in the Compassionate Use Program, and also lists who to contact. She said it is becoming more accessible for those seeking access to the Compassionate Use Program and those seeking access outside of that program, she said.

[1:29:57 PM](#)

REPRESENTATIVE LEDOUX questioned whether any of these drugs are available in other countries, even when they haven't been approved by the FDA.

MS. IVY described Representative LeDoux's question as powerful because when discussing this legislation people are thinking about experimental drugs the nation had never seen before, but some of the treatments going through the FDA approval process are currently in use. For example, in Europe cancer treatments have been in use for 15 years successfully, but those treatments still have to go through the FDA process, which could take anywhere from 10 - 15 years to reach approval. In the event a treatment passes Phase 1 of the FDA process, per this legislation, a person would be able to work with their doctor and the manufacturer to access that treatment.

REPRESENTATIVE LEDOUX referred to drugs available in other countries which are unavailable from the United States manufacturers, and asked what it would take to import those drugs as she assumed this bill doesn't do it.

MS. IVY replied that she was unsure that would be legal under federal law, and the patient would have to travel to that country to utilize the drug.

[1:32:33 PM](#)

EBRAHIM DELPASSAND, M.D., Excel Diagnostics & Nuclear Oncology Center, said his specialty is Nuclear Oncology, and he is a professor at the University of Texas, Department of Radiation Oncology. He commented that Houston, Texas has been using Right to Try to offer high power targeted radiation nuclear therapy for a (indisc.) cancer, which are rare cancers in terms of other common cancers such as, breast, prostate, or colon cancer. There is a special targeted therapy that was given to patients more than 10 years ago in Europe, and his patients had to travel to Europe to receive those treatments. In 2007, he found an investigation for new drug applications with the FDA to offer these treatments in Houston. He said it took him approximately 2.5 years to go through the FDA process and receive approval to start the investigation of trial to give patients access to these treatments. He explained that he received permission from the drug's owner to start these trials in the United States because, at that time, the drug was not ready to start a trial. He said they went through all of the hoops, and finally made the treatments available to their patients with the FDA's "sort of approval," and in 2015, their Investigational New Drug Application (IND) was active at his center for treatment of these patients. Initially, he advised, he requested the treatment for 60 patients, then increased it to 100 patients, and then 150 patients. In February 2015, as the center was moving closer to a 150 patient enrollment, he requested another 100 patients from the FDA because the drug was still not commercially available. The FDA responded that it did not want him to increase the number, not due to complaints because his patients had good responses, the drug had a very good safety profile, and there were many peer reviewed medical publications on this drug from other centers, but rather because it felt that would affect the commercialization of the drug and "This is why you have to stop." He said he advised the FDA that investigation of trial approval for this drug had already completed enrollment, and actually his center was one of the main contributors to that clinical trial so there was no way his continuation of treating these patients would have an effect on the commercialization of the drug. (Indisc.) to continue our treatment while the FDA had essentially stop them from providing these treatments to the patients. He pointed out that this is one of the scenarios in which the Right to Try laws can help

patients receive their treatments while the FDA reviews all of the data to approve the drug and then later commercialize. He stressed that this is the gap in which patients will benefit from this law in receiving their medication if it is available to them.

[1:38:25 PM](#)

REPRESENTATIVE KOPP referred to Dr. Delpassand's testimony regarding the FDA's decision affecting the commercialization of the drug, and asked whether he had ever witnessed the FDA colluding with pharmaceutical companies. Especially in the area of expediting or delaying approvals of investigational drugs through Phases 1-3 of clinical trials that Dr. Delpassand believed were harmful to a patient's interest.

DR. DELPASSAND responded that the nature of the overall process in obtaining approval has been a lengthy process, and there are several reasons for that, such as, some clinical trials require follow up information and the long term effect on the patient, especially when discussing oncology and cancer. He related that that is the nature of clinical trials because the FDA wants to be sure the drug is safe and also effective. He explained there are several reasons for that length of time because after a review of considerable data, the final package is submitted to the FDA, and thereafter, he said, it sometimes takes between 12 and 18 months until the FDA is actually able to review the entire data and come back with its opinion as to whether it approves or does not approve the drug. It is this period of time wherein lies the problem, especially if the drug had already shown effectiveness, had many publications in the oncology community, or whatever physicians groups, and this drug becomes common knowledge because then patients come in and ask for the drug. The physician, knowing this drug could help their patient, has nothing to offer because the drug had not yet been approved and this is how Right to Try law comes into play in certain situations. He stressed that this law does not, by any means, provide a shortcut or cutting of corners for the FDA, or any kind of due diligence in terms of making sure the drug is safe and effective.

[1:42:09 PM](#)

REPRESENTATIVE FANSLER asked whether the exact bill was passed in every state.

MS. IVY answered that most of the other versions included the same FDA criteria, but there were different elements in each state.

1:43:05 PM

REPRESENTATIVE FANSLER referred to a letter, in the committee packet recommending adding amendments, and also changing the definition of terminal illness, and he asked Ms. Ivy's response to the letter.

MS. IVY pointed to the [3/7/17] letter from Premera, Blue Cross Blue Shield of Alaska, and offered that the first two suggestions were clarifying language in that a patient's health care insurance plan was not required to cover the investigational drugs or its possible adverse effects. She said that coverage is not required under federal or state statute at this time, it could be included for clarification purposes, but it is not something the sponsor is requiring in this legislation. Also, she noted, part of the written informed consent form required in the bill involves a conversation between a patient and their doctor regarding the lack of coverage for the investigational drug, which is FDA guidance on those informed consent forms. The third recommendation had to do with "what they may not deny coverage for," and the sponsor's reading was that it may add additional protections to the bill for the patient in that, "a health insurer may not deny coverage to a patient for pre-existing conditions, benefits that accrued before the day in which the patient was treated with the unapproved investigational drug or palliative care for a patient previously treated who is no longer currently using the investigational drug." She opined that a "majority of this" was already mandated in the Affordable Care Act; however, it could be something the committee could consider including if it wanted to look down the road whether there may be changes at the federal level. She advised that the sponsor's office spoke with Legislative Legal and Research Services regarding this language and it didn't indicate there were particular risks involved in including the language. Finally, she advised, the definition Premera, Blue Cross Blue Shield of Alaska suggested would streamline it with Medicare's definition of terminal illness and limit it to those who may die within the next six months. She explained that the sponsor believes the definition is narrow in that if a terminally ill patient was given seven months to live, they would not be eligible to participate under the Right to Try laws. The sponsor could not see this narrow definition, even

though the Compassionate Use Program, and he does not necessarily support that amendment.

[1:46:33 PM](#)

REPRESENTATIVE FANSLER thanked Ms. Ivy for the map because it depicted the almost universal acceptance of this program, and noticed that Hawaii vetoed the legislation. He asked whether she had any information as to the veto.

MS. IVY answered that previously, California Governor Jerry Brown had vetoed the Right to Try law, and later the legislation was brought forward again and Governor Brown changed his mind based on its success stories. As far as Hawaii, Governor David Ige, in his veto statement listed four reasons, as follows: the Compassionate Use Program already existed and provided access; this could interfere with the overall FDA system which may have unintended consequences in delaying development of potentially lifesaving drugs, of which the bill sponsor would argue that this doesn't impact the Phases 1-3 clinical trial process; it violated the Supremacy Clause; and, he was unclear as to the actual benefits to the patient.

MS. IVY, in response to Representative Fansler, agreed to provide the committee with Dr. Delpassand's written testimony.

[1:49:50 PM](#)

MS. IVY, in responded to Representative Reinbold, answered that this bill is limited solely to the Right to Try in pharmaceuticals.

REPRESENTATIVE REINBOLD commented that she was in pharmaceutical sales for almost 10 years in Alaska, and in response to Representative LeDoux's previous question, answered that within the company she worked for, it took approximately 17 years to move from inception to the FDA's final approval. In getting Alaskans on clinical trials, the company had to compete with big states because it is easier to have many patients in a concentrated effort. She encouraged continued vetting and related that the comment about giving "false hope" was valid. Recently, she said, a friend was put on a clinical trial in California, was given great hope that this would be a successful drug for her, and it ended up that there was no result at all. She said she appreciates the bill coming forward and that this is an opportunity for Alaska to participate.

1:52:54 PM

REPRESENTATIVE EASTMAN commented that with the success of this legislation in 34 states, and states trying to expand the program to the chronically ill, asked the sponsor's perspective on an amendment that may expand it to the chronically ill based upon its success.

MS. IVY responded that Texas is the one state looking at potentially expanding the definition of terminal illness to debilitating diseases due to the law's successes. The Goldwater Institute offered concerning regarding that concept and preferred the initial narrow definition move forward before looking to expand because it was a new process throughout the different states. Additionally, she said, there is the potential for a court challenge, and the bill sponsor is trying to target the existing access through the Compassionate Use Program and streamline that timing. Expanding the definition, she pointed out, could potentially get into questions as to whether the legislation was taking on the FDA's process on a larger scope, and how far to expand that definition. She offered that it is a policy call, and at this time the sponsor would prefer to stay within the more narrow definition of terminal illness.

1:54:56 PM

REPRESENTATIVE EASTMAN acknowledged there are several parallels with this bill and a separate bill making its way through the legislature in dealing with assisted suicide. Due to the bills being similar, he asked the sponsor's thoughts as to inserting language into the bill to make clear that is definitely not the direction of this bill.

MS. IVY advised that it is the sponsor's position that these bills are different as to intent because the issues are Right to Die and Right to Try; however, the sponsor is open to discussions regarding adding clarifying language.

1:55:52 PM

REPRESENTATIVE LEDOUX noted that she was late attending this hearing, that some of her questions may have already been answered, and asked the committee's indulgence. She then asked whether there had been any organized opposition to this legislation, or organized opposition to similar bills in other states.

MS. IVY answered, not to her knowledge in Alaska, but nationally there had been concern over creating false hope. Some individuals, in response to that concern have said, "It's better to have some hope than no hope at all." The Alaska Medical Board and the Commission on Aging offered letters of support, and as to the national support, she said she would defer to Starlee Coleman at the Goldwater Institute.

[1:56:47 PM](#)

REPRESENTATIVE LEDOUX noted that either Aetna Insurance or Premera Blue Cross Blue Shield of Alaska had suggested an amendment, and asked the sponsor's view of that amendment.

MS. IVY pointed to the 3/7/17 letter from Premera Blue Cross Blue Shield of Alaska that Representative Fansler had previously inquired about, and explained that the first two suggested amendments may be unnecessary as they are not currently requiring insurers to cover investigational drugs under federal or state statute. The third suggestion could add additional protections if that was the will of the committee, but currently, some of these are mandated by the Affordable Care Act. She advised that in terms of narrowing the scope of the definition of terminal illness, the sponsor does not support that suggestion.

[HB 43 was held over.]

HB 108-FIDUCIARY ACCESS TO DIGITAL ASSETS

[1:58:34 PM](#)

CHAIR CLAMAN announced that the next order of business would be HOUSE BILL NO. 108, "An Act adopting and relating to the Revised Uniform Fiduciary Access to Digital Assets Act." [Before the committee was CSHB 108, Version U.]

CHAIR CLAMAN advised that this is the second hearing on the bill and being the sponsor of the bill, passed the gavel to Vice Chair Fansler for the duration of the hearing on HB 108.

[Chair Claman passed the gavel to Vice Chair Fansler.]

[1:58:58 PM](#)

VICE CHAIR FANSLER advised that committee members did not submit amendments for HB 108, Version U, and asked whether there was further discussion.

REPRESENTATIVE KOPP asked whether there had been any organized opposition to HB 108.

[2:00:09 PM](#)

DEBORAH BEHR, Member, Alaska Uniform Law Delegation, answered that this legislation has passed in 24 states, pending in 18 states, and of those 18 states, 2 are on the governors' desks. She offered that there had been no organized opposition on Google or Facebook, the industry, senior groups, or AARP Alaska, and that a major trust company in Alaska supports it. She continued that she was unaware of anyone raising any objection to HB 108.

VICE CHAIR FANSLER asked for final comments from the members, and seeing none, he asked for a motion.

[2:01:09 PM](#)

REPRESENTATIVE KREISS-TOMKINS moved to report CSHB 108, Version 30-LS0210/U, out of committee with individual recommendations and the accompanying fiscal notes. There being no objection, CSHB 108(JUD) passed from the House Judiciary Standing Committee.

[Vice Chair Fansler passed the gavel back to Chair Claman.]

HB 42-FORFEITURE & SEIZURE: PROCEDURE; LIMITS

[2:01:46 PM](#)

CHAIR CLAMAN announced that the next order of business would be HOUSE BILL NO. 42, "An Act relating to seizure of property; relating to forfeiture to the state; relating to criminal law; amending Rules 3, 4, 11, 12, 16, 32, 32.2, 32.3, 39, 39.1, and 42, Alaska Rules of Criminal Procedure, Rules 501, 801, and 803, Alaska Rules of Evidence, and Rules 202, 209, and 217, Alaska Rules of Appellate Procedure; and providing for an effective date." [Before the committee was CSHB 42, Version U.]

CHAIR CLAMAN advised as follows: this is the fifth hearing on this bill; Amendments 1, 2, and 3, were adopted; Amendment 4 failed; and Amendments 5 - 7 were withdrawn. Since the last

hearing he worked with committee members, the Department of Law, and the bill sponsor to re-draft Amendment 4, which was before the committee as Amendment 8.

[2:02:24 PM](#)

REPRESENTATIVE LEDOUX moved to adopt Amendment 8, Version 30-LS0193\U.12, Martin, 3/28/17, which read as follows:

Page 7, line 5:

Delete all material and insert:

"(4) obtained the property

(A) as a bona fide purchaser for fair market value;

(B) by inheritance before the date of the offense resulting in forfeiture;

(C) as a gift from a person other than the defendant; or

(D) lawfully in a manner the court considers just."

CHAIR CLAMAN there being no objection, Amendment 8 was adopted.

[2:02:45 PM](#)

REPRESENTATIVE EASTMAN commented that with all of the changes to this bill he was unsure it accomplished everything within the original bill; however, he was hopeful that with passage of this bill "we can take a small step closer to where we want to be."

REPRESENTATIVE KOPP said he appreciated the team effort in moving this bill forward. Although, it may not have accomplished everything in the bill, he pointed out that not everything intended in the bill was beneficial overall to good public policy. Certainly, he said, the bill sponsor's intent was to make sure there was due process any time there was a seizure of property and forfeiture, and great strides were taken in that direction.

[2:04:16 PM](#)

REPRESENTATIVE FANSLER moved to report CSHB 42, Version 30-LS0193\U, Martin, 3/20/17, out of committee with individual recommendations and the accompanying fiscal notes. There being no objection, amended CSHB 42(JUD) passed from the House Judiciary Standing Committee.

HB 123-DISCLOSURE OF HEALTH CARE COSTS

2:04:48 PM

CHAIR CLAMAN announced that the final order of business would be HOUSE BILL NO. 123, "An Act relating to disclosure of health care services and price information; and providing for an effective date." [Before the committee was CSHB 123, Version D.]

2:05:27 PM

REPRESENTATIVE KREISS-TOMKINS requested that Amendment 1 be moved to the bottom of the amendments stack because he recently received "fresh data" he would like to circulate amongst the committee members and the bill sponsor.

2:05:48 PM

REPRESENTATIVE REINBOLD moved to adopt Amendment 2, Version 30-LS0380\I.3, which read as follows:

Page 3, line 18, following "municipal,":
Insert "federal,"

Page 3, line 24:
Delete "'health care facility" does not include"

Page 3, line 25, through page 4, line 3:
Delete all material.

REPRESENTATIVE FANSLER objected.

2:06:16 PM

REPRESENTATIVE REINBOLD noted that during her discussion with the sponsor she mentioned this amendment and the sponsor did not offer opposition. This amendment, she explained, removes the federal exemption and keeps everyone on the same page.

2:06:41 PM

The committee took a brief at-ease.

2:09:13 PM

CHAIR CLAMAN noted that the initial question of Representative Reinbold was whether the bill sponsor supported or did not support Amendment 2.

[2:09:51 PM](#)

REPRESENTATIVE IVY SPONHOLTZ, Alaska State Legislature, said she does not support Amendment 2 because it is in conflict with the Supremacy Clause of the United States Constitution [Article VI, Clause 2], which read as follows:

This Constitution, and the laws of the United States which shall be made in pursuance thereof; and all treaties made, or which shall be made, under the authority of the United States, shall be the supreme law of the land; and the judges in every state shall be bound thereby, anything in the Constitution or laws of any State to the contrary notwithstanding.

REPRESENTATIVE SPOHNHOLZ continued that there is not a bright line separating government institutions from private institutions in this bill, but rather it separates out federally funded organizations. She opined it would put the state in the position of defending costly lawsuits which is not in the best interests of the state.

[2:10:48 PM](#)

REPRESENTATIVE REINBOLD said that her impression, during their discussion on this bill, was that Representative Spohnholz did not have any strong feelings one way or another. She stressed that federal dollars are private tax dollars; therefore, the private sector dollars would fund public facilities, and this amendment eliminates exemptions for public facilities funded by private dollars. Also, she commented, sometimes with state facilities there are matches, such as Medicaid dollars, which is also the peoples' money. She opined that, at a minimum, it is only fair that public facilities be on the same playing field as the private sector.

[2:12:12 PM](#)

REPRESENTATIVE LEDOUX related that she understands page 3, line 18, and inserting federal, but she doesn't follow when it comes to [Section 1, AS 18.15.360(h)], page 3, lines 24-25, and page 4, lines 1-3, which read as follows:

(A) the Alaska Pioneers' Home and the Alaska Veterans' Home administered by the department under AS 47.55;

(B) an assisted living home as defined in AS 47.33.1990;

(C) a nursing facility licensed by the department to provide long-term care;

(D) a facility operated by an Alaska tribal health organization; and

(E) a hospital operated by the United States Department of Veterans Affairs or the United States Department of Defense, or any other federally operated hospital or institution;

REPRESENTATIVE LEDOUX asked how a nursing facility licensed by the department to provide long-term care would be federal.

[2:12:59 PM](#)

REPRESENTATIVE SPOHNHOLZ answered "that it is not," and clarified that she was speaking to the first section of which inserts "federal." The second section would delete out the Pioneers' Homes, Veterans' Homes, assisted living homes, and nursing facilities, in particular. She said she chose not to include those facilities because everyone living in those facilities knew exactly what their stay would cost, no one goes into a long term care facility or the Pioneers' Home without knowing the exact daily cost. Therefore, having it posted on the wall was not additional information. In the case of the tribal health organizations and subparagraph (E), it was her understanding that the tribal health organizations were largely federally funded, and she actually received verbal feedback that a lawsuit would probably ensue because it viewed itself as part of a federal entity. She said she chose not to take that on because her primary focus was on the individual marketplace and having the most opportunity to make a big difference.

[2:15:04 PM](#)

REPRESENTATIVE LEDOUX referred to a nursing facility licensed by the department to provide long term care, and opined that with some of these facilities possibly basic "stuff" was provided, but there's the "other stuff" that's provided upon request for necessity. She said she was thinking of her folks in California, when her father broke his hip he went into a long term care facility and was billed for specific services. It wasn't just that he had to pay "X" amount of dollars in order to

enter the place, and she asked how the facilities are run in Alaska.

REPRESENTATIVE SPOHNHOLZ opined that the facilities tend to be that the patient pays for the level of care they need, there may be some individual distinctions, but the pricing tends to be based on the level of care for the patient. She explained there are different pricings for different levels of care, and generally speaking, the patient knows the cost, and their bill doesn't change dramatically from one month to another, unless there was a major medical event. She explained that she was not discussing that level of care, but rather care such as, routine and/or elective care when going to the traditional health care provider. It was her intent, she said, to focus in on that routine and/or elective care, of which makes up the bulk of the particular kind of marketplace this bill could influence.

[2:18:06 PM](#)

REPRESENTATIVE KOPP referred to Amendment 2 and inserting the word "federal," and noted that any person or provider eligible under the federally funded Indian Health Service program does not compete in the marketplace with respect to price transparency. Also, with respect to the word "federal," how would this impact military hospitals, such as the hospital on Joint Base Elmendorf-Richardson (JBER). He said he was not familiar with how TRICARE works currently, and opined that with the intent being marketplace transparency he was unsure how it aligned with a military hospital posting a price disclosure.

[2:19:26 PM](#)

REPRESENTATIVE SPOHNHOLZ remarked that they were discussing two distinct elements when talking about this one specific population served through TRICARE, the Veterans Affairs, or the United States Department of Defense (DoD) delivered health care services. In the case of the federal facilities operated on bases, or just outside of the military bases in the case of the Department of Veterans Affairs, those are excluded on page 4, lines 1-3, [subparagraph (E)], which read as follows:

(E) a hospital operated by the United States Department of Veterans Affairs or the United States Department of Defense, or any other federally operated hospital or institution;

REPRESENTATIVE SPOHNHOLZ pointed out that those were treated as separate because they are federal institutions. Although, in the event a veteran with TRICARE received approval for some sort of care outside of the military system and visited a private provider in the marketplace, the veteran should be able to see that information. TRICARE can be used within the private market, with some restrictions outside of military installations, but she said she did not know all of the details.

[2:20:51 PM](#)

REPRESENTATIVE KOPP referred to Amendment 2, page 1, lines 4-5, deleting subparagraphs (D) and (E), and asked whether there would be a problem leaving subparagraphs (A), (B), and (C).

REPRESENTATIVE SPOHNHOLZ advised that the way the bill was drafted was actually the inverse because ...

REPRESENTATIVE KOPP clarified that he asked the question backwards.

REPRESENTATIVE SPOHNHOLZ responded that she did not object to his suggestion, although she did not believe anyone moves into an assisted living home without first receiving the exact cost, how they are charged for services, and how the services will be paid. Therefore, she remarked, the need for transparency was not the same when compared to the needs at the Pioneers' Home or an assisted living home, and walking into an emergency room at the hospital and considering an MRI, or to the local doctor for additional bloodwork.

[2:23:01 PM](#)

CHAIR CLAMAN explained that when his family had to determine which assisted living community center would be best for his parents, his siblings talked to approximately four and six different assisted living centers, and they knew the exact price for each center.

[2:23:54 PM](#)

REPRESENTATIVE EASTMAN referred to federal jurisdiction and opined that it made sense for the Department of Veterans Affairs to determine what goes on in its facilities, and to keep those standards consistent state-to-state. Which, he commented, is different from the federal medical facilities not competing with the private sector in the marketplace because they absolutely do

compete in this state. For example, he said, the Alaska Native Medical Center (ANMC) provides treatment for federally eligible beneficiaries and also any number of different people. It is the only hospital in Anchorage with the ability to serve multiple trauma cases simultaneously, and it can compete with other aspects of the private sector. He offered concern with the idea that transparency was needed for all of the various facilities covered under this bill because transparency was already working well, such as with a senior center. He said he hoped for consistency and equity in applying these requirements to everyone in Alaska, and if the legislature made the requirement to post prices, that requirement should be made for everyone regardless of the facility. In the event the word "federal" was not inserted at line 18, he said, there would be no need for any of the federal references in subparagraphs (D) or (E).

[2:31:21 PM](#)

REPRESENTATIVE FANSLER related that he could see a difference between subparagraphs (A), (B), and (C), and what this bill was attempting to provide in that he could not walk into an assisted living facility and have his broken arm examined unless he lived there. The bill encourages transparency in the situation of an elective surgery and the patient would know where they would want to go based on that transparency. As for subparagraphs (D) and (C), he could see their complete difference, obviously, with the Supremacy Clause. Perhaps, he suggested, when facilities are required to post fees, if the federal facilities suddenly were no longer taking in the patients they once did because it didn't have that transparency, he pointed out, that chances are that the free market would pull them into the transparency on its own.

[2:33:10 PM](#)

REPRESENTATIVE REINBOLD offered that she was open to a friendly amendment, but in reviewing the Supremacy Clause she would like the Department of Law to weigh in. She opined that the Supremacy Clause had nothing to do with this and that it was an overuse of that clause. However, she said she would go to the United States Constitution, Amendment IX and X, which read as follows:

Amendment IX

The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.

Amendment X

The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people.

REPRESENTATIVE REINBOLD asked whether it was the sponsor's intention that the private sector be required to publically post their CPT codes and fees, while the public sector, using private sector dollars, would not be required to post those codes and fees.

[2:34:23 PM](#)

REPRESENTATIVE SPOHNHOLZ pointed out that page 3, lines 18-24, read as follows:

(2) "health care facility" means private, municipal, or state hospital, psychiatric hospital, independent diagnostic testing facility, residential psychiatric treatment center ...

REPRESENTATIVE SPOHNHOLZ continued that it is a long list, several of which include public entities. She pointed out that she had said several times that the distinction was not between public and private institutions. She reiterated that the only entities carved out, specifically due to the Supremacy Clause, are federal in nature, and she stressed that was the only distinction.

REPRESENTATIVE REINBOLD asked that the Department of Law weigh in on the Supremacy Clause because she believed it was a misuse of the Supremacy Clause.

[2:35:09 PM](#)

REPRESENTATIVE LEDOUX pointed out that she did not pretend to be an expert in the Supremacy Clause, but there is a long line of judicial precedent stating that the state can't make the federal government do things. For example, she said, the state cannot tax the federal government, and while the states do not always have to adhere to what the federal government tells them what to do, the state cannot make the federal government do things.

[2:35:53 PM](#)

CHAIR CLAMAN commented that he completely agrees with Representative LeDoux about the Supremacy Clause, and as he offered during the last hearing, he intends to move this bill out of committee today. He pointed out that the question of the Supremacy Clause came up during the last hearing on this bill and Representative Reinbold could have followed up with the Department of Law or Legislative Legal and Research Services before today. He stated that there was no reason to call Legislative Legal and Research Services during this hearing because the courts have consistently ruled, again and again, exactly as Representative LeDoux described.

REPRESENTATIVE REINBOLD argued that it is important for the Department of Law or Legislative Legal and Research Services to weigh in on the Supremacy Clause, and the committee needs to discuss the Constitution of the United States, Amendments IX and X. She then described herself as a federalist "and I do believe that the -- the rights that are not absolutely specifically ... and I see nothing in the constitution that says that -- that they can't, you know, post, or they shouldn't be transparent with -- with public dollars. It just -- it just seems to me outlandish to be using that Supremacy Clause in this case." She said the committee needs [this bill] to be on a fair playing field.

[2:38:27 PM](#)

A roll call vote was taken. Representatives Eastman and Reinbold voted in favor of adopting Amendment 2. Representatives Fansler, Kopp, Kreiss-Tomkins, LeDoux, and Claman voted against it. Therefore, Amendment 2 failed to be adopted by a vote of 2-5.

[2:39:07 PM](#)

REPRESENTATIVE REINBOLD moved to adopt Amendment 3, Version 30-LS0380\I.4, which read as follows:

Page 1, line 1, following "**information**";:
Insert "**relating to health care insurers**;"

Page 2, line 1, following "**AS 18.23.400**";:
Insert "**and AS 21.96.125**"

Page 4, following line 21:

Insert a new bill section to read:

"* **Sec. 3.** AS 21.96 is amended by adding a new section to read:

Sec. 21.96.125. Disclosure of health care services and price information by health care insurers. (a) A health care insurer shall annually

(1) compile a list describing, by procedure code, including a brief description in plain language that an individual with no medical training can understand, the 50 most common health care services covered by the insurer in this state in the previous calendar year and the total cost to the insurer for each of those health care services during that period;

(2) publish and update the list on the insurer's Internet website by January 31 each year; and

(3) submit the list by January 31 each year to the Department of Health and Social Services for entry in the database under AS 18.15.360(a).

(b) The Department of Commerce, Community, and Economic Development may adopt regulations under AS 44.62 (Administrative Procedure Act) to implement this section.

(c) A health care insurer that fails to comply with the requirements of this section is liable for a civil penalty. The Department of Health and Social Services may impose a civil penalty of not more than \$150 for each day after March 31 that a health care insurer fails to provide and post information as required under (a) of this section. The total penalty may not exceed \$2,500. A person penalized under this subsection is entitled to a hearing conducted by the office of administrative hearings under AS 44.64.

(d) In this section,

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

(2) "health care service" has the meaning given in AS 18.23.400;

(3) "insured" means an individual covered by a health care insurance policy."

Renumber the following bill section accordingly.

REPRESENTATIVE FANSLER objected

[2:39:25 PM](#)

REPRESENTATIVE REINBOLD explained that Amendment 3, requires a posting of the prices paid by the insurance companies.

[2:39:52 PM](#)

REPRESENTATIVE SPOHNHOLZ offered that while she appreciates the intent of expanding price transparency, unfortunately, in looking at Amendment 3, she could not support it at this time. She noted that lines 15-16 ask for the total cost to the insurer for each of those health care services during that period, and she was unsure what that meant because there are a variety of definitions of health care costs are out there. She asked whether Amendment 3 referenced the total amount they've paid out, in which case that would be getting into a totally different issue than under HB 123, because it is about informing consumer price transparency. She noted that it could also mean what the insurers are paying to different providers, and that would vary depending upon whether or not that providers was within a preferred provider network or out of the provider network. She related that a lot of time was spent in determining how to have a clean, clear bill that was understandable by the end user, and Amendment 3 muddies the water.

[2:41:20 PM](#)

REPRESENTATIVE LEDOUX asked Representative Reinbold to explain Amendment 3 because she was unsure whether the amendment was so doctors could see what the insurance companies were going to pay, or whether the consumer would see what the insurance company pays.

REPRESENTATIVE REINBOLD explained that doctors will post their rack rate fee, the CPT codes, except doctors receive different reimbursements from insurers for their different types of insurance patients. Unfortunately, she said, patient's will "freak out" over the posted charge, not understanding that is not the amount the doctor is actually reimbursed, and it becomes more complicated under managed care. For example, while working in a doctor's business office in Texas, the office was only allowed to charge \$400 and the rack rate fee may have been \$10,000 because it had negotiated a low price. The amendment allows that the reimbursable price the insurance companies pay be transparent, she said.

[2:43:50 PM](#)

REPRESENTATIVE LEDOUX offered that while she was sympathetic to what this amendment was trying to do, but was complicated in its manner because around here things are sometimes accomplished through baby steps. She remarked that she will not support this amendment because, in the context of this bill, it would not work.

[2:44:51 PM](#)

REPRESENTATIVE EASTMAN referred to page 2, line 3, wherein the fine appears to have tripled and asked why it went from \$50 per day to \$150 per day.

REPRESENTATIVE REINBOLD noted that she had not requested that language and asked that the drafter explain the difference.

[2:45:28 PM](#)

REPRESENTATIVE SPOHNHOLZ pointed out that this amendment requires the health care insurer to post information allowing patients to see what the insurer would charge for the service. In that manner, a person would have to review the doctor's rack rates and then review their insurer's website to determine what the insurer would pay. Essentially, she related, her source at the Department of Health and Social Services advised that an all payor claims database would be required to mesh this amendment with the bill.

[2:46:49 PM](#)

REPRESENTATIVE REINBOLD advised that her intention is to include insurers because the third party insurance company pays the bills. She commented that the amendment is fair if the goal is to get true transparency and make this a consumer friendly bill.

[2:48:26 PM](#)

REPRESENTATIVE EASTMAN commented that Amendments 1 and 3 appear to be going in the same direction, yet applying different language to get there.

CHAIR CLAMAN interjected that Amendment 1 has nothing to do with information from insurance carriers, and Amendment 3 is all about information from insurance carriers. He pointed out that Representative Eastman cannot claim they address the same issue as they are completely different.

REPRESENTATIVE EASTMAN opined that they do, and that obtaining information from insurers appears to be a fairly important part of this whole equation. He related that when he visits a doctor's office, that office queries his insurance company for information and relays that information to him. He said, "I work with them on whether or not I'm gonna actually contract with them for the services." His concern with the bill, unamended, is that it runs into the "bridge too far problem." He explained that there was an idea to go straight from Britain to Berlin, during World War II, by way of several bridges. Unfortunately, the forces were unable to reach the last bridge, and; therefore, the whole idea and effort crumbled because they never got there. He related that if the legislature doesn't actually get to the point of an Alaska resident receiving helpful information, then it appears like a lot of effort and it doesn't get the legislature where it needs to be.

2:50:50 PM

REPRESENTATIVE KOPP suggested that this amendment raises questions in that the health care insurance market negotiates rates for procedures individually with health care facilities and employers. Certainly, he commented, those rates are different depending upon volume, how well the health care program is managed, history with the insurer, and a host of issues. He suggested getting an insurance expert online and ask whether the legislature can do this because it will get into market proprietary information between insurance companies. Also, he said, possibly the committee would be interfering with insurers as to the market by requiring them to disclose their negotiated rates for a whole host of entities, such as health care facilities or employers.

2:52:24 PM

CHAIR CLAMAN commented that the House Health and Social Services Standing Committee heard this bill and the insurance companies said little, but they did say there were significant privacy issues between commercial relationships, the insurance companies, and their insured.

He commented that he recognizes the sponsor's intent for more transparency as to health care costs and insurance costs, and rather than try to globally fix everything, the sponsor prefers to take baby steps toward improved transparency. He related that the [amendment] requires Premera, Blue Cross Blue Shield of

Alaska to voice how much it paid in the state last year for all of the completed blood counts, and to give a total number. He suggested this amendment asks that, instead of letting the consumer know the average price for a complete blood count paid by insurance company "X," it would provide the total number of the many hundreds of thousands of people they provide insurance for, and the consumer would not be helped.

CHAIR CLAMAN advised that Ms. Glover was online regarding the \$150 penalty. He said he believes the committee could agree to change the figure to \$50 consistent with the bill, and treat it as an informal amendment.

[2:55:50 PM](#)

CHAIR CLAMAN asked the committee to agree that on page 2, line 3, delete "\$150" and insert "\$50." There being no objection, the informal amendment was adopted.

[2:56:28 PM](#)

REPRESENTATIVE REINBOLD opined that Chair Claman said something about insurance companies not wanting to disclose their information due to it being proprietary information, even though a lot of doctors don't want to do that either due to sticker shock. She commented that people believe the rate posted is the amount the doctor receives and it turns the patient against the doctor. Unfortunately, she said, the patient doesn't know their doctor has far more specialties, went through 10-20 more years of schooling with loans, or that the doctor may take a Medicare patient and only receive 10 percent of the rack rate posted. She argued that if the legislature doesn't require government facilities to meet the same standards as the private sector, they don't have to comply. The fact that these doctors may post a \$500 fee, they may only receive \$50 for their service because the insurance company negotiated a deal where it racks in hundreds of millions of dollars and takes no risk. Yet, she pointed out, it is the doctors seeing the patients, the doctors have the insurance, the doctors have to deal with the follow up, and now the insurance companies "get scot-free clean." She stressed that it would be completely misguided if the insurance companies were not included in this bill.

[2:58:59 PM](#)

A roll call vote was taken. Representatives Eastman, Reinbold, Kopp voted in favor of adopting Amendment 3. Representatives

LeDoux, Fansler, Kreiss-Tomkins, and Claman voted against it. Therefore, Amendment 3 failed to be adopted by a vote of 3-4.

[2:59:31 PM](#)

REPRESENTATIVE REINBOLD moved to adopt Amendment 4, Version 30-LS0380\I.5, which read as follows:

Page 2, line 11, following "charged":

Insert "and the amount the provider actually received"

Page 2, line 16, following "charged":

Insert "and the amount the provider actually received"

REPRESENTATIVE FANSLER objected.

[2:59:35 PM](#)

REPRESENTATIVE REINBOLD referred to her comments regarding a posted fee of \$500, and explained that the doctor may only receive \$50 or write off the entire fee, and Amendment 4 requires "the amount the provider actually received" because that information is important for the patients. Some patients may believe their doctors are millionaires, not knowing they may have extensive education loans, and insurance costs to pay. She related that the insurance companies treat doctors "horrendously," the sticker shock can be high, and the amendment requires the amount the providers actually received for their services to be posted.

[3:00:52 PM](#)

REPRESENTATIVE EASTMAN commented that Amendment 4 moves the committee closer to actual transparency by requiring all doctors to post the actual amount they receive from the insurer, thereby allowing an even playing field.

[3:02:34 PM](#)

REPRESENTATIVE LEDOUX said she was sympathetic to what this amendment was trying to do, but if the committee was really concerned about the impact on the private sector, she was hesitant to ask doctors to post the amount they actually receive from insurers, Medicaid, Medicare, or workers' compensation insurance. In response to Representative Eastman's argument

that doctors certainly have the opportunity to explain their rack rates during the patient's visit, she pointed out that there is nothing in the bill prohibiting physicians from posting all of those rates.

[3:03:59 PM](#)

REPRESENTATIVE KREISS-TOMKINS noted that Amendments 3 and 4, appear to approach health care price transparency from the insurance side of the equation, as opposed to the provider side, and agreed that it was important to approach it in both directions. Amendment 4 is elegant in its simplicity, he described, but the element he struggles with was what Represented LeDoux pointed out, that different insurers have different rates and no one has any idea how much anything costs. He commented that he was unsure this bill was the correct vehicle because it was more of a provider based bill. He then read the language in the amendment "and the amount the provider actually received," and asked how Representative Reinbold saw that being implemented and practiced.

REPRESENTATIVE REINBOLD responded that if this was a provider based bill, because most providers hate this bill, and it will make patients "freak out" at the sticker shock. In response to Representative LeDoux comment that nothing prohibits the doctor from discussing their rates, she answered that some doctors may not want to tell their patients they receive \$50 for a Medicare patient, \$55 for a veteran, and \$200 for a lawyer. She opined that doctors want to discuss the patient's medical and emotional issues, and not get into this "price fixing, this anti-trust, this movement toward -- I think this is a much bigger issue, like with stark laws and anti-trust laws, and all sorts of other things." She said she believes that even with this amendment, "it's none of our business."

[3:07:52 PM](#)

REPRESENTATIVE EASTMAN surmised that, currently the bill states the discounted price charged, and this amendment would then add the amount the provider received, and commented that he hoped the committee was not worried about having too much transparency. There is a medical facility in his district with a history of "being on the high side," but with that information available it would give patients the opportunity to ask why the prices are high. He described the bill as helpful in starting conversations so that 10 years from now the population would not be looking at the same problem.

3:09:41 PM

REPRESENTATIVE KOPP commented that a couple of years ago he threw his lower back out, and the chiropractor advised it would be \$80 if he self-paid, or \$260 would be billed to the insurance company. He commented that Amendment 4 gets right at this issue because if the committee was really looking at transparency in the marketplace, at some point it must be recognized there is a business relationship, which is not inherently evil or nefarious, with third party payor insurance companies. Currently, patients are not directly paying physicians, and if the goal is transparency without including the insurer in any manner, it does make it harder to get there, he commented. While realizing Amendment 4 was problematic, he said he would support the amendment.

REPRESENTATIVE REINBOLD commented that she would stick with Representative Kopp's good comments.

3:11:40 PM

REPRESENTATIVE FANSLER maintained his objection.

3:11:47 PM

A roll call vote was taken. Representatives Eastman, Reinbold, and Kopp voted in favor of adopting Amendment 4. Representatives Kreiss-Tomkins, LeDoux, Fansler, and Claman voted against it. Therefore, Amendment 4 failed to be adopted by a vote of 3-4.

3:12:46 PM

REPRESENTATIVE KREISS-TOMKINS withdrew Amendment 1, labeled 30-LS0380\I.2 [prior to offering a motion to adopt the amendment].

REPRESENTATIVE KREISS-TOMKINS commented that after reviewing actual CPT codes in a facility realized that many of the CPT codes are diagnostic and testing in nature and that none of the "meat and potatoes" procedures the committee was interested in actually made the top 50 CPT codes. After reviewing a workers' compensation medical fee schedule which included all of the meat and potatoes procedures, such as MRIs, X-rays, stitches for a laceration, he drafted an amendment to maintain the simplicity of the bill and integrates all of that information. The Alaska State Hospital and Nursing Association (ASHNA) worked closely

with his office to provide a list of the top 10 grossing procedures at a sample facility, and from a different facility, and there was 100 percent overlap between the top 10 grossing procedures and the top 50 most common procedures. Therefore, Amendment 1 is redundant; however, he opined, the way to get there is using NTCI data which comes from workers' compensation. It listed the 10 top grossing procedures within different AMA service categories, and the four largest AMA service categories in health care include: surgery at 31 percent of all health care costs; physical medicine at 29 percent; evaluation and management at 16 percent; and radiology at 13 percent. Those four AMA service areas account for the preponderance of medical costs. He summarized that today is not the day, but he felt it was important to put on the record that possibly there is a way to get at the meat and potatoes procedures while still working within the parameters of the simplicity in this legislation.

[3:15:59 PM](#)

CHAIR CLAMAN advised that the bill was back before the committee with no amendments attached, and asked for further comments or discussion.

[3:16:12 PM](#)

REPRESENTATIVE EASTMAN said that Representative Kreiss-Tomkins solution was not before the committee, and he could not support the bill. In determining how to get from "where we are" to a more transparent system and possibly more economical pricing in dealing with the cost of delivering health care, he said this bill "gets us somewhere" but was unsure whether it moves the state closer to where it wants to be and was possibly pulling the committee farther away. The bill imposes more government regulations, institutes the threat of fines on health care facilities, and the problem of the disparity between what is expected of the state's facilities and state departments and what is being asked of the private sector hasn't been solved. For example, the sponsor made an effective date of HB 123 at January 1, and on that date the requirements would be instituted for health care facilities with total penalties not to exceed \$2,500, but the fiscal note has a department that will not have the regulations in place for it to uphold its end of the bargain until July 1, 2019. He said he will vote against the bill.

[3:19:44 PM](#)

REPRESENTATIVE REINBOLD offered that the bill is coming from a "fabulous place," but her philosophy is that this will have some negative unintended consequences in patients against their doctors due to fees. She described it as a double standard when asking the private sector to post fees without requiring public facilities to also post fees, and that the is being missed if the bill doesn't include insurance companies, which are the key third party payor, as part of this government solution. She referred to the Constitution of the State of Alaska, Article 1, Section 22, and commented, "It is the legislature's job to not infringe on privacy of our citizens" and this may be on the verge of that infringement.

[3:23:22 PM](#)

REPRESENTATIVE FANSLER moved to report CSHB 123(HSSS), Version 30-LS0380\I, out of committee with individual recommendations and the accompanying fiscal notes.

REPRESENTATIVE EASTMAN objected.

[3:23:35 PM](#)

A roll call vote was taken. Representatives Kopp, Kreiss-Tomkins, LeDoux, Fansler, and Claman voted in favor of CSHB 123. Representatives Eastman and Reinbold voted against it. Therefore, CSHB 123(HSS) was reported out of the House Judiciary Standing Committee by a vote of 5-2.

[3:25:02 PM](#)

ADJOURNMENT

There being no further business before the committee, the House Judiciary Standing Committee meeting was adjourned at 3:25 p.m.