

**ALASKA STATE LEGISLATURE
HOUSE LABOR AND COMMERCE STANDING COMMITTEE**

March 23, 2022

3:18 p.m.

MEMBERS PRESENT

Representative Zack Fields, Co-Chair
Representative Ivy Spohnholz, Co-Chair
Representative Calvin Schrage
Representative Liz Snyder
Representative David Nelson
Representative James Kaufman
Representative Ken McCarty

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

SENATE JOINT RESOLUTION NO. 12

Urging the United States Congress to repeal the Windfall Elimination Provision and Government Pension Offset of the Social Security Act.

- MOVED SJR 12 OUT OF COMMITTEE

HOUSE BILL NO. 176

"An Act relating to insurance; relating to direct health care agreements; and relating to unfair trade practices."

- HEARD & HELD

SENATE BILL NO. 143

"An Act relating to horizontal property regimes and common interest communities; and relating to mortgages, deeds of trust, and other property liens."

- MOVED SB 143 OUT OF COMMITTEE

PREVIOUS COMMITTEE ACTION

BILL: SJR 12

SHORT TITLE: SOCIAL SECURITY BENEFIT REDUCTION REPEAL

SPONSOR(S): SENATOR(S) WIELECHOWSKI

03/29/21	(S)	READ THE FIRST TIME - REFERRALS
03/29/21	(S)	STA, FIN
04/27/21	(S)	STA AT 3:30 PM BUTROVICH 205
04/27/21	(S)	<Bill Hearing Canceled>
05/04/21	(S)	STA AT 3:30 PM BUTROVICH 205
05/04/21	(S)	Heard & Held
05/04/21	(S)	MINUTE(STA)
05/06/21	(S)	STA AT 3:30 PM BUTROVICH 205
05/06/21	(S)	Moved SJR 12 Out of Committee
05/06/21	(S)	MINUTE(STA)
05/07/21	(S)	STA RPT 1DP 3NR
05/07/21	(S)	DP: SHOWER
05/07/21	(S)	NR: HOLLAND, COSTELLO, REINBOLD
02/24/22	(S)	FIN AT 9:00 AM SENATE FINANCE 532
02/24/22	(S)	Heard & Held
02/24/22	(S)	MINUTE(FIN)
03/01/22	(S)	FIN AT 9:00 AM SENATE FINANCE 532
03/01/22	(S)	Moved SJR 12 Out of Committee
03/01/22	(S)	MINUTE(FIN)
03/04/22	(S)	FIN RPT 6DP
03/04/22	(S)	DP: STEDMAN, BISHOP, HOFFMAN, WILSON, WIELECHOWSKI, OLSON
03/11/22	(S)	TRANSMITTED TO (H)
03/11/22	(S)	VERSION: SJR 12
03/14/22	(H)	READ THE FIRST TIME - REFERRALS
03/14/22	(H)	STA
03/14/22	(H)	L&C REPLACES STA REFERRAL
03/21/22	(H)	L&C AT 3:15 PM BARNES 124
03/21/22	(H)	Heard & Held
03/21/22	(H)	MINUTE(L&C)
03/23/22	(H)	L&C AT 3:15 PM BARNES 124

BILL: HB 176

SHORT TITLE: DIRECT HEALTH AGREEMENT: NOT INSURANCE
SPONSOR(S): REPRESENTATIVE(S) RASMUSSEN

04/16/21	(H)	READ THE FIRST TIME - REFERRALS
04/16/21	(H)	L&C, HSS
05/03/21	(H)	L&C AT 3:15 PM BARNES 124
05/03/21	(H)	Heard & Held
05/03/21	(H)	MINUTE(L&C)
05/07/21	(H)	L&C AT 8:00 AM GRUENBERG 120
05/07/21	(H)	Heard & Held
05/07/21	(H)	MINUTE(L&C)
05/12/21	(H)	L&C AT 3:15 PM BARNES 124
05/12/21	(H)	<Bill Hearing Canceled>
03/23/22	(H)	L&C AT 3:15 PM BARNES 124

BILL: SB 143

SHORT TITLE: COMMON INTEREST COMMUNITIES; LIENS

SPONSOR(S): SENATOR(S) REVAK

01/18/22	(S)	PREFILE RELEASED 1/7/22
01/18/22	(S)	READ THE FIRST TIME - REFERRALS
01/18/22	(S)	L&C
02/09/22	(S)	L&C AT 1:30 PM BELTZ 105 (TSBldg)
02/09/22	(S)	Moved SB 143 Out of Committee
02/09/22	(S)	MINUTE(L&C)
02/11/22	(S)	L&C RPT 3DP
02/11/22	(S)	DP: STEVENS, MICCICHE, GRAY-JACKSON
02/16/22	(S)	TRANSMITTED TO (H)
02/16/22	(S)	VERSION: SB 143
02/17/22	(H)	READ THE FIRST TIME - REFERRALS
02/17/22	(H)	L&C
02/17/22	(H)	CRA REFERRAL ADDED BEFORE L&C
03/01/22	(H)	CRA AT 8:00 AM BARNES 124
03/01/22	(H)	Heard & Held
03/01/22	(H)	MINUTE(CRA)
03/03/22	(H)	CRA AT 8:00 AM BARNES 124
03/03/22	(H)	Heard & Held
03/03/22	(H)	MINUTE(CRA)
03/08/22	(H)	CRA AT 8:00 AM BARNES 124
03/08/22	(H)	Moved SB 143 Out of Committee
03/08/22	(H)	MINUTE(CRA)
03/09/22	(H)	CRA RPT 5DP
03/09/22	(H)	DP: MCCARTY, MCCABE, DRUMMOND, HANNAN, SCHRAGE
03/14/22	(H)	L&C AT 3:15 PM BARNES 124
03/14/22	(H)	-- MEETING CANCELED --
03/16/22	(H)	L&C AT 3:15 PM BARNES 124
03/16/22	(H)	Heard & Held
03/16/22	(H)	MINUTE(L&C)
03/23/22	(H)	L&C AT 3:15 PM BARNES 124

WITNESS REGISTER

DAVID GUTTENBERG

Fairbanks, Alaska

POSITION STATEMENT: Testified in support of SJR 12.

TAMMY SMITH

Fairbanks, Alaska

POSITION STATEMENT: Testified in support of SJR 12.

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

POSITION STATEMENT: During the hearing on HB 176, testified that with the proper consumer protections the bill would help in Alaska's healthcare system.

JOHN HALEY, Assistant Attorney General
Special Litigation and Consumer Protection
Civil Division (Anchorage)
Department of Law
Anchorage, Alaska

POSITION STATEMENT: Answered questions during the hearing on HB 176.

CRYSTAL KOENEMAN, Staff
Representative Sara Rasmussen
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: During the hearing on HB 176, answered questions about the bill on behalf of Representative Rasmussen, prime sponsor.

LEE S. GROSS, MD
Epiphany Health Direct Primary Care
North Port, Florida

POSITION STATEMENT: Answered questions during the hearing on HB 176.

ACTION NARRATIVE

[3:18:34 PM](#)

CO-CHAIR ZACK FIELDS called the House Labor and Commerce Standing Committee meeting to order at 3:18 p.m. Representatives Schrage, McCarty, Nelson, Spohnholz, and Fields were present at the call to order. Representatives Snyder and Kaufman arrived as the meeting was in progress.

SJR 12-SOCIAL SECURITY BENEFIT REDUCTION REPEAL

[3:18:59 PM](#)

CO-CHAIR FIELDS announced that the first order of business would be SENATE JOINT RESOLUTION NO. 12, Urging the United States

Congress to repeal the Windfall Elimination Provision and Government Pension Offset of the Social Security Act.

[3:19:16 PM](#)

CO-CHAIR FIELDS opened public testimony on SJR 12.

[3:19:39 PM](#)

DAVID GUTTENBERG testified in support of SJR 12. He recounted that he worked as a laborer for over 20 years, then worked four years as a staff person in the legislature, followed by 16 years as a legislator. When he became eligible to retire from the state he learned that the Windfall Elimination Provision (WEP) would take about \$400 out of his retirement. He said he has been amazed at it ever since and how detrimental it has been to those who have split their time between the private sector and the public sector. He did not anticipate this big hit and an estimated \$70 million a year is not received by Alaskans because of this provision. He paid Social Security for more than 20 years while working as a laborer, but because he split his career between the private and public sectors he is penalized, as are many Alaskans. People just want to get back the money they put into Social Security; nobody is asking for more than that. He said there is support [for repeal] in Congress and urged the passage of SJR 12.

[3:22:06 PM](#)

TAMMY SMITH testified in support of SJR 12. She related that she is a teacher in Fairbanks with the benefit of being Tier I, and she will be retiring after 40 years of teaching in Alaska. She said she began her career as a teacher in Minnesota and then taught at a Catholic school in Fairbanks, both positions in which she paid into Social Security. In 1986 she moved into the public school system and eventually learned about WEP and the Government Pension Offset (GPO) and how they would significantly impact her retirement, which is part of the reason why she continues to teach. Her husband worked with the plumbers and pipefitters for over 30 years. At his death seven years ago, she realized the significant impact that the GPO/WEP would have on her, as there is a double impact for certain individuals. The work that her husband did has been taken away from her.

MS. SMITH stated that as a board member of the National Education Association-Alaska (NEA-Alaska) she has taken this issue to Alaska US Senator Dan Sullivan and Alaska US Senator

Lisa Murkowski. While they understand the issue, she said, they need the legislature's encouragement. She related that in a letter Senator Sullivan wrote to the Internal Revenue Service (IRS) and the Social Security Administration (SSA) he talks about how 70 percent of the Alaskan teachers that are in the Tier III system may run out of money after a certain amount of time. Senator Sullivan's work targets what is going to happen to the Tier III individuals who do not have a defined benefit and the significant impact that this will have on these Alaska teachers without Social Security.

MS. SMITH said she is only asking for consideration of what she has donated to Social Security. She pointed out that young Alaskans are also being impacted and don't feel they can stay in Alaska. Three years ago, her daughter, a public employee, decided to leave Alaska because as a Tier III or Tier IV she could do better elsewhere. She urged the committee to help senators Sullivan and Murkowski going forward. Even if it isn't a total fix or isn't retroactive, she said, it would be something to support Alaskans working in the state.

[3:26:44 PM](#)

REPRESENTATIVE NELSON thanked Ms. Smith for her 40 years of teaching.

[3:27:05 PM](#)

CO-CHAIR FIELDS closed public testimony after ascertaining that no one else wished to testify.

[3:27:14 PM](#)

CO-CHAIR SPOHNHOLZ moved to report SJR 12 out of committee with individual recommendations and the accompanying [zero] fiscal notes. There being no objection, SJR 12 was moved out of the House Labor and Commerce Standing Committee.

[3:27:40 PM](#)

The committee took an at-ease from 3:27 p.m. to 3:29 p.m.

HB 176-DIRECT HEALTH AGREEMENT: NOT INSURANCE

[3:29:35 PM](#)

CO-CHAIR FIELDS announced that the next order of business would be HOUSE BILL NO. 176, "An Act relating to insurance; relating to direct health care agreements; and relating to unfair trade practices."

CO-CHAIR FIELDS invited Ms. Lori Wing-Heier to outline some of the recommended changes or clarifications that the Division of Insurance has in terms of consumer protections for those consumers purchasing direct care agreements, with the goal of getting them addressed prior to the bill's next hearing.

[3:30:45 PM](#)

LORI WING-HEIER, Director, Division of Insurance, Alaska Department of Commerce, Community, and Economic Development (DCCED), testified that with the proper consumer protections HB 176 would help in Alaska's healthcare system. She stated that the division supports direct care agreements and that there is a need for them in Alaska. Direct care agreements would help with access to health care, particularly for Medicare recipients who cannot find a primary doctor.

MS. WING-HEIER advised, however, that the division thinks there needs to be some consumer protections. She said the bill should not be able to discriminate. As well, if charging a fee [the provider should be required to] give notice if the fee is going to be increased. In addition, both parties should be able to cancel with proper notice and perhaps with a nominal or minimum termination fee. The contract should clearly spell out what the consumer is going to get during the contract; for example, two check-ups annually, a certain amount of bloodwork, and whatever else the doctor wants to provide under the contract. Ms. Wing-Heier further advised that if the treatment or whatever the consumer is receiving from the doctor exceeds the contract, then insurance would be available. With proper consumer protections, she stated, this is a bill worth considering and it would help in Alaska's healthcare system.

[3:32:03 PM](#)

REPRESENTATIVE MCCARTY requested that the committee be sent a list of the division's suggestions.

MS. WING-HEIER agreed to do so.

CO-CHAIR FIELDS added that [the committee], along with the sponsor, will work with Ms. Wing-Heier on a committee substitute

(CS) that will include some of these clarifications. He invited Mr. Haley of the Department of Law to comment on Ms. Wing-Heier's suggestions.

[3:32:47 PM](#)

JOHN HALEY, Assistant Attorney General, Special Litigation and Consumer Protection, Civil Division (Anchorage), Department of Law, clarified he is before the committee to answer questions that the committee might have regarding how enforcement under the Unfair Trade Practices Act (UTPA) would work. The Department of Law, he said, does not have any specific recommendations as far as what consumer protections should exist in the law.

[3:33:23 PM](#)

CO-CHAIR SPOHNHOLZ said the committee is interested in adding some consumer protections and transparency language to the bill. She requested Mr. Haley to discuss how consumer protection statutes are typically structured and what the process is for consumers if they have a challenge related to unfair contract practices and how that might be enforced in the state of Alaska.

MR. HALEY responded that the Unfair Trade Practices Act is a common consumer protection statute. He said Section 3 of HB 176 would make violating the new AS 45.45.915 an unfair trade practice. He stated that AS 45.50.471 includes a list of [57] enumerated violations of the [Alaska Unfair Trade Practices and Consumer Protection Act]. The UTPA has two remedies - a private cause of action and a government cause of action.

MR. HALEY explained that in the private cause of action, once something has been made an Unfair Trade Practices Act violation, which this draft of HB 176 would do for section 915, any person who has suffered an ascertainable loss of money or property could file a lawsuit against anyone who has violated the act. It may not necessarily be easy to prove the suffering of an ascertainable loss of money or property for every type of unfair trade practice. But if a person could prove that a loss has been suffered, he or she could file a private cause of action and would be entitled to either treble damages or \$500 of statutory damages, whichever is greater, as well as full attorney's fees.

MR. HALEY specified that a government cause of action works in some ways like other government enforcement activity. If a

consumer has had an issue with a business and believes it may be an unfair trade practice, the consumer can call [the Consumer Protection Unit at the Department of Law] and submit a consumer complaint. The office typically gets about 400 actual consumer complaints a year, although it receives more calls than that. The office can investigate those complaints, but with a staff of two attorneys and one investigator the office must pick and choose what to investigate. After an investigation, the office can file a lawsuit seeking an injunction and then penalties of \$1,000-\$5,000 per violation, plus full attorney's fees.

MR. HALEY offered his understanding that possibly the committee or some legislators may be considering adding additional violations beyond 45.45.915, Section 2, making more things into consumer protection violations, violations of the UTPA. If the committee is going to do that, he advised, it would be best to use similar language to that used in section 915 where it is very clear what obligation a particular person has, what that person shall do and what that person may not do. That clarity in language helps a lot to understand who it is that may be violating the law and what exactly that person would have to do to violate it.

[3:38:22 PM](#)

CO-CHAIR SPOHNHOLZ asked whether the government cause of action is the structure that the Division of Insurance uses to enforce compliance.

MS. WING-HEIER answered that the Division of Insurance looks at both civil and criminal, and when it becomes criminal the division works with the attorney general. She said the division has authority under Alaska statutes to remedy civil infractions, fine penalties, and assess the damages. Then, whoever has caused the bad deed would pay the money to the division to cover the general fund and the division enters into stipulated agreements as such. If it becomes criminal, the division refers it over for resolution to either the federal government or the state government depending on what the crime is.

CO-CHAIR SPOHNHOLZ surmised that keeping direct care agreements under Title 21 would give the public additional possible protection against potential unfair practices as it is related to direct care agreements than if direct care agreements were moved into a different section of law.

MS. WING-HEIER replied that that is the division's belief.

[3:39:39 PM](#)

REPRESENTATIVE SNYDER remarked that during the bill's previous hearing she felt enthusiastic about some of the things it could achieve. She inquired about the mechanism of this model whereby it reduces health care cost.

[3:40:46 PM](#)

CRYSTAL KOENEMAN, Staff, Representative Sara Rasmussen, Alaska State Legislature, on behalf of Representative Rasmussen, prime sponsor of HB 176, replied that one way this has a potential to lower health care costs is by utilizing better preventative care. If an individual and family members have access to their provider, it sets up a way for them to see the doctor when they may not necessarily go for cost reasons or other reasons. Doing this and ensuring better preventative care provides the option of finding any issues within that individual before they escalate to higher cost of care.

REPRESENTATIVE SNYDER expressed her concern that [a direct primary care agreement] could be utilized as an "express pass" whereby a person is able to jump the line. She asked whether the sponsor has considered this and whether ways can be built to prevent that from being the primary application of this option.

MS. KOENEMAN deferred to Dr. Gross to provide an answer.

[3:43:07 PM](#)

LEE S. GROSS, MD, Epiphany Health Direct Primary Care, answered questions during the hearing on HB 176. He first related that since 2002 he has been in private practice as a primary care physician in southwest Florida. In 2010 he transitioned to one of the first direct primary care (DPC) practices in the US, so his is probably one of the longest practicing direct primary care practices in the nation. Regarding how [his practice] saves cost, Dr. Gross stated that much of primary care in a traditional practice is on a fee-for-service (FFS) basis, which is designed to drive up charges and generate as much billable revenue from the patient or the patient's insurance company as possible. It is designed to serve the intermittent sick care. However, a direct primary care practice is more a whole-body health care that also focuses on getting out in front of disease and prevention.

DR. GROSS explained that in traditional practice it may take three minutes to write a prescription for someone with diabetes. [In direct primary care] it will take 30 minutes to educate the patient how not to need a prescription for diabetes, which is included at no additional cost, so downstream complications, downstream medications, and unnecessary hospitalizations can be prevented. A primary care practitioner is spending less time on the administrative burden of the practice, which gives the practitioner much more clinical time to focus on and interact with the patient.

DR. GROSS reviewed a case study that began in 2019 in which direct primary care was integrated as an option for an employee health plan for DeSoto Memorial Hospital in rural southwest Florida. The hospital itself had a self-funded insurance plan and gave its employees an option to sign up for the direct primary care. The employees who signed up had it paid for by the hospital but still could keep their traditional option of going to their fee-for-service doctor. One year later in 2020, he reported, the direct primary care practices were compared to the non-direct primary care practices and the following was seen: a 48 percent reduction in all money paid for by the health clinic; a 45 percent reduction in all out-of-pocket costs by the patient, which included co-pays, co-insurance, and deductibles; a 52 percent reduction in emergency room visits due to the means of access; and a 57 percent reduction in specialty cost spend. Despite the primary care being pre-paid in the direct primary care model, there was a 25 percent reduction in primary care spend because the goals of the practice were much better. Dr. Gross further reported that over the past three years the case study results show that a direct primary care practice managed diabetes at 72 cents per member per month compared to a national average of \$4.04, an 82 percent reduction in health clinic cost. He noted that DeSoto Memorial Hospital has 49 beds and is in the second poorest county in the state of Florida. In 2019, the Rural Accountable Care Organization generated \$64 per beneficiary savings and in 2019 the DeSoto Memorial Hospital plan generated \$2,420 per beneficiary savings.

[3:47:29 PM](#)

REPRESENTATIVE SNYDER stated that as a public health official she is a fan of preventative health care and its value. She observed that the sponsor statement focuses on being able to get in quicker, perhaps the next day or so. She said this is wonderful if it doesn't come at the expense of others who may

have fewer resources. She asked what sidebars have been used elsewhere to prevent that [from happening].

DR. GROSS replied that the direct primary care practice model is designed for efficiency, so by nature DPC patients will have faster access than traditional practice. He noted that [his clinic] has had telemedicine at no additional cost, so during the pandemic while probably 40 percent of practices were near insolvency because of the challenges of COVID-19, [his clinic] converted to parking lot practices on day one and did house calls, so [his clinic] was a more efficient model. He stated that people who are participating will get more efficient care. Perhaps it is true, he continued, that people will come to these practices specifically to have improved efficiency and improved access, but better outcomes will be seen which will drive more direct primary care growth which will ultimately transition into practice. All the practices will be better because of the drive of the market forces of direct primary care making the traditional practices more efficient.

[3:49:47 PM](#)

CO-CHAIR FIELDS offered his understanding that there is generally a flat fee per month or per year for a certain amount of services. He asked whether there are DPC practices that have differentiated fees where higher fees get a person in quicker or whether there is just a level fee for a given amount of service.

DR. GROSS responded he is unaware of practices that charge additional fees for moving to the front of the line. He said it is a challenge to discern between a concierge practice and a direct primary care practice. A concierge practice, he explained, specifically charges an access fee that gets people front-of-the-line service, and then also bills a third party for services provided on a fee-for-service basis. A concierge practice is a different model than the direct primary care bundle service model which has no additional fee. If direct primary care practices tier their membership fees, it is usually based upon age, not upon insurance status or health conditions.

MS. KOENEMAN added that another facet of direct health care agreements that may be seen is additional doctors who have either recently retired or are about to retire starting their own practice or moving into another avenue to provide this care. Because there is less overhead, doctors are working for themselves versus working for, say, a hospital. Instead of these doctors leaving the field entirely, this would provide an

additional avenue for them to still provide health care to others. So, it may ultimately keep more providers on the market, thereby reducing an individual's overall wait times for traditional methods as well as this model.

[3:52:23 PM](#)

CO-CHAIR FIELDS asked whether Ms. Wing-Heier's suggestions for consumer protections in HB 176 are reflected in what is seen in other states.

DR. GROSS confirmed that similar consumer protections have been included in the bills passed by other states, such as highlighting very clearly what is included in the contract and what is not included in the contract, specific exclusions, and whether there are additional charges for services that are outside the defined scope of services and what those charges are going to be. Those are included in his contracts, he noted, as well as in any other contracts he has seen.

[3:53:14 PM](#)

CO-CHAIR SPOHNHOLZ recalled Dr. Gross stating that direct care agreement practices do not tier cost based on priority but based on age. She asked how this typically works.

DR. GROSS answered that every practice is different but at his practice the fee for adults up to age 64 is \$80 per month, the first child is \$30 per month, and each additional child is \$15 per month. At age 65 the price for adults increases to \$100 per month. It is not a tier based upon health status, so a 68-year-old diabetic with hypertension and heart disease would pay the same price as a 68-year-old who is on no medications.

CO-CHAIR SPOHNHOLZ asked Ms. Wing-Heier whether Dr. Gross's description of pricing is consistent with the way that insurance pricing operates.

MS. WING-HEIER replied that that's exactly how insurance is priced. She offered to provide the committee with the rates for the individual market in which it would be seen that the rate for a 21-year-old might be \$250 a month whereas the rate for a 64-year-old might be close to \$800 a month.

CO-CHAIR SPOHNHOLZ confirmed that she pays more as a 49-year-old than she did as a 21-year-old.

3:55:10 PM

REPRESENTATIVE KAUFMAN observed that beginning on page 3, line 24 of the bill, it states, "Before terminating a direct health care agreement with an existing patient, a health care provider shall ensure that the patient is transferred to a health care provider who" provides the services that are subsequently listed thereafter in the bill. He asked whether this is typical in other forms of health care because this did not happen when his own physician retired. He further asked about the background on why this provision is included and if it is different, why it is different relative to other forms of health care.

MS. KOENEMAN responded that [the sponsor] wanted this language in the bill for additional protections for the patient. She related a personal anecdote in which her general practitioner referred her to a rheumatologist and a neurologist for medical care. Specialized medicine, she explained, isn't typically covered under direct health care agreements, and [the sponsor] wanted to ensure that the level of care that was provided to the patient was consistent with what the patient needs to happen. By putting in this language the provider cannot say, "Sorry, it's not in our contract, I can't help you," and leave the patient out in the cold. The sponsor wanted to ensure that there is a mechanism in place where, if a doctor is not with the specialty, that doctor does work with that patient to provide the care that the patient needs.

REPRESENTATIVE KAUFMAN stated that it sounds like a good motivation, but asked whether this might discourage someone from engaging in this type of contract if there is a high burden of getting out of it as the practitioner.

MS. KOENEMAN answered that it is optional whether a practitioner wants to participate in these health care agreements. She deferred to Dr. Gross to provide his experience in this regard.

CO-CHAIR FIELDS invited Dr. Gross to provide comment.

DR. GROSS qualified that he is not attempting to criticize this very good bill but allowed that the provision does stand out to him because of the concrete nature of the language. He said the burden of ensuring that the patient is handed off to another provider before discontinuing the doctor-patient relationship is probably higher than the requirement that would be placed on any other practice within the country. For discontinuing care of a patient there are usually standards within the state for giving

ample notice, such as a 15- or 30-day notice. That notice can sometimes be shorter if there is an issue or if there is a threat to staff safety by the patient. Some states have broader language that still has the patient protections but also has some safety nets for standard of care within the state or within the community for discharging patients from care.

CO-CHAIR FIELDS invited Ms. Wing-Heier to provide comment.

MS. WING-HEIR responded that the only thing to which she can relate this is the recently passed federal law called the No Surprises Act. The Act, she explained, provides that if there is a change in insurer by the insurance company, the new insurance company must allow the same kind of care with the same provider, which is called continuity of care. For example, she said, if she goes from Aetna to Premera and her new doctor is not in-network, the care to her must still be continued. She said she thinks that that is what this provision is doing - it is saying there will still be the same kind of care, but it will be a different physician.

REPRESENTATIVE KAUFMAN stated he sees the intent but wonders if it will put a damper on the marketplace.

[4:00:57 PM](#)

REPRESENTATIVE MCCARTY surmised there is no preferential treatment in scheduling [between those who do and don't have this type of service]. He asked whether in an agreement a doctor is agreeing to a certain length of time when a person comes in. For example, traditional practices bill to a specific [current procedural terminology (CPT) code] that is based on the length of time spent with the patient. He further asked whether there are any boundaries to ensure that the person will be seen [long enough] for effective care.

DR. GROSS answered that direct primary care practices don't bill based upon time, but rather upon fixed increments and bundled services. Therefore, the distinction between a time code of 99211 versus 99215 is a language that is not spoken in a direct primary care practice. The patient gets as much, or as little, time as needed to handle the problem and can come in as frequently as needed to address an issue at no additional cost or charge. He related that in his practice a new patient visit is an hour long and each follow up is 30 minutes long. Some people want 30 minutes, he noted, and some want to be in and out in five. A person with an arm laceration can come right over

and he will treat the laceration but the billable to the patient doesn't change based upon the level of care. He allowed it is possible to have a certain individual patient's needs exceed the time that the practitioner has for that day. However, he explained, the flexibility within the practice model allows for addressing it on subsequent visits at no additional charge or co-pays, so the patient is more likely to more efficiently and more cost effectively get an issue resolved.

MS. WING-HEIER pointed out that under these agreements there is no billing. The patient is paying a fee like a gym membership. There is no bill unless it goes outside what the contract says, and then it would bill insurance and that is when the CPT codes would come in. There shouldn't be a separate charge for more or less time because it is all covered within the agreement.

4:04:48 PM

REPRESENTATIVE MCCARTY clarified that the intent of his question was not about the CPT code, but about the expectation of service that is received. He posed a scenario of buying into an agreement for \$80 per month, and asked whether the doctor could see him "quick and dirty" rather than spending the expected amount of time with him.

MS. WING-HEIER offered her understanding that that is covered in the contract. If the practice says the patient's appointment is going to be an hour or will give the patient up to an hour without billing the patient's insurance company, then the Division of Insurance would expect that the patient would be given an hour to talk to the doctor, or a half hour, or whatever the contract stipulates. That is what should be received as the service for the direct health care agreement.

REPRESENTATIVE MCCARTY surmised the news would get out when a practitioner is seeing lots of people and getting lots of money up front but is not a very good provider. He asked whether there are provisions so that those people could get out of their contracts sooner because the service was not being rendered.

MS. WING-HEIER replied that that comes back to the consumer protections built in. If a consumer has a contract that states two visits a month of at least 30 minutes each, and the consumer comes to the division saying he or she cannot get appointments or the provider is only spending 10 minutes per appointment, then "we've got a consumer complaint."

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CO-CHAIR SPOHNHOLZ stipulated that this is why it is important to have good consumer protection and enforcement mechanisms in place. It must be ensured that it is known what the whole regulatory framework for insurance is, that all stakeholders involved are made whole, and that there is clarity about roles and responsibilities and the enforcement mechanisms. A new framework in the state of Alaska is being created. She inquired about how to ensure that patients know what they need and are buying a product that meets their needs when entering a contract. She posed a scenario in which a person develops diabetes and that the current fee-for-service model allows for service growth as is needed along the way. She asked how this would work under a direct care agreement to ensure that a patient's needs are met in the direct care model.

DR. GROSS responded that the most unique aspect of direct care is the direct relationship. There is not typically a third party paying that bill, he said, so the doctor must look the patient in the eye and directly justify the value of his or her services. It's the purest and most ethical relationship that if the patient does not feel like the doctor is giving adequate time and counsel the patient can cancel. As a business owner himself, he related, it is far more cost effective to maintain an existing patient and keep that patient satisfied than to recruit a new patient from scratch. He has a built-in incentive to make sure the patient's needs are met because he wants the patient to renew his or her membership, not cancel it.

MS. WING-HEIER agreed with Dr. Gross that the patient has the right to cancel, and that is one of the provisions the division wants to ensure is in the bill and that there is not a huge termination fee. She posed a scenario in which someone's health care insurance doesn't start until January and has a large deductible, so the consumer offsets the cost of that deductible by purchasing a direct health care plan. If come February the direct health care plan is not working for the consumer, the consumer should not have to pay the entire 12-month premium but rather the one month that the consumer used it, and any outstanding charges that should have been billed to insurance should still be billed to insurance. The consumer can then go to another provider that suits the consumer's needs.

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CO-CHAIR FIELDS asked why HB 176 is necessary from a legal or regulatory perspective and whether providers could provide direct care under direct care agreements now.

MS. WING-HEIER answered that right now providers cannot provide this type of agreement. These agreements, she explained, fall right within the definition of what a health care insurer is or a health maintenance organization (HMO). An upfront premium is being taken to direct health care and [the consumer] should get something in return for that premium, the consumer should know that the insurance company is going to pay his or her doctor bills, and in these agreements the consumer should know that the provider is going to provide the care. They are viewed as an insurance policy, yet nowhere in Alaska law are they registering or going through the hoops that are expected of an insurance company, and [the division] is not asking them to, nor does she think they should have to, much like the air ambulance memberships. There is a reason for provisions to protect the consumer, but they are not going to go through what insurance companies do.

CO-CHAIR FIELDS, in terms of consumer protections and consumer expectations, asked whether other states have guidelines on what type of provider the consumer is seeing, such as an MD, physician's assistant (PA), or nurse practitioner (NP).

MS. WING-HEIER deferred to Dr. Gross to answer the question.

DR. GROSS replied that that is mostly defined by the state law that defines the scope of practice for an individual provider's license. The expectation is that a physician assistant would practice within the scope of practice that is outlined by Alaska law for physician assistant, and so on.

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REPRESENTATIVE KAUFMAN inquired about the intersection between this health care service and what is outside of the service through insurance, as per page 1 of HB 176. He asked whether there have been any challenges with getting that intersection defined well and not having complaints around that area.

DR. GROSS responded that there is not a tremendous amount of direct interaction between the direct primary care practice and the insurance per se because the practice is not filing claims. However, the practice still interacts with the insurance company for services outside of its office, he explained. For example,

if the patient needs to see a cardiologist the practice will work through the protocols of the insurance company to make sure that the patient sees an in-network cardiologist. If the patient needs to have some imaging services that require prior authorization from the insurance company then the direct primary care practices usually work through the process of the insurance company's protocols, even though they are out of network, to get those services approved. For prescription medications that fall outside of the formulary requirements, the practices will go through the process of getting those services approved.

DR. GROSS added that the biggest issue he has seen between the direct care practice and an insurance is when an HMO insurance requires that referrals from the primary come from an in-network primary care provider, in which case the patient will have to establish with an in-network primary to secure those referrals. He said Maine tackled that issue by passing legislation that says if an out-of-network primary is willing to follow the protocols and practices of the insurance company through the referral process and in referring [a patient] to an in-network provider then the insurance company would honor that referral. In his experience, most insurance companies find it quite nice that they are not filing claims and processing claims for every single interaction with the health care system.

REPRESENTATIVE KAUFMAN offered his understanding, then, that it is not so much in-house but more of interfacing with the specialties externally.

DR. GROSS answered that that has been his experience and he has not heard any other stories to the contrary.

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REPRESENTATIVE MCCARTY posed a scenario in which a direct primary care provider's schedule includes some patients that are direct care agreements and some that are coming in under their insurance and both are getting the same type of service.

DR. GROSS clarified that direct primary care practices do not have distinguished classes of patients where direct care and insurance patients are seen; they are typically one or the other. For example, he said, his practice does not have any commercial insurance contracts whatsoever. Patients wanting to come to his practice enter into a direct care agreement with his practice and his practice does not have a direct contract with an insurance provider for any patients.

[HB 176 was held over.]

SB 143-COMMON INTEREST COMMUNITIES; LIENS

[4:18:18 PM](#)

CO-CHAIR FIELDS announced that the final order of business would be SENATE BILL NO. 143, "An Act relating to horizontal property regimes and common interest communities; and relating to mortgages, deeds of trust, and other property liens."

[4:19:06 PM](#)

CO-CHAIR FIELDS opened public testimony on SB 143, then closed it after ascertaining that no one wished to testify.

[4:19:27 PM](#)

CO-CHAIR SPOHNHOLZ moved to report SB 143 out of committee with individual recommendations and the accompanying fiscal notes. There being no objection, SB 143 was reported out of the House Labor and Commerce Standing Committee.

[4:19:57 PM](#)

ADJOURNMENT

There being no further business before the committee, the House Labor and Commerce Standing Committee meeting was adjourned at 4:20 p.m.