ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
February 28, 2023
3:02 p.m.

MEMBERS PRESENT

Representative Mike Prax, Chair
Representative Justin Ruffridge, Vice Chair
Representative Dan Saddler
Representative Zack Fields
Representative Genevieve Mina

MEMBERS ABSENT

Representative CJ McCormick
Representative Jesse Sumner

COMMITTEE CALENDAR

HOUSE BILL NO. 60
"An Act relating to the licensing of runaway shelters; relating to advisors to the board of trustees of the Alaska Mental Health Trust Authority; relating to the sharing of confidential health information between the Department of Health and the Department of Family and Community Services; relating to the duties of the Department of Health and the Department of Family and Community Services; and providing for an effective date."

- HEARD & HELD

HOUSE BILL NO. 47
"An Act relating to insurance; relating to direct health care agreements; and relating to unfair trade practices."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: HB 60
SHORT TITLE: RUNAWAYS; DFCS/DOH: DUTIES/LICENSING/INFO
SPONSOR(s): RULES BY REQUEST OF THE GOVERNOR

02/03/23	(H)	READ THE FIRST TIME - REFERRALS
02/03/23	(H)	HSS, FIN
02/28/23	(H)	HSS AT 3:00 PM DAVIS 106

BILL: HB 47
SHORT TITLE: DIRECT HEALTH AGREEMENT: NOT INSURANCE
SPONSOR(s): MCCABE

01/25/23	(H)	READ THE FIRST TIME - REFERRALS
01/25/23	(H)	HSS, L&C
02/18/23	(H)	HSS AT 3:00 PM DAVIS 106
02/18/23	(H)	-- MEETING CANCELED --
02/28/23	(H)	HSS AT 3:00 PM DAVIS 106

WITNESS REGISTER

HEATHER CARPENTER, Health Care Policy Advisor
Department of Health
Juneau, Alaska
POSITION STATEMENT: Introduced HB 60 and gave the sectional analysis on behalf of the sponsor, House Rules by request of the governor.

CLINTON LASLEY, Deputy Commissioner
Department of Family and Community Services
Juneau, Alaska
POSITION STATEMENT: Gave an overview of the goals of HB 60, on behalf of the sponsor, House Rules by request of the governor.

REPRESENTATIVE KEVIN MCCABE
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: As prime sponsor, presented HB 47.

BUDDY WHITT, Staff
Representative Kevin McCabe
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Gave the sectional analysis for HB 47 on behalf of Representative McCabe, prime sponsor.

PETER DIEMER, Attorney
Clayton and Diemer
Anchorage, Alaska
POSITION STATEMENT: Responded to questions during the hearing on HB 47.

LEE GROSS, MD
Epiphany Health
North Port, Florida

POSITION STATEMENT: Gave invited testimony during the hearing on HB 47.

JOSH UMBEHR, MD
Atlas, MD
Wichita, Kansas
POSITION STATEMENT: Gave invited testimony during the hearing on HB 47.

ACTION NARRATIVE

3:02:42 PM

CHAIR MIKE PRAX called the House Health and Social Services Standing Committee meeting to order at 3:02 p.m. Representatives Mina, Saddler, Ruffridge, Fields, and Prax were present at the call to order.

HB 60-RUNAWAYS; DFCS/DOH: DUTIES/LICENSING/INFO

3:04:11 PM

CHAIR PRAX announced that the first order of business would be HOUSE BILL NO. 60, "An Act relating to the licensing of runaway shelters; relating to advisors to the board of trustees of the Alaska Mental Health Trust Authority; relating to the sharing of confidential health information between the Department of Health and the Department of Family and Community Services; relating to the duties of the Department of Health and the Department of Family and Community Services; and providing for an effective date."

3:04:59 PM

HEATHER CARPENTER, Health Care Policy Advisor, Department of Health, introduced HB 60 on behalf of the bill sponsor, House Rules by request of the governor. She summarized how, under Executive Order (EO) 121, the former Department of Health and Social Services (DHSS) was bifurcated into the Department of Health (DOH) and the Department of Family and Community Services (DFCS). She explained that the proposed legislation seeks to perform the anticipated "clean-up" to clarify the changes that resulted from creating the two departments. She then turned to Deputy Commissioner Clinton Lasley to discuss the proposed legislation.

3:06:20 PM

CLINTON LASLEY, Deputy Commissioner, Department of Family and Community Services, on behalf of the sponsor, House Rules by request of the governor, spoke about the goals of HB 60. He said the proposed legislation would ensure that DOH and DFCS share information, including confidential and protected information, as necessary to administer programs and services for Alaskans; it is the same authority as DHSS had. Next, HB 60 would add a commissioner to DFCS to the advisory board of the Alaska Mental Health Trust, which is a substantive change supported by the trust. The bill would clarify statute related to licensing duties assigned to the former DHSS and related to runaway shelters and foster homes. He explained that it is necessary to point the right authority to the appropriate departments. He further explained that the category of runaway shelters needs to be moved under the purview of DOH. Finally, he noted that there is an amendment that would define the term department in AS 18.65.340 to include DFCS.

3:09:02 PM

MS. CARPENTER offered the sectional analysis for HB 60 [included in the committee packet], which read as follows [original punctuation provided]:

> Section 1
> Amends AS 12.62.400(a) to assign responsibility for criminal history checks for the licensing of runaway shelters to the Department of Health rather than the Department of Family and Community Services. This is done to correct a mistake from EO 121 that assigned the licensing of runaway shelters to Department of Family and Community Services even though a division of Department of Health performs this work. Sections 4-9 also implement this correction.
>
> Section 2
> Amends AS 44.25.260 to add the Department of Family and Community Services Commissioner to the Alaska Mental Health Trust Authority board of advisors.
>
> Section 3
> Amends AS 47.05 by adding a new section:
> (1) requiring the Department of Health and Department of Family and Community Services share identifiable health information between and within departments as necessary to enable the efficient and

effective administration and operation of both departments;

(2) establishing that information acquired, used, disclosed, and stored under this section be stored in a confidential and secure environment;

(3) establishes the definition of "identifiable health information" with the existing definition in AS 18.15.395.

Sections 4-9
Amends statute to identify that the Department of Health holds responsibility for the licensure of programs and drafting regulations related to runaway minors.

Sections 10
Amends AS 47.32.032 to provide clarifying language in licensing statute to identify that the Department of Family and Community Services is responsible for foster home licensing. This corrects a mistake from EO 121 that assigned the licensing of foster homes to Department of Health even though a division of Department of Family and Community Services performs this work.

Section 11-15
Amends AS 47.32 to provide clarifying language in licensing statute about the respective departments having responsibility for actions related to the entities they license.

Section 16
Establishes an immediate effective date.

3:13:08 PM

REPRESENTATIVE SADDLER questioned what is considered "necessary" in terms of confidential information shared.

MS. CARPENTER explained that an employee [of DOH or DFCS] would have access only to information within the scope of his/her work.

REPRESENTATIVE SADDLER referenced Section 2 of HB 60 and offered clarification regarding the aforementioned advisory board of the Alaska Mental Health Trust by stating, "There is no separate advisory board to which these commissioners are members."

MS. CARPENTER replied that Representative Saddler is correct, and said that misinformation would be fixed. She confirmed, "The commissioners are statutory advisors to the board of trustees."

3:15:37 PM

REPRESENTATIVE RUFFRIDGE, referencing Section 3, regarding access to identifiable health information, suggested this is redundant, since those departments are covered already under the Health Insurance Portability and Accountability Act (HIPAA).

MS. CARPENTER emphasized the importance of ensuring that all those who follow in the footsteps of current [DOH] employees know the expectation is they will share information with [DFCS] employees, which is also covered by HIPAA. In response to a follow-up question, she said sometimes leadership encourages the sharing, but clarity in statute will ensure no barriers in helping the public.

3:18:00 PM

REPRESENTATIVE SADDLER asked whether the split resulted in the wished for benefits.

3:18:24 PM

DEPUTY COMMISSIONER LASLEY answered that DOH has expressed it is pleased with the way that this reorganization is working in providing "more bandwidth" and allowing DOH to focus on its resources and provide support and meet technical needs. He pointed out that the change happened just eight months ago, but there have been positive changes already.

REPRESENTATIVE SADDLER mentioned a backlog in the Supplemental Nutrition Assistance Program (SNAP) and inquired whether the bifurcation of DHSS played a part in it.

3:19:44 PM

MS. CARPENTER responded that she would not say it was a direct correlation. She stated that the split of DHSS has allowed Commissioner Designee Heidi Hedberg to focus solely on the Division of Public Assistance. Before the department was split, it was so large that [working there was like going] "from fire to fire."

MS. CARPENTER, in response to Chair Prax, noted there would be an upcoming technical amendment for HB 60.

[HB 60 was held over.]

3:22:11 PM

The committee took a brief at-ease at 3:22 p.m.

HB 47-DIRECT HEALTH AGREEMENT: NOT INSURANCE

3:22:58 PM

CHAIR PRAX announced that the final order of business would be HOUSE BILL NO. 47, "An Act relating to insurance; relating to direct health care agreements; and relating to unfair trade practices."

3:23:43 PM

REPRESENTATIVE KEVIN MCCABE, Alaska State Legislature, as prime sponsor, presented HB 47. He stated that the proposed legislation seeks to address the issue of Alaska's high cost of health care. Alaska is ranked third in the nation in health care expenditure, at $13,642 per capita. It ranks second in the nation in private health insurance spending, at $6,523 per enrollee. The proposed legislation would provide guidelines for direct health care agreements – not insurance - between providers and patients, expanding access to health care at a price point that may be more affordable for Alaskans.

REPRESENTATIVE MCCABE explained that with direct health care agreements, consumers pay a recurring fee directly to a provider for medical services; the monthly amount can vary depending on the doctor, area, and type of plan. The bill seeks to restore the direct connection between doctor and patient. Cost would not be determined by what insurance will cover, but on what provider and patient agree. He asked the committee to help make direct health care an option by supporting HB 47.

3:27:03 PM

BUDDY WHITT, Staff, Representative Kevin McCabe, Alaska State Legislature, on behalf of Representative McCabe, prime sponsor, gave the sectional analysis for HB 47, [included in the

committee packet], which read as follows, [original punctuation provided]:

Section 1 – 21.03.025 – Page 1, Line 4 through Page 5, Line 9 Adds new section "Direct Health Care Agreements" to Chapter 3 of Title 21.

[Sub]section (a), page 1, line 5 through 11 – Defines a Direct Health Care Agreement as a written agreement between patient or patient representative and a health care provider to provide services in exchange for a periodic fee. This section also stipulates that Medicaid recipients under AS 47.07 and those receiving assistance for catastrophic illness and chronic or acute medical conditions under AS 47.08 are not eligible to enter into a Direct Health Care Agreement.

[Sub]section (b), page 1, line 12 through page 2, line 19 – Specifies that these agreements must contain a description of the health care services provided in exchange for the periodic fee and the locations where services are available. The agreements must also specify the amount of the periodic fee, the period of time covered by the agreement, and any additional fees that may be charged including cancellation fees.

The agreement must also include contact information for representative(s) of the health care provider designated to receive complaints, prominently state that the agreement is not health insurance, and state that the patient is not entitled to protections under Patient Protections Under Health Care Insurance Policies or Trade Practices and Frauds (AS 21.07 and 21.36 respectively).

[Sub]section (c), page 2, lines 20 through 29 - Directs that providers must allow a patient to terminate the agreement within 30 days and that if the agreement is terminated, the provider shall provide a refund of the payments made under the agreement, less payments made for services already provided that are not included in the periodic fee. The provider may charge a termination fee equal to one month's cost of the periodic fee.

[Sub]section (d), page 2, line 30 through page 3, line 8 – An agreement between provider and patient may be

terminated by either party with at least thirty days written notice. The agreement must include that the patient pay the prorated periodic fee through the date of termination and any fees for services outstanding. The provider may charge a termination fee equal to one month's cost of the periodic fee.

[Sub]section (e), page 3, lines 9 through 11 – The health care providers must provide 45 days written notice of a change in periodic fee, and that fee may only be changed once a year.

[Sub]section (f), page 3, lines 12 through 14 – The billing for the periodic fee occurs after the period covered by the fee.

[Sub]section (g), page 3, lines 15 through 20 – An employer may cover the cost of the direct health care agreement of the employee, but that is not considered insurance or dealing in the business of insurance.

[Sub]section (h), page 3, lines 21 through 31 – A provider can immediately terminate a direct health care agreement if the patient, (1) repeatedly fails to follow a treatment plan, (2) exhibits behavior that is a threat to safety of the provider or staff, (3) engages in disrespectful, derogatory or prejudiced behavior.

[Sub]section (i), page 4, lines 1 through 5 – Either party may terminate the agreement at any time if the other party breaches terms of the agreement.

[Sub]section (j), page 4, lines 6 through 9 – AS 21.07 "Patient Protections Under Health Care Insurance Policies" and AS 21.36 "Trade Practices and Frauds" do not apply to Direct Health Care Agreements but are subject to other consumer protections.

[Sub]section (k), page 4, lines 10 through 22 – A Direct Healthcare agreement is not insurance in any form and is therefore not subject to any regulation under the division of insurance. Additionally, a certificate of authority or license to market is not required in order to sell a direct health care agreement or services under a direct health care

agreement. Definitions for this section are also included.

Section 2 – AS 45.45.915 – Page 5, line 11 through page 6, line 4 Adds new section "Direct Health Care Agreements" to Chapter 45 of Title 45

[Sub]section (b), page 5, line 18 through 22 – A health care provider may decline to enter an agreement or cancel an existing agreement if the patients care needs are beyond that which the health care provider can provide or the provider does not have the capacity to accept new clients.

[Sub]section (c), page 5, lines 24 through 27 – A provider may use health care status as a reason for terminating a direct health agreement only if the health care provider is unable to provide services that the patient needs or in accordance with AS 21.03.025 (h) and (i).

[Sub]section (d), page 5, line 28 through page 6, line 2 – Provides definitions for this section

Section 3 – AS 45.50.471(b) – Page 6, lines 3&4 Adds violation of section 2 of the bill to the list of unfair methods of competition and unfair or deceptive acts or practices in the conduct of trade or commerce that are declared to be unlawful

3:35:02 PM

REPRESENTATIVE FIELDS referred to [Section 1, subsection (d)] and questioned whether this provision would allow the provider to terminate an agreement and then charge a termination fee.

MR. WHITT read the language from Section 1, subsection (d), then deferred to Peter Diemer.

3:37:38 PM

PETER DIEMER, Attorney, Clayton and Diemer, pointed out that Section 1, subsection (c) addresses what happens when a patient cancels; it allows the provider to charge a cancellation fee in that event but is limited to an amount no greater than one month of the periodic fee. He highlighted that this would be initiated by the patient within 30 days of entering into the

agreement. Subsection (d), he clarified, addresses the ability of any party to terminate the agreement with 30-day notice. He told Representative Fields that subsection (d) would not allow a provider to charge a cancellation fee under that circumstance if the provider initiates the termination; it would only allow the provider to charge the termination fee if the termination is initiated by the patient or patient's representative, and it would be limited to an amount not to exceed one month's costs of periodic fee.

REPRESENTATIVE FIELDS opined that is good intent, but indicated the language should be restructured.

3:40:47 PM

REPRESENTATIVE MCCABE said he would welcome an amendment to clarify that.

3:41:05 PM

REPRESENTATIVE SADDLER asked to what degree a provider could or could not decline to see a patient and whether there would need to be justification for either a patient or provider giving 30-day notice.

MR. WHITT deferred to Mr. Diemer.

3:42:30 PM

MR. DIEMER noted that Section 2 of HB 47 outlines the restrictions on cancellation by providers, which relate to AS 45.45.915, the Unfair Trade Practices Act amendments. He said, "It is far more protective of the patient."

REPRESENTATIVE SADDLER paraphrased [Section 2, subsection (b), paragraph (1)], which read:

> (b) A health care provider or health care business may decline to enter into a direct health care agreement with a new patient if the health care provider or health care business (1) is unable to provide to the patient the health care services the patient requires; or

REPRESENTATIVE SADDLER asked if that would be based solely on the provider's judgement.

3:44:45 PM

MR. DIEMER answered that's correct. He stated that HB 47 is designed not to amend or alter "the substantial body of existing regulation" imposed on providers. He expounded upon this with examples. In response to a follow-up question, he informed Representative Saddler that it is not permissible for a provider to terminate an agreement based on workload; however, that would be an acceptable reason for declining a new health care agreement. In response to Representative Saddler and Mr. Whitt, he confirmed the language in [Section 2, subsection (c)], regarding termination of a direct health care agreement by provider, can be done "if the health care provider is unable to provide to the patient the health care services the patient requires".

3:51:11 PM

CHAIR PRAX described a situation in which a provider takes on more patients than he/she can handle, thus cannot provide care for them all, and he asked if, under this scenario, the provider would be able "to terminate one of those agreements or any of those agreements."

MR. DIEMER answered yes, "but under a different section." He explained that the ability "to adjust the panel" once the agreement is in effect will be limited by [sub]section (d), beginning on page 2, line 30, through page 3, line 8 of HB 47. It cannot be based upon any of the categories within AS 45.45.915. In response to a follow-up question, he confirmed that there can be an adjustment of "the panel size" with the 30-day notice.

3:53:28 PM

REPRESENTATIVE FIELDS asked for confirmation that "if the company fails to provide the services," it is the Office of the Attorney General to which a consumer would apply for relief.

REPRESENTATIVE MCCABE offered his understanding that that is correct.

REPRESENTATIVE FIELDS asked the bill sponsor if he would support "additional regulatory backstop" to ensure relief available to consumers, "should an outside company ... cancel contracts on a patient."

REPRESENTATIVE MCCABE responded that he would be open "to anything that does not change the agreement back into an insurance policy."

3:55:24 PM

REPRESENTATIVE RUFFRIDGE said he thinks HB 47 is a good bill. He asked if there is a mechanism under which direct health care agreements could be altered to address a situation wherein, for example, a patient has increased needs in terms of services.

3:56:21 PM

MR. WHITT deferred to Mr. Diemer, but added that he thinks there is nothing in HB 47 that would preclude renegotiation of the agreement. He indicated the process would entail termination of the existing agreement and creating a new one.

MR. DIEMER stated that HB 47 would allow services to be provided to patients outside the scope of the periodic fee. He described this as a menu of services. There is nothing that would prevent the provider from providing additional services at "the fee for service model." Additionally, he said there is nothing that would prevent the amendment or modification of a direct health care agreement to change the scope of the services for the periodic fee, should the patient's needs change. That said, he advised that HB 47 is designed to fundamentally provide "a safe harbor for patients and providers by outlining the boundaries of what a direct health care agreement must ... contain and the rights and obligation of the patients and the providers that enter into these agreements." He directed attention to language on page 2, line 8, which addresses additional fees, including cancellation fees.

3:59:56 PM

LEE GROSS, MD, Epiphany Health, gave invited testimony on HB 47. He said he has been practicing the "direct primary care practice model" for 12 years. The price range is: $80/month for one adult; $30/month for the first child; and $15/month for each additional child. That covers every service done at the office. He indicated that the concerns raised by committee members today have never been an issue for his practice. He noted that Epiphany Health exists in a rural setting in a county with the second-lowest income in Florida. The practice works in conjunction with a rural hospital and has saved the hospital 55 percent in health care costs.

4:02:00 PM

DR. GROSS, in response to Representative Fields, listed the scope of services Epiphany Health provides its patients under the health care agreement.

4:04:06 PM

REPRESENTATIVE RUFFRIDGE asked if, within the $80/month fee for an adults, there are tiers to accommodate patients with "higher needs." He also asked how many patients Epiphany Health serves.

DR. GROSS answered there is no tier based upon health status. He noted that many of the practices do tier based on age. Those 55 and older are charged $100 per month. He pointed out that the service for children lasts up to a child's twenty-sixth birthday [for dependent children living at the parent address]. He shared that Epiphany Health, which is just a few years old, serves approximately 400 patients.

4:06:20 PM

REPRESENTATIVE MINA asked Dr. Gross to clarify whether his practice is direct primary care and whether direct health care agreements, as compared to direct primary care, are legal in Florida.

DR. GROSS answered that the State of Florida recently passed a bill on direct primary care, then subsequently changed it to direct health care "because they were happy with it and they wanted to expand the services to all specialties" rather than restricting it to primary care.

4:07:31 PM

JOSH UMBEHR, MD, Atlas, MD, gave invited testimony on HB 47. He said Atlas, MD has been practicing direct primary care since 2010, and over 1,200 doctors are now practicing under the Atlas, MD software/model. He shared that the pricing is: $10/month for children; and $58, $75, or $100/month for adults. No pre-existing condition is excluded, and there is a flat fee for everything but labs, which are charged based on the cost to the practice. He echoed Dr. Gross' statement that the majority of the concerns raised today by committee members are not things that Atlas, MD sees in its practice. He spoke of a desire to be

known as a practice that cares for patients, no matter how sick, and does not drop patients for being "too sick."

4:09:53 PM

REPRESENTATIVE SADDLER asked about resolutions of disputes regarding breech of agreement.

4:10:15 PM

MR. DIEMER answered that there are two avenues of recourse. The first would be through the Department of Law (DOL). Another would be to file a complaint with the court system.

4:11:12 PM

REPRESENTATIVE MCCABE, in wrap-up, noted that as of 2020, there were 32 states that had legislation such as HB 47, with 12 states "pending." He added that there are actually 48 states "doing this," because "some states didn't require this particular legislation." He offered his understanding that currently, close to 11,000 practices are operating under a direct primary care agreement. He indicated this effort to pass HB 47 stems from support of people in Wasilla and "further north" in order to "get back to the doctor/patient relationship" and allow medical professionals to do what they were trained to do rather than doing coding and coaxing insurance companies to pay.

4:12:29 PM

REPRESENTATIVE MINA asked about price transparency and guarantee of outlined services.

4:13:06 PM

REPRESENTATIVE MCCABE offered his understanding that that is covered in the agreement.

REPRESENTATIVE MINA asked if that contract would be publicly available.

MR. WHITT said he would get back to Representative Mina with answer following the meeting.

REPRESENTATIVE MINA asked why Medicaid patients are not included under the provisions of HB 47.

MR. WHITT deferred to Mr. Diemer.

4:15:14 PM

MR. DIEMER responded that the Department of Health (DOH) considered the potential for those persons to "come under the scope of a health care agreement." Ultimately, it would require some complicated amendments to statute to allow that to happen. Some states do allow this under pilot programs. He noted that the Medicaid program has both state and federal funding, as well as certain compulsory billing and coverage requirements that are inconsistent with a direct health care agreement. That said, he allowed that coverage could be expanded in the future "to allow for participation of those program beneficiaries into these types of agreement."

4:16:54 PM

REPRESENTATIVE FIELDS said he would like the bill sponsor to get back to him with information regarding the number of businesses involved in this that are physician-owned versus investor-owned.

REPRESENTATIVE MCCABE said he can look into that.

4:18:22 PM

CHAIR PRAX announced that HB 47 was held over.

4:18:36 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 4:19 p.m.