

ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

April 4, 2019

3:09 p.m.

MEMBERS PRESENT

Representative Ivy Spohnholz, Co-Chair
Representative Tiffany Zulkosky, Co-Chair
Representative Matt Claman
Representative Harriet Drummond
Representative Geran Tarr
Representative Sharon Jackson

MEMBERS ABSENT

Representative Lance Pruitt

COMMITTEE CALENDAR

HOUSE BILL NO. 84

"An Act relating to the presumption of compensability for a disability resulting from certain diseases for firefighters, emergency medical technicians, paramedics, and peace officers."

- HEARD & HELD

HOUSE BILL NO. 89

"An Act relating to the prescription of opioids; relating to the practice of dentistry; relating to the practice of medicine; relating to the practice of podiatry; relating to the practice of osteopathy; relating to the practice of nursing; relating to the practice of optometry; and relating to the practice of pharmacy."

- HEARD & HELD

HOUSE BILL NO. 92

"An Act exempting direct health care agreements from regulation as insurance; establishing a direct care payment program for medical assistance recipients; and providing for an effective date."

- HEARD & HELD

HOUSE BILL NO. 114

"An Act relating to a workforce enhancement program for health care professionals employed in the state; and providing for an effective date."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: HB 84

SHORT TITLE: WORKERS' COMP: POLICE, FIRE, EMT, PARAMED

SPONSOR(S): REPRESENTATIVE(S) JOSEPHSON

03/06/19 (H) READ THE FIRST TIME - REFERRALS
03/06/19 (H) HSS, L&C
04/04/19 (H) HSS AT 3:00 PM CAPITOL 106

BILL: HB 89

SHORT TITLE: OPIOID PRESCRIPTION INFORMATION

SPONSOR(S): REPRESENTATIVE(S) SPOHNHOLZ

03/11/19 (H) READ THE FIRST TIME - REFERRALS
03/11/19 (H) HSS, FIN
04/04/19 (H) HSS AT 3:00 PM CAPITOL 106

BILL: HB 92

SHORT TITLE: DIRECT HEALTH: NOT INSUR; ADD TO MEDICAID

SPONSOR(S): REPRESENTATIVE(S) JOHNSTON

03/13/19 (H) READ THE FIRST TIME - REFERRALS
03/13/19 (H) HSS, FIN
04/04/19 (H) HSS AT 3:00 PM CAPITOL 106

BILL: HB 114

SHORT TITLE: MEDICAL PROVIDER INCENTIVES/LOAN REPAYM'T

SPONSOR(S): REPRESENTATIVE(S) SPOHNHOLZ

03/27/19 (H) READ THE FIRST TIME - REFERRALS
03/27/19 (H) HSS, FIN
04/04/19 (H) HSS AT 3:00 PM CAPITOL 106

WITNESS REGISTER

ELISE SORUM-BIRK, Staff
Representative Andy Josephson
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Presented HB 84 on behalf of the bill sponsor, Representative Josephson.

PAMELA MILLER, Executive Director
Alaska Community Action on Toxics
Anchorage, Alaska

POSITION STATEMENT: Testified in support of HB 84.

DARCEY PERRY, Vice President
Public Safety Employees Association
Anchorage, Alaska

POSITION STATEMENT: Testified in support of HB 84.

MIRANDA DORDAN, Intern
Representative Ivy Spohnholz
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Presented the Sectional Analysis for HB 89 on behalf of the bill sponsor, Representative Spohnholz.

ERIN SHINE, Staff
Representative Jennifer Johnston
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Presented HB 92 on behalf of the bill sponsor, Representative Johnston.

LEE GROSS, MD
Epiphany Health
North Port, Florida

POSITION STATEMENT: Testified and answered questions in support of HB 92.

ANNA LATHAM, Deputy Director
Juneau Office
Division of Insurance
Department of Commerce, Community & Economic Development
Juneau, Alaska

POSITION STATEMENT: Answered questions during discussion of HB 92.

BERNICE NISBETT, Staff
Representative Ivy Spohnholz
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Presented HB 114 on behalf of the bill sponsor, Representative Spohnholz.

JILL LEWIS, Deputy Director - Juneau
Central Office
Division of Public Health
Department of Health and Social Services
Juneau, Alaska

POSITION STATEMENT: Presented a PowerPoint titled "HB 114 Medical Provider Incentives/Loan Repayment."

RACHEL GEARHART, Co-Chair
SHARP Council
Juneau, Alaska

POSITION STATEMENT: Testified during discussion of HB 114.

NANCY MERRIMAN, Executive Director
Alaska Primary Care Association
Anchorage, Alaska

POSITION STATEMENT: Testified in support of HB 114.

JANE ERICKSON, President
Alaska Nurses Association
Palmer, Alaska

POSITION STATEMENT: Testified in support of HB 114.

CONNIE BEEMER, Vice President
Alaska State Hospital and Nursing Home Association (ASHNHA)
Anchorage, Alaska

POSITION STATEMENT: Testified in support of HB 114.

ACTION NARRATIVE

[3:09:53 PM](#)

CO-CHAIR TIFFANY ZULKOSKY called the House Health and Social Services Standing Committee meeting to order at 3:09 p.m. Representatives Zulkosky, Spohnholz, Claman, Tarr, Drummond, and Jackson were present at the call to order.

HB 84-WORKERS' COMP: POLICE, FIRE, EMT, PARAMED

[3:10:36 PM](#)

CO-CHAIR ZULKOSKY announced that the first order of business would be HOUSE BILL NO. 84, "An Act relating to the presumption of compensability for a disability resulting from certain diseases for firefighters, emergency medical technicians, paramedics, and peace officers."

[3:11:02 PM](#)

ELISE SORUM-BIRK, Staff, Representative Andy Josephson, Alaska State Legislature, presented a PowerPoint titled "HB 84, An Act relating to the presumption of compensability for a disability resulting from certain diseases for firefighters, emergency medical technicians, and peace officers." She directed attention to slide 1, "Purpose of the bill," and paraphrased the slide, which read:

Firefighters are already covered in current law

To extend "presumption of compensability" for certain diseases to three more professions:

Emergency Medical Technicians

Peace Officers

Paramedic

These first responder professions often are exposed to the same dangerous situations and toxins that firefighters are

MS. SORUM-BIRK pointed out that, although firefighters were already covered under a statute passed in the 25th Alaska State Legislature with bi-partisan support and an effective date of August 19, 2008, this proposed bill would expand presumptive coverage for three professions left out of that legislation.

[3:12:56 PM](#)

MS. SORUM-BIRK paraphrased slide 2, "What is "presumptive" legislation?" which read:

With work-related illness or injury-

Typically worker must prove their ailment is a result of occupational exposures

With presumptive legislation-

Line-of-duty claim, and subsequent benefits, can be automatically approved as long as the specific criteria are met under the state's regulations

Some states choose broad language and some choose to be much more specific

MS. SORUM-BIRK explained that Alaska had used very specific language in the 2008 legislation, although many states used much broader language.

[3:13:26 PM](#)

MS. SORUM-BIRK paraphrased slide 3, "Alaska's Criteria," which read:

Narrowly defined and limited in AS 23.30.121

Presumption of coverage may be rebutted based on tobacco use, physical fitness, weight, lifestyle, hereditary factors, exposure from other employment or non-employment activities

May not extend for more than 3 months for each year of service or 60 months following last date of employment

Only to those who have served for a minimum of seven years

Only to individuals who have undergone qualifying medical exam and requisite annual exams with no evidence of disease

Only if the individual with cancer was exposed to known carcinogens in the course of employment

[3:14:22 PM](#)

MS. SORUM-BIRK shared slide 4, "Sectional Analysis," which read:

Section 1:

Amends AS 23.30.121(b) throughout to add emergency medical technician, paramedic and peace officer to professions presumed covered for disability or disease.

Creates a new section to include breast cancer under diseases for which a covered professional can claim compensation.

Extends coverage to certain professionals who entered active service prior to August 19, 2008.

Section 2, Section 3, Section 4:

Includes emergency medical technician, paramedic and peace officer among presumptively covered professions

Section 5:

Provides definitions of "emergency medical technician," "firefighter," "paramedic," and "peace officer."

Section 6:

Clarifies that AS 23.30.121 as amended applies to claims made on or after the effective date of this Act.

Section 7:

Encourages revisors to update catch line of AS 23.30.121 to reflect changes made by this Act.

[3:15:39 PM](#)

MS. SORUM-BIRK moved on to paraphrase slide 5, "Diseases covered in Alaska," [original punctuation provided] which read:

Currently covered: respiratory disease, certain cardiovascular events related to toxin exposure, primary brain cancer, malignant melanoma, leukemia, non-Hodgkin's lymphoma, bladder cancer, ureter cancer, kidney cancer, prostate cancer

Added by HB 84: breast cancer

Emerging literature suggests a higher rate of breast cancer among women firefighters

MS. SORUM-BIRK directed attention to an article [Included in members' packets] regarding research regarding higher rates of breast cancer with earlier onset for women firefighters.

[3:16:35 PM](#)

MS. SORUM-BIRK explained slide 6, "First responders who entered service prior to August 19, 2008," which read:

AS 23.30.121(b)(4)-Allows these individuals to be covered if a firefighter, emergency medical technician, paramedic, or peace officer received "all medical examination provided by the department" no evidence of the disease during the first seven years of employment

August 19, 2008 is date of original enactment of "presumptive" legislation in Alaska

MS. SORUM-BIRK stated that this would set up parameters for individuals who entered service prior to this August date. She reported that the one case dealing with this issue which had gone to the Supreme Court had referred to this presumptive date.

[3:18:29 PM](#)

MS. SORUM-BIRK referred to slide 7, "Expands definition of firefighters," which read:

Adds firefighters who are state employees to the definition of firefighter

MS. SORUM-BIRK paraphrased slide 8, "Conclusions," which read:

A question of providing similar protections to professional and volunteers who take comparable risk

Protecting those who protect our state and communities

[3:19:30 PM](#)

CO-CHAIR SPOHNHOLZ asked how the rate of breast cancer in female firefighters and other first responders compared to those rates in the general population.

MS. SORUM-BIRK replied that, although research was still on-going, it was suggesting that these rates were "quite a bit higher."

CO-CHAIR SPOHNHOLZ shared that a concern for the proposed bill was for the costs related to the inclusion of breast cancer, and that these facts would be important in consideration for the proposed bill.

[3:21:24 PM](#)

PAMELA MILLER, Executive Director, Alaska Community Action on Toxics (ACAT), stated that ACAT was an environmental health, research, and advocacy organization that assisted worker concerns with chemical exposure. She paraphrased from a letter of support for the proposed bill dated March 21, [Included in members' packets] [original punctuation provided] which read:

Thank you for your leadership in introducing and serving as prime sponsor for HB No. 84, "An Act

relating to the presumption of compensability for a disability resulting from certain diseases for firefighters, emergency medical technicians, paramedics, and police officers. We also thank Representatives Tuck and Hopkins for co-sponsoring this bill.

We strongly support HB No. 84 because it is inclusive of emergency medical technicians, paramedics, and peace officers in addition to firefighters who are employed by a state or municipal fire department and volunteer firefighters who are registered with the state fire marshall. It is critical to include all first responders under the provisions of this bill so that they and their families are eligible for compensation in the tragic event of disability resulting from the performance of their duties.

First responders risk their lives every day to protect the communities they live in. However, the risk of injury responding to fires is not the only aspect that makes their service a dangerous occupation. First responders face significant chemical exposures on the job due to the vast quantity of chemicals added to building materials, consumer products and the equipment they use every day. Many of these chemicals have been linked to cancer and other negative health concerns. Firefighters dying from occupational-related cancers now account for 65 percent of the line-of-duty deaths each year as reported to the International Association of Firefighters. This is the largest health-related issue facing the profession. Other first responders are similarly at risk.

In 2010, a NIOSH (National Institute for Occupational Safety and Health) study examined cancer incidence and cancer deaths in approximately 30,000 firefighters from San Francisco, Chicago, and Philadelphia fire departments between 1950 and 2009. The results showed that firefighters have higher rates of the digestive, oral, respiratory, and urinary systems cancers than the general U.S. population. A meta-analysis of 32 studies found an association between firefighting and increased incidence of cancers such as 2 multiple myeloma, non-Hodgkin's lymphoma, prostate cancer, and testicular cancer, compared to the general population.

We support the inclusion of breast cancer among the diseases for presumptive compensability because of increasing evidence of the association with higher rates among women firefighters. A study conducted in the San Francisco Fire Department found the rate of breast cancer among female firefighters aged 40-50 is six times the national average. Studies also show that firefighters are at greater risk of contracting the following cancers: testicular cancer (102% greater risk); multiple myeloma (53% greater risk); non-Hodgkin lymphoma (51% greater risk); skin cancer (39% greater risk); prostate cancer (28% greater risk); malignant melanoma (32% greater risk); brain cancer (32% greater risk); rectum (29% greater risk; stomach (22% greater risk); colon cancer (21% greater risk). Testicular cancer should be included in the provisions of this bill for presumptive compensability because of the high occupational risk and the fact that PFAS exposure (used in industrial firefighting foams), for example, is closely associated with testicular cancer.

We urge support and passage of HB 84 and additional measures to protect the health and safety of our first responders.

[3:25:10 PM](#)

CO-CHAIR SPOHNHOLZ asked how the rates of cancer for firefighters compared to the population at large.

MS. MILLER offered to provide the information.

[3:26:20 PM](#)

DARCEY PERRY, Vice President, Public Safety Employees Association, said that she had been a firefighter at Anchorage International Airport since 2005 and was shocked to find out in 2008 that she was not covered by the legislation. She explained the oversights in that legislation and offered her belief that it had not been intended "to leave our own off." She stated her support of the proposed legislation, pointing out that all first responders should be covered as they were often entering unknown situations.

[3:29:11 PM](#)

CO-CHAIR ZULKOSKY opened public testimony.

[3:29:49 PM](#)

REPRESENTATIVE JACKSON asked if the firefighters were covered by an insurance policy.

MS. SORUM-BIRK replied that there was some insurance for firefighters, dependent on their employers. She clarified that the proposed bill was directed toward workers compensation.

[3:30:57 PM](#)

CO-CHAIR ZULKOSKY closed public testimony.

[HB 84 was held over.]

HB 89-OPIOID PRESCRIPTION INFORMATION

[3:31:03 PM](#)

CO-CHAIR ZULKOSKY announced that the next order of business would be HOUSE BILL NO. 89, "An Act relating to the prescription of opioids; relating to the practice of dentistry; relating to the practice of medicine; relating to the practice of podiatry; relating to the practice of osteopathy; relating to the practice of nursing; relating to the practice of optometry; and relating to the practice of pharmacy."

[3:31:35 PM](#)

The committee took a brief at-ease.

[3:32:09 PM](#)

REPRESENTATIVE TARR moved to adopt the proposed committee substitute (CS) for HB 89, labeled 31-LS0421\U, Fisher,4/3/19, as the working draft.

CO-CHAIR ZULKOSKY objected for discussion.

[3:32:25 PM](#)

CO-CHAIR SPOHNHOLZ introduced HB 89, explaining that this was re-visiting a bill that had previously been introduced by Representation Gara in 2018. She stated that the purpose of the proposed bill was to ensure that Alaska did everything possible to reduce access to opioids and the associated unnecessary

risks. She introduced a PowerPoint titled "House Bill 89: Opioid Addiction Risk Disclosure." She reported that there had been 100 overdoses from opioids in 2017, and although there had been progress through a prescription drug monitoring program, easier disposal of opioids, and a reduction of use, it was still a problem as 80 percent of addiction to street level heroin began with legally prescribed opioids, whether or not it was their legal prescription. She suggested that it was best to flip the conversation and begin with an introduction to the risks associated with opioids before they were taken. She stated that the proposed bill offered "a couple of opportunities for a patient to be educated about the risks of addiction and dependence on opioids before they can consume it." She allowed that there would be exclusions for emergencies and other times when it was not possible for an informed consent. She offered her belief that education should take place at multiple points as research had indicated that it takes multiple times for an individual to hear a message before the information is internalized. She paraphrased slide 3, "Research and Statistics," which read:

A recent meta-analysis of research (Schmidt & Eisend, 2015) published in the Journal of Advertising found that it takes an average of 8-10 exposures for a person to remember a concept.

The more often a patient hears a message about the inherent risks of opioids, the more likely they are to have an increased awareness of the potential dangers of physical dependence and addiction.

Statistics on Opioid Misuse and Opioid Related Deaths:

Drug overdose was Alaska's leading cause of accidental death in 2016 (Alaska Department of Health and Social Services).

More than 3 out of 5 drug overdoses involve an opioid (Centers for Disease Control and Prevention, AK DHSS).

4 out of 5 heroin users started out misusing prescription opioids (American Society of Addiction Medicine).

New research (Weinheimer, Michelotti, Silver, Taylor, & Payatakes, 2018) on effective pain management:

A combination of Ibuprofen 200 mg and Acetaminophen 500 mg is approximately 3 times more effective than 15 mg of Oxycodone. (Dr. Don Teater, Teater Health Solutions).

CO-CHAIR SPOHNHOLZ moved on and paraphrased slide 4, "Goals of House Bill 89, which read:

Reduce the use of opioids for pain management and increase use of non-opiate pain management tools and medications.

Increase communication about the dangers and risks of opioids.

Decrease opioid misuse and opioid-related deaths in Alaska.

Mitigate the opioid related public health crisis Alaska is currently facing.

Provide a positive example to other states in the US that are facing similar public health crises.

[3:36:45 PM](#)

MIRANDA DORDAN, Intern, Representative Ivy Spohnholz, Alaska State Legislature, paraphrased slide 5, "Section 1: Legislative Findings" which read:

Legislative findings hold that the state has a moral, financial, and public health interest in reducing opioid and heroin addiction in Alaska.

Medically documented evidence finds that opioid prescription drugs can lead to physical dependence and potential addiction.

Studies have shown that a significant amount of heroin users started as opioid drug users.

The Opioid Epidemic increases crime in the state, and the presence of heroin dealers in the state poses a public safety threat.

Opioid addictions tear families apart, destroy a person's ability to hold a job, and decimate lives.

Addiction treatment is costly and hard on families, affecting quality of life.

Addiction treatment and additional public safety costs are also expensive for consumers and the state.

[3:38:08 PM](#)

MS. DORDAN paraphrased slide 6, "Section 2: Dentists," which read:

Requires dentists to inform patients of the potential addictive dangers of opioids and any reasonable treatment alternatives using oral and written information before prescribing an opioid.

The State Board of Dental Examiners will craft and enforce regulations that satisfy requirements of HB 89.

MS. DORDAN directed attention to a handout on the Department of Health and Social Services website as a visual aide with great information for opioid statistics specific to Alaska.

[3:40:02 PM](#)

CO-CHAIR SPOHNHOLZ pointed out that the bill sponsors did not want to over prescribe the way this should be implemented at the Board level, but to instead, allow each of the Boards to identify for themselves the best way to regulate and manage the information. She emphasized that the sponsors only wanted to ensure that providers in Alaska offered oral and written communication about the risks and alternatives.

[3:40:40 PM](#)

MS. DORDAN moved on to paraphrase slide 7, "Section 3: Medical, Osteopathy, and Podiatry Providers," which read:

Requires Medical, Osteopathy, and Podiatry Providers to inform patients of the potential addictive dangers of opioids and any reasonable treatment alternatives using oral and written information before prescribing an opioid.

The State Medical Board will craft and enforce regulations that satisfy requirements of HB 89.

[3:41:51 PM](#)

MS. DORDAN directed attention to slide 8, "Section 4: Registered Nurses," which read:

Requires registered nurses to inform patients of the potential addictive dangers of opioids and any reasonable treatment alternatives using oral and written information before prescribing an opioid.

The Alaska Board of Nursing will craft and enforce regulations that satisfy requirements of HB 89.

[3:42:24 PM](#)

MS. DORDAN shared slide 9 "Section 5: Optometrists," which read:

Requires optometrists to inform patients of the potential addictive dangers of opioids and any reasonable treatment alternatives using oral and written information before prescribing an opioid.

The State Board of Examiners in Optometry will craft and enforce regulations that satisfy requirements of HB 89.

[3:42:56 PM](#)

MS. DORDAN indicated slide 10 "Section 6: Pharmacists," which included the changes in the proposed committee substitute, Version U, which read:

Requires pharmacists to inform patients of the potential addictive dangers of opioids using oral and written information before dispensing an opioid.

The Alaska Board of Pharmacy will craft and enforce regulations that satisfy requirements of HB 89.

[3:44:57 PM](#)

MS. DORDAN directed attention to slide 11 "Section: Visual Aid," which read in part:

DHSS must create a visual aid that providers can hand out to patients when they are being prescribed opioids.

MS. DORDAN reiterated that the handout had already been created and was on the Department of Health and Social Services website.

[3:46:16 PM](#)

MS. DORDAN shared the references and letters of support on slide 12, "Letters of Support:" which included the Alaska Dental Society and Fallen Up Ministries.

[3:46:37 PM](#)

REPRESENTATIVE JACKSON offered her belief that doctors had taken an oath to do everything within their power to keep their patients healthy and that there was a federal requirement for doctors to explain each drug and its side effects. She asked if the proposed bill was requiring the state to manage doctors for how they inform and educate their patients.

[3:47:37 PM](#)

CO-CHAIR SPOHNHOLZ explained that the proposed bill was designed to add another layer of education for patients. She shared a personal experience with opioids and noted that the bill proposed to begin the conversation in the health care provider's office. She offered her belief that more conversation would reduce the number of opioids prescribed, consumed, and distributed into our communities.

[3:49:34 PM](#)

REPRESENTATIVE JACKSON acknowledged awareness for the opioid crisis, with a variety of organizations enforcing education on opioids. She asked for clarification that Co-Chair Spohnholz had been offered medications without any education.

CO-CHAIR SPOHNHOLZ replied that she had been offered opioids by a full range of medical professionals.

REPRESENTATIVE JACKSON asked if the proposed bill would ensure monitoring through the various Boards that doctors were offering this education.

CO-CHAIR SPOHNHOLZ replied that the intent of the proposed bill was to require medical personnel to educate patients about the risks associated and give them printed materials to take home. The proposed bill would give the power to the Boards for enforcement. She emphasized that it was not intended to define in law specific steps that should be taken. She offered her belief that a way to build consensus was to allow the professionals to determine the best way to regulate and enforce.

[3:51:51 PM](#)

REPRESENTATIVE JACKSON acknowledged that "the idea and the intention is fabulous" but asked if there had been discussions with the various boards for a timeframe. She suggested that enforcement legislation may be necessary if the boards did not comply.

CO-CHAIR SPOHNHOLZ shared the history of a prior compromise to allow Department of Health and Social Services to create and distribute information. However, it had been decided that it was time to introduce legislation, as the boards had a limited scope of responsibility and needed a law in order to take on new regulations. She stated that she had been talking with providers to craft a bill that was practical while achieving the public health goal for reduction of opioid dependence.

[3:53:49 PM](#)

REPRESENTATIVE DRUMMOND directed attention to slide 2 and expressed her surprise regarding the combination of ibuprofen and acetaminophen as three times more effective than 15 mg of oxycodone. She asked if this was a prescription combination or was it available over the counter.

CO-CHAIR SPOHNHOLZ explained that the combination was a legal over the counter level for each of those medications. She acknowledged that this combination was so much more effective than opioids.

[3:55:44 PM](#)

REPRESENTATIVE DRUMMOND directed attention to slide 3 and expressed that she was impressed with the 36 percent decrease in opioid overdoses and a 67 percent decrease in fentanyl overdoses. She asked if each overdose resulted in death.

CO-CHAIR SPOHNHOLZ clarified that these were overdose related deaths and not just overdoses. She reported that overdose death had decreased with the broad distribution of naloxone as it allowed emergency responders to reverse an overdose.

[3:57:28 PM](#)

REPRESENTATIVE DRUMMOND referred to slide 7 and asked about exemptions for palliative and hospice care.

MS. DORDAN explained that these exemptions could be offered although ultimately the Board would decide who was exempt.

CO-CHAIR SPOHNHOLZ added that, as the delivery of health care was very complex, it was the intention not to define in law exactly where the education should take place and that, instead, the medical professionals make that decision. She noted that the implementation could be addressed later if there were concerns.

[3:59:12 PM](#)

REPRESENTATIVE DRUMMOND pointed to slide 9 and asked about treatments performed by optometrists which required an opioid.

CO-CHAIR SPOHNHOLZ explained that, although it was not routine care, optometrists could perform some minor procedures which could create some pain and necessitate the prescription of pain medication.

[4:00:34 PM](#)

CO-CHAIR ZULKOSKY removed her objection. There being no further objection, the proposed committee substitute (CS) for HB 89, labeled 31-LS0421\U, Fisher,4/3/19, was adopted as the working draft.

[4:01:05 PM](#)

CO-CHAIR ZULKOSKY opened public testimony.

[4:01:22 PM](#)

CO-CHAIR ZULKOSKY said she would keep public testimony open.

[HB 89 was held over.]

HB 92-DIRECT HEALTH: NOT INSUR; ADD TO MEDICAID

[4:01:30 PM](#)

CO-CHAIR ZULKOSKY announced that the next order of business would be HOUSE BILL NO. 92, "An Act exempting direct health care agreements from regulation as insurance; establishing a direct care payment program for medical assistance recipients; and providing for an effective date."

[4:01:44 PM](#)

ERIN SHINE, Staff, Representative Jennifer Johnston, Alaska State Legislature, paraphrased the Sponsor Statement [Included in members' packets], which read:

HB 92 amends the state insurance code by exempting direct care agreements from the definition of insurance. It also, includes conditional language for the Department of Health and Social Services to apply for a State Plan Amendment with the Centers for Medicare & Medicaid Services to allow for direct care agreements for and, if approved, requires that providers accept Medicare and Medicaid patients up to 20 percent of their patient population. This bill does not mandate that direct care practices be formed; it only exempts them from regulation by the division of insurance.

Direct care agreements consist of a practitioner or group of physicians who contract with individual patients to provide care outlined in a contract for a monthly, quarterly or semiannual fee. The relationship between physician and patient is contractual and the contractual relationship can be altered or amended by the same means that already govern existing contractual relationships. Through this arrangement patients gain access to as much care as they need.

Under existing care models, a patient sees a doctor and then the doctor bills the patient's insurance. In a direct care practice, no bill is submitted to a third-party payer. The only money exchanged is the patient's monthly, quarterly or semi-annual membership payments. This arrangement liberates the physician from all involvement with insurance and are relieved from paperwork required by payers. Physicians have more time to spend on direct patient care.

The American Academy of Family Physicians "Principles for Reform of the U.S. Health Care System" holds that: "Less complicated administrative systems are essential to reduce costs, create a more efficient health care system, and maximize funding for health care services."

HB 92 creates an environment where a new market for the delivery of health care can exist and grow by allowing direct care agreements to create a less complicated administrative system.

4:04:20 PM

REPRESENTATIVE DRUMMOND asked if the requirement that doctors accept Medicare and Medicaid patients for up to 20 percent of their patient population would increase the availability of primary care providers to those patients.

MS. SHINE offered her belief that this would create an avenue to access care and that a provider with a direct care agreement practice would be one more provider accepting Medicare and Medicaid patients.

4:05:14 PM

REPRESENTATIVE JACKSON asked if this offered practitioners and physicians the opportunity to set up a co-op for affordable care between the physician and the patient.

MS. SHINE replied that it allowed patients to pay a revolving fee to a provider or a group of providers for access to care as outlined in a contract. She pointed out that this was not insurance and that the proposed bill exempted them from the definition of insurance.

REPRESENTATIVE JACKSON stated her support for legislation that would allow physicians to have direct payment from patients as an alternative for those without insurance. She asked about making this mandatory for physicians to accept Medicaid and Medicare patients.

MS. SHINE said that providers who accepted Medicare and Medicaid patients could continue as status quo, whereas the proposed bill would allow a provider to set up a different form of health care delivery. This would allow a contract directly with the patient and not with a third party. The proposed bill stated that a physician who chose to set up this type of practice must accept Medicare and Medicaid patients.

4:08:01 PM

REPRESENTATIVE CLAMAN expressed concern that the proposed bill would provide access to middle class whereas those with "much

tighter financial situations really would never be able to take advantage of this kind of situation." He asked how this would work with medical savings accounts.

MS. SHINE offered her belief that this was an affordable way for the patients in 25 states to access primary care. She opined that Alaska would be the first state to open-up for other forms of care, and not direct that this be primary care. She said that the use of medical savings accounts was a grey area and that there were testifiers who could more adequately answer the question.

REPRESENTATIVE CLAMAN asked what areas beyond traditional primary care did the bill propose to offer.

MS. SHINE explained that this had been left broad to determine whether this was a good model for access to care in a more efficient manner. She offered her assumption that most providers would set up an agreement practice for primary care as most general surgery could not charge enough on a monthly basis.

REPRESENTATIVE CLAMAN asked if there were specialties more likely to be interested in this beyond primary care.

MS. SHINE offered her belief that some states were currently trying to expand the scope beyond primary care.

[4:12:18 PM](#)

REPRESENTATIVE DRUMMOND asked about statistics, history in the states where the program is allowed, and the cost to consumers for the direct care agreements. She asked if those other states with direct care agreements contained the Medicare and Medicaid percentage requirement.

MS. SHINE offered her belief that about 25 states had direct primary care agreements, although she did not know anything about the cost of care. In response, she opined that, although no other states included the proposed Medicare and Medicaid percentage requirement, that was not to say that Medicare and Medicaid patients did not access this form of care.

REPRESENTATIVE DRUMMOND offered her belief that it was difficult to find primary care physicians that accepted Medicare in Alaska, even as Medicare accepting physicians were much more available in other states while being reimbursed at a better rate. She opined that this could also be true for Medicaid.

4:14:35 PM

LEE GROSS, MD, Epiphany Health, reported that he was a full-time practicing family doctor. He stated that this model could simplify health care delivery, reduce the cost of care, lower barriers to access, reduce physician burn-out, and restore the central focus of the health care system to the patient. He shared the history of his practice, noting that the name, Epiphany Health, evolved from the question for why to insure primary care as this created far too many barriers between the doctor and the patient. He stated that health insurance was being used incorrectly. He declared that routine health care should be made affordable for everyone, with predictable, price transparency, that insurance should be a hedge against catastrophic loss, and not to pay for basic, essential care. He reported that, in 2010, his practice had created a membership based primary care program for patients aged five years and older with a flat monthly fee of \$60 per month for an adult, which covered all the services his practice provided. He added that a child was \$25 per month, with each additional child in the family for \$10 per month. He pointed out that there were not any co-pays for any services which could be done in the office. He explained that, in order to practice outside a traditional third-party payment system, he had reached out to independent labs, image services, and others to secure wholesale prices. He compared the prices of these services to those through a traditional office visit. He reported that, currently, there were about 1,000 of these practices with a direct primary care model. He added that some of these practices also offered wholesale dispensing of medications to allow affordable access. He reiterated that there were 25 states with legislation to protect this practice model, pointing out that no states had regulated against the provision of direct primary care services. He noted that he did oppose provisions in the proposed bill that set quotas for Medicare and Medicaid, pointing out that no other states set these quotas, and that portion of the proposed bill would be the first in the nation to mandate participation in Medicare and Medicaid. He stated his enthusiastic support for the rest of the proposed bill.

4:20:04 PM

CO-CHAIR SPOHNHOLZ asked how the rates were developed.

DR. GROSS replied that, as the cost for routine care was cheaper than a cell phone plan, they had determined that this was a

reasonable price. He added that this had also stabilized the finances for his practice. He noted that prior to shifting his practice model, his office was not a Medicaid provider, but with his new primary care model, he did have Medicaid patients as they could afford the services provided.

CO-CHAIR SPOHNHOLZ asked about the risks to the consumers if a patient became too expensive to care for.

DR. GROSS replied that, under existing law, a doctor could drop a patient for any reason, adding that the provision in the proposed bill which allowed for cancellation by either party with two months' notice was longer than the notice which existed in current law. He pointed out that the model was designed to attract people with chronic diseases, heavier utilizers, although it was not always the same utilizer each month. He stated that these were the people a practice should keep.

CO-CHAIR SPOHNHOLZ asked how many patients he had let go in the last year.

DR. GROSS replied that he had not terminated anyone, and that he had a three month wait list for new patients to his practice.

CO-CHAIR SPOHNHOLZ asked how this practice model made money without culling the expensive patients.

DR. GROSS explained that this practice was not financially viable as a fee for service insurance-based practice because of all the expenses necessary to provide medical care through the insurance companies, which included proprietary software, staffing, and the other 60 percent of overhead necessary to bill the insurance companies. He noted that his overhead was now some of the lowest in the country, between 20 - 30 percent. He shared some of the costs, noting that there was little incentive to cull the high utilizers.

[4:25:20 PM](#)

DR. GROSS, in response to Representative Claman, said that the main office for his practice was in North Fork, Florida, with an expansion office in rural Florida where there was a 50 percent uninsured rate with a median income of \$25,000 per year. He added that they had integrated with the critical access rural hospital an employee benefit into their health plan as an option to a traditional health plan. He reported that 80 percent of the hospital employees signed up for membership with his

practice, a projected savings of more than \$1 million in the first year for the hospital while also reducing employee premiums 20 percent and eliminating their network restrictions, co-pays, and deductibles for routine care.

REPRESENTATIVE CLAMAN asked how many physicians were in his main clinic.

DR. GROSS replied that there were two doctors and a nurse practitioner. In response to Representative Claman, he acknowledged that he was one of the doctors.

REPRESENTATIVE CLAMAN asked about Medicaid payments.

DR. GROSS explained that his practice did not take any money directly from Medicaid as the Medicaid patients paid his practice directly. He reported that, because the State of Florida had a Medicaid share of cost with a high patient deductible which reset every month, the patients could not afford access to chronic care management.

REPRESENTATIVE CLAMAN asked if the State of Florida offered any reimbursement to Medicaid recipients for payment to his practice.

DR. GROSS replied that it was most likely easier for Medicaid recipients to pay his monthly fee out of pocket instead of trying to work through the Medicaid system for routine primary medical services. He declared that it was difficult to find a doctor in Florida who took Medicaid.

REPRESENTATIVE CLAMAN asked if the monthly fee included prescription medications.

DR. GROSS said that his practice encouraged patients to have insurance for non-routine and catastrophic expenses. He reiterated that the monthly fee only included services provided in his office. He reported that some practices did offer medications as a path through cost directly to the patient, and he shared the prices of some generic drugs used to manage chronic conditions. He noted that often it was more expensive for a patient to use their insurance to pay for the medications instead of paying cash.

REPRESENTATIVE CLAMAN asked if medication services as a pass-through cost did not add to the base monthly fee and was only reimbursed to his office.

DR. GROSS agreed that there would be a pass-through cost for the wholesale cost for the medication.

REPRESENTATIVE CLAMAN asked how many providers similar to his clinic were in Florida.

DR. GROSS offered that there were about 60 providers, and that the legislation had only just passed about one year prior. He added that the Florida legislature was already looking to expand this.

[4:31:21 PM](#)

REPRESENTATIVE JACKSON stated that she thought this was a great idea and asked if the current laws under the Patient Protection and Affordable Care Act (PPACA) recognized this process.

DR. GROSS said that Section 1301 of the PPACA did contain a provision that specifically allowed direct primary care with a wrap around catastrophic plan to qualify as minimal coverage in order to avoid the tax penalty.

[4:32:58 PM](#)

REPRESENTATIVE DRUMMOND asked if the prescriptions for a Type II diabetic counted as a heavy utilizer in his practice.

DR. GROSS said that the Type I and Type II diabetics were the ideal patients in his practice because they came in for visits "five, six, seven times a year." He noted that, as the A1C test for the three-month average blood sugar monitoring, was administered in his office there was no charge for the point of care testing. He explained that these patients could be managed over the phone, by text, or by e-mail. He reported that one diabetic patient could no longer afford to see the endocrinologist because of the \$600 per visit.

REPRESENTATIVE DRUMMOND asked about the cost of the insulin, as it had skyrocketed in the last few years even though the medication had not changed.

DR. GROSS expressed his agreement that the new pricing for insulin was a national problem. He said they did the best they could given the available resources and would often work directly with the manufacturers. He noted that sometimes, given

the income level of his patients, they did not have to pay anything for medications.

REPRESENTATIVE DRUMMOND asked how diabetic patients could afford the best insulins. She asked if these prescriptions were covered by insurance.

DR. GROSS said that patients who did have insurance would use it to pay for the prescriptions, although his practice would work with the manufacturers for patients without insurance. He reported that Type II diabetics required more time to teach them lifestyle changes and wean them away from the medications. He declared that it took 3 minutes to prescribe a medication but 30 minutes to not prescribe a medication.

REPRESENTATIVE DRUMMOND asked if the manufacturers supplied free insulin forever to a Type I diabetic who could not live without insulin.

DR. GROSS replied, "at the moment, they do. Forever, I can't certainly tell you that." He explained that, if a patient was not eligible for a government program such as Medicare, Medicaid, or benefits, and they were not presently getting health insurance, then, in most cases they would qualify for free insulin based on income. He expressed his desire to see federal changes to the pharmacy benefits management as it could not be fixed at the direct primary care level.

[4:40:34 PM](#)

CO-CHAIR ZULKOSKY shared concern that an exemption for direct care agreements from insurance regulations would remove consumer protections, and ultimately limit patients to contractual items contained in the care agreements. She asked about the regulation of rates and the guaranteed coverage allowed through the various care agreements ensuring that clients who may get sick outside the contracts were able to receive coverage.

DR. GROSS explained that they were not asking for physicians to not be regulated, but that physicians should not be regulated as insurance companies. He declared that physicians were very heavily regulated and that would not change for direct primary care.

CO-CHAIR ZULKOSKY asked if regulations of these direct care agreements were managed through contractual law in the State of Florida.

DR. GROSS replied that this law managed the actual agreement; whereas, the conduct of the practice, the practitioner, and the delivery of care was monitored through the State Medical Board.

CO-CHAIR ZULKOSKY asked if the Division of Insurance had conducted an analysis for the impact on consumer protections in Alaska with the exemption of direct care agreements from insurance regulations.

[4:43:06 PM](#)

ANNA LATHAM, Deputy Director, Juneau Office, Division of Insurance, Department of Commerce, Community & Economic Development, said that the division had not analyzed any impact to consumers should these agreements occur. She directed attention to a report by the Office of the Insurance Commissioner in the State of Washington. She said that Washington had been groundbreaking in direct care practices, with 41 direct care practices currently exempted from the insurance code. She noted that direct care and concierge medicine had been prevalent in Washington since the early 2000s and were exempted in 2007. She reported that part of the regulation required an extensive report to the Office of the Insurance Commissioner. She suggested that this report could have some analysis for the consumer impact. She pointed out that these agreements were very transparent for what services were provided.

CO-CHAIR ZULKOSKY asked for the history to the management and regulation of rates and coverages within the direct care agreements. She suggested that they were managed largely by the provider groups and not through regulation by the Division of Insurance.

MS. LATHAM explained that the rates were set by the practices. She offered some information to the variance of the rates in the past two years. From 2016 - 2018, 11 practices increased fees, 6 decreased fees, and 5 offered no changes in fees. According to the Direct Primary Care coalition, the median fee was about \$70 per person per month, or \$165 per month for a family of four.

CO-CHAIR ZULKOSKY asked about the percentage of average increase.

MS. LATHAM said that she could provide the Office of the Insurance Commissioner report.

REPRESENTATIVE CLAMAN asked if Health Savings Accounts could be used to pay the fees.

MS. LATHAM offered her belief that the use of Health Savings Accounts was not allowed for these plans. She noted that there had been some federal effort in 2017 to allow for this but the bill did not pass.

DR. GROSS expressed his agreement that Health Savings Accounts could not be used to pay for direct care contracts, as they were not eligible under federal code.

DR. GROSS, in response to Representative Jackson, said that the Health Savings Accounts had to be used with a qualifying high deductible health plan. He pointed out that these high deductible health plans could not cover direct primary care as it was first dollar coverage. He offered his belief that most people believed that direct primary care membership should qualify under the Internal Revenue code.

[4:49:34 PM](#)

CO-CHAIR ZULKOSKY opened public testimony.

[4:49:58 PM](#)

CO-CHAIR ZULKOSKY closed public testimony.

[HB 92 was held over.]

HB 114-MEDICAL PROVIDER INCENTIVES/LOAN REPAYM'T

[4:50:11 PM](#)

CO-CHAIR ZULKOSKY announced that the final order of business would be HOUSE BILL NO. 114, "An Act relating to a workforce enhancement program for health care professionals employed in the state; and providing for an effective date."

[4:50:55 PM](#)

CO-CHAIR SPOHNHOLZ paraphrased from the Sponsor Statement for HB 114 [Included in members' packets], which read:

Health care is one of the largest and most dynamic industries in Alaska, yet many citizens, especially in rural areas, continue to experience challenges with accessing care. The availability of health care services is important for maintaining health, preventing and managing disease, and reducing costs from unnecessary emergency room visits, and hospital readmissions and temporary staffing. One reason access to care is limited, particularly in rural Alaska, is due to shortages of healthcare professionals. Health care sites struggle with recruiting and retaining health care professionals. Further, health care professionals have challenges with large student loan debt and high cost of living in rural and remote locations.

To meet the ongoing demand, Alaska must continue to address the shortage of health care professionals. HB 114 (SHARP-3) does this by establishing the Health Care Professionals Workforce Enhancement Program, a public-private partnership that will increase the number of providers while minimizing the use of state funds. Health care professionals agree to work for minimum of three years in Alaska in underserved areas in exchange for repayment of student loans or direct incentives. Employers will fully fund the program, taking advantage of a federal tax exemption available only to a state-run program.

The success of healthcare loan repayment and incentive programs in increasing the healthcare workforce in Alaska was demonstrated in SHARP-2. Between 2013 and 2015, SHARP-2 was successful in recruiting and/or retaining 83 clinicians statewide, with most clinicians placed in locations off the road system and emphasizing care for rural and underserved populations. With the sunset of SHARP-2 on June 30, 2019, other healthcare practitioner incentive programs are needed to reduce healthcare workforce shortages throughout Alaska.

SHARP-3 builds on the success of SHARP-2 with new practice settings, new occupations, new employers, new locations, and new roles. Employers can hire much-needed staff, providers get assistance with their loan payments which makes it more affordable to work in a rural community, and Alaskans living in rural

communities have improved access to health care--all without the use of state general funds.

4:54:22 PM

JILL LEWIS, Deputy Director - Juneau, Central Office, Division of Public Health, Department of Health and Social Services, presented a PowerPoint titled "HB 114 Medical Provider Incentives/Loan Repayment." She directed attention to slide 2, "HB 114," which read:

Establishes a Health Care Professionals Workforce Enhancement Program to address shortage of health care workforce.

Health care professionals agree to work for three years in underserved areas in exchange for repayment of student loans or direct incentives.

Employers fully fund the program. No unrestricted general funds are involved.

Replaces the existing program in AS 18.29 scheduled for sunset June 30, 2019.

4:55:38 PM

MS. LEWIS noted that Representative Spohnholz had already reviewed the challenges listed on slide 3, "Challenges in health care access," and she directed attention to slide 4, "SHARP - 2," which read:

Operated 2013 - 2018
No new contracts after 2015 due to GF budget reductions
83 contracts: 39 Tier 1 and 44 Tier 2
47-53% positions very hard-to-fill
\$25,560 average payment per contract per year
10-30% employer match
31 employers distributed across 25 communities
Primarily non-profit and hospital associated
Similar numbers of tribal and non-tribal affiliated organizations

MS. LEWIS moved on to paraphrase slide 5, "An innovative solution," which read:

A public-private partnership that ensures access to health care by expanding the distribution of health care professionals all Alaskans at no cost to the state.

SHARP-3 builds on the success of SHARP-1 and SHARP-2 with new practice settings, new occupations, new employers, new locations, and new roles.

Benefit will not be limited to rural areas or primary care; there is also room for specialists and urban health care professionals.

Takes advantage of a federal law that exempts loan repayment from federal income tax if awarded through a state-run program.

Public-private partnerships increases the number of providers while minimizing the use of state funds.

[4:56:56 PM](#)

MS. LEWIS shared slide 6, "Benefits," which read:

Health care sites can hire much needed staff
Health care professionals get assistance with their student loans
Alaskans have improved access to health care
Access to health care is important for maintain health and reducing costs
All without the use of undesignated general funds

[4:57:21 PM](#)

MS. LEWIS explained slide 7, "SHARP - 3," which read:

Health care professionals receive student loan repayment and/or direct incentives for working in underserved areas.
Employer sites provide health care services in underserved or health care professional shortage areas.
3 year contract with renewals; 12 year lifetime limit.
Employer payments fully cover cost of the professional's program payment and an administrative fee.

An advisory council recommends eligibility criteria, prioritization of sites and professionals for participation, and contract awards.

[4:58:36 PM](#)

REPRESENTATIVE CLAMAN asked whether the 3-year contract with the 12-year lifetime limit was intended to pay the entirety of a loan or only the amount due each year of that contract time. He offered an example of a 20-year loan, asking if a 3-year contract would allow payment for 3 years of the 20-year loan.

MS. LEWIS replied that a provision only allowed up to one-third repayment of a loan in each of the 3 years if a person was using the loan repayment option and not a direct incentive.

[4:59:31 PM](#)

MS. LEWIS directed attention to slide 8, "SHARP - 3," adding that this could further address the question posed by Representative Claman, which read:

Tier 1: dentist, pharmacist, physician
\$35,000/year regular or \$47,250 very hard-to-fill
Tier 2: dental hygienist, registered nurse, advanced practice registered nurse, physician assistant, physical therapist, clinical psychologist, counseling psychologist, professional counselor, board certified behavior analyst, marital and family therapist, or clinical social worker
\$20,000/year regular or \$27,000 very hard-to-fill
Tier 3: not otherwise eligible under Tier 1 or Tier 2
\$15,000/year regular or \$20,250 very hard-to-fill

MS. LEWIS stated that, although these were the current amounts currently set in statute for SHARP 1 and SHARP 2, the amounts could be set by the commissioner. She pointed out that Tier 3 was new with the proposed bill, stating that each tier addressed different levels of educational attainment and practice.

[5:01:49 PM](#)

MS. LEWIS moved on to the diagram on slide 9, which described the process for the program. She explained that health care professionals who have applied and were accepted would work at an eligible site for a calendar quarter. At the end of that quarter, the site would report back to the SHARP program on that

professional's hours worked and the amount of care given. She noted that SHARP could adjust the maximum payments based on the actual hours worked, and that individuals had an option for full or half time. She noted that the service was provided before the employer made any payments. SHARP would invoice the sites for the professional's payment and the administrative fee. The sites would send payment back to the SHARP program with that money being used to make loan payment to the lender, or a direct incentive payment to the professional. She reported that SHARP routinely provided data back to the Advisory Council to prioritize and establish criteria.

[5:04:07 PM](#)

MS. LEWIS presented slide 10, "In closing..." which read:

HB 114

Keeps health care professionals in rural communities

Promotes health and economic community stability

Ensuring a healthier future for all Alaskans

At the lowest possible cost.

[5:04:35 PM](#)

CO-CHAIR ZULKOSKY referenced slide 4 and noted that the SHARP program offered opportunities to all communities throughout Alaska.

[5:05:01 PM](#)

REPRESENTATIVE DRUMMOND, directing attention to slide 4, asked if SHARP - 2 was paying an average of \$25,500 per year for 83 different contracts. She stated that this was about \$2.1 million per year from the general fund and asked if this was before or after the employer match.

MS. LEWIS reported that the program had ramped up in 2013 and 2014 and was fully operating in 2015 with more than 40 contracts added each year. After that, as there were no additional general funds, no new contracts were extended. She added that there had been significant state match, with the employers paying between 10 and 30 percent for each of the contracts.

REPRESENTATIVE DRUMMOND asked if the \$2.1 million was before or after the employer match.

MS. LEWIS stated that this was the total cost and included the employer's share.

[5:06:53 PM](#)

CO-CHAIR SPOHNHOLZ pointed out that there was a "Final Report to the Legislature," dated December 2018, [Included in members' packets] and she directed attention to page 9, which listed the range of health care providers and contract expenses listed under SHARP 2. She emphasized that the proposed current legislation for SHARP 3 was all privately funded. She reported that under SHARP 2 the general fund expense had been \$4,909,038 and the employer match was \$1,455,438.

REPRESENTATIVE DRUMMOND asked where the money was coming from to pay for proposed HB 114.

CO-CHAIR SPOHNHOLZ explained that the SHARP 3 program would be entirely funded by the employer community, as there was an interest in recruiting health care providers and providing incentives. She noted that there was a tax benefit to both the employer and the employee. She offered her belief that there was still a state interest to ensure that health care was provided, both in Rural Alaska and underserved populations in urban Alaska. She noted that it was necessary to use "all of the tools in our tool kit to recruit and retain providers in those underserved areas of health care."

REPRESENTATIVE DRUMMOND asked what would happen to the health care providers currently covered by the loan repayment program if proposed HB 114 did not pass.

[5:09:50 PM](#)

MS. LEWIS explained that there would be no new contracts for the SHARP 2 program, and that all the existing contracts have been paid. She reported that SHARP 1, the federal option, was an on-going grant that was not affected by either SHARP 2 or proposed HB 114.

[5:10:44 PM](#)

RACHEL GEARHART, Co-Chair, SHARP Council, reported on the status of health care professionals in each committee member's district and noted that the proposed bill provided a benefit to all their constituents. She acknowledged how valuable the proposed bill would be for recruiting and retaining quality health care

professionals with no additional expenditure to the state. She noted that she had been a SHARP 2 recipient, which had allowed her to be free of student loan, and that she was still working for the same agency as when she had received her benefit. She pointed to the letters of support from SHARP recipients. She shared that the SHARP data from the quarterly work reports offered tracking for important demographics to further recruitment and retention efforts, noting the retention of permanent workers in substance use capacity. She noted that proposed HB 114 would allow the biggest community mental health centers to be eligible sites without also having to be a federally qualified health center. SHARP 3 would expand eligible sites and eligible professions, including respiratory therapists, occupational therapists, case managers, chemical dependency councilors, and training coordinators. She noted that, in mental health work, the therapeutic alliance with a client was considered one of the most important factors for working together. She explained that, when those with high ACEs scores started to connect with a mental health professional, progress was made. She pointed to disruption to service delivery due to staff turnover, which SHARP 3 could help alleviate.

[5:16:00 PM](#)

NANCY MERRIMAN, Executive Director, Alaska Primary Care Association, stated support for proposed HB 114 to establish the SHARP 3 program and help Health Centers better serve Alaskans. She declared that there was a shortage of health care professionals of all types in Alaska, and that Health Center leaders constantly grappled with vacant health care clinician positions. Although health care jobs remained the fastest growing sector in the Alaska labor force, the demands outpaced the availability and, as Alaskans grew older, there was an increased need for health care with an increased incidence of chronic disease requiring more constant care. She pointed out that health care professionals were not distributed evenly across the state.

MS. MERRIMAN declared that the SHARP programs were critical for community health centers, reporting that the SHARP 1 program had issued 172 contracts to health centers since its inception in 2010; the SHARP 2 program had issued 47 contracts with health care providers. She shared that APCA surveys revealed that the most important work force issues were for recruitment and retention, with noted appreciation for SHARP. She relayed that SHARP had also addressed some of the disparity for the

distribution of providers. She added that Alaska community health centers had benefited from the SHARP program, sharing that 80 of the 105 candidates awarded into the SHARP 1 program were practicing in community health centers.

MS. MERRIMAN stated that SHARP 3 was innovative and did not require any state general fund dollars, while offering a valuable state infrastructure. It would provide the ability to expand the benefits of SHARP to many areas not currently designated as health professional shortage areas. The proposed bill would also expand the provider types eligible for loan repayment.

REPRESENTATIVE CLAMAN asked if the increase of funding by employers to 100 percent for the proposed SHARP 3 program would be an issue.

MS. MERRIMAN explained that the program funding would not be 100 percent by the employers, as there would be a request to other bodies for a cost share to help support the additional necessary funding.

REPRESENTATIVE CLAMAN asked for information as to the other bodies.

MS. MERRIMAN suggested that these could be philanthropic organizations, labor unions, or associations.

[5:21:56 PM](#)

JANE ERICKSON, President, Alaska Nurses Association, stated support of proposed HB 114. She stated that the Alaska Nurses Association strongly believed in the value of the SHARPS program, which improved access to high quality health care by providing incentives to health care professionals to create a more equitable distribution of health professionals throughout Alaska. She reported that Alaska faced continual difficulties in recruitment and retention for a health care workforce, especially in rural and remote communities. She declared that SHARP 3 was a critical need for this recruitment and retention of health care professionals. She declared that the SHARP program had made a tremendous positive difference and was the main state program to support placement of a range of providers. She added that the program was a smart financial move for the state. She pointed out that private funds would be used instead of state dollars and would expand the eligibility beyond the

strictures of the previous SHARP programs. This would greatly impact the health and welfare of communities statewide.

[5:24:57 PM](#)

CONNIE BEEMER, Vice President, Alaska State Hospital and Nursing Home Association (ASHNHA), stated support for proposed HB 114. She paraphrased from a prepared statement [Included in members' packets] which read:

The Alaska State Hospital and Nursing Home Association (ASHNHA) is offering this letter of support for SHARP - 3. As a member of the SHARP Council we have been involved with the program since its inception and believe in the value of the program to support high quality care through an equitable distribution of health professionals throughout Alaska.

The SHARP program has helped Alaska's hospitals ensure an adequate supply of healthcare providers and is an important tool to help with recruitment and retention. We support the addition of a third component through SHARP - 3 legislation.

SHARP - 3 will support a variety of practice settings, locations (especially those not eligible as a HPSA or other federal programs for SHARP - 1) and provider types. We need to use whatever tools are available to support healthcare organizations to recruit and retain employees. SHARP - 3 would expand the use of federal tax exemption for education loan repayment and enhance the number and variety of financial contributors. There is a need to give local control to allow communities to designate funds to support recruitment of providers. SHARP - 3 utilizes the existing SHARP infrastructure while maximizing contributions from local communities or foundations. Money could be contributed from different local sources such as a business, private foundation, trade association, government entity, foundations or employers.

SHARP 3 provides valuable state infrastructure, without additional state general funds, and will provide us the ability to expand the benefits of SHARP to areas that are not Health Professional Shortage Areas (HPSAs), a require for SHARP 1.

ASHNHA is prepared to support our members in efforts to utilize SHARP 3 as soon as it is available. We're eager to continue the momentum of SHARP and to support workforce development efforts in Alaska in this way.

[5:27:56 PM](#)

CO-CHAIR ZULKOSKY opened public testimony.

[5:28:15 PM](#)

CO-CHAIR ZULKOSKY closed public testimony.

[HB 114 was held over.]

[5:29:16 PM](#)

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:29 p.m.