

**ALASKA STATE LEGISLATURE**  
**SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE**

February 7, 2023

3:30 p.m.

**MEMBERS PRESENT**

Senator David Wilson, Chair  
Senator James Kaufman, Vice Chair  
Senator Löki Tobin  
Senator Forrest Dunbar  
Senator Cathy Giessel

**MEMBERS ABSENT**

All members present

**COMMITTEE CALENDAR**

SENATE BILL NO. 45

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

- HEARD & HELD

**PREVIOUS COMMITTEE ACTION**

BILL: SB 45

SHORT TITLE: DIRECT HEALTH AGREEMENT: NOT INSURANCE

SPONSOR(S): SENATOR(S) WILSON

01/25/23	(S)	READ THE FIRST TIME - REFERRALS
01/25/23	(S)	HSS, L&C
02/07/23	(S)	HSS AT 3:30 PM BUTROVICH 205

**WITNESS REGISTER**

JASMIN MARTIN, Staff  
Senator David Wilson  
Alaska State Legislature  
Juneau, Alaska

**POSITION STATEMENT:** Presented the sponsor statement and sectional analysis for SB 45 on behalf of the sponsor.

PETER DIEMER, Partner  
Clayton & Diemer LLC.

Anchorage, Alaska

**POSITION STATEMENT:** Testified by invitation on SB 45.

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

**POSITION STATEMENT:** Testified by invitation on SB 45.

DR. JOSH UMBEHR, CEO  
Atlas MD  
Wichita, Kansas

**POSITION STATEMENT:** Testified by invitation on SB 45.

DR. LEE GROSS, Direct Primary Care Provider  
Patient Care Foundation  
North Point, Florida

**POSITION STATEMENT:** Testified by invitation on SB 45.

#### **ACTION NARRATIVE**

[3:30:06 PM](#)

**CHAIR DAVID WILSON** called the Senate Health and Social Services Standing Committee meeting to order at 3:30 p.m. Present at the call to order were Senators Kaufman, Dunbar, Tobin, Giessel, and Chair Wilson.

#### **SB 45-DIRECT HEALTH AGREEMENT: NOT INSURANCE**

[3:30:33 PM](#)

**CHAIR WILSON** announced the consideration of SENATE BILL NO. 45 "An Act relating to insurance; relating to direct health care agreements; and relating to unfair trade practices."

[3:31:28 PM](#)

**CHAIR WILSON**, District N, speaking as the sponsor of SB 45, provided the sponsor statement as follows:

[Original punctuation provided.]

Senate Bill 45 is necessary to reduce barriers between Alaskans and their chosen health care provider. This bill allows patients and healthcare providers to enter into direct health care agreements (DHCA). A direct health care agreement is a contractual agreement between a patient and a provider

for health care services. The patient pays a flat, periodic fee (generally monthly) in exchange for routine visits and access to their healthcare provider.

These agreements are only between a provider and a patient. Unlike the insurer-patient-provider trifecta, in a DHCA agreement, no third-party is directly participating in or profiting from the provider-patient relationship. Doctors currently spend about half their working hours on paperwork - including paperwork for third party insurance. Direct Health Care (DHC) reduces bureaucracy by allowing patients to pay a flat fee for routine care instead of billing insurance for every doctor's visit. The reduction in administrative burden leads to greatly reduced costs and more time in the day for doctors to spend with their patients.

While a person with private health insurance may elect to obtain a DHCA to supplement their current health insurance - such as a high deductible plan, but these models are not health insurance - nor do they replace it - and should not be regulated as such.

This bill will clearly exclude qualified DHCA from Title 21, or insurance regulations, and will clear up any confusion regarding the legality of direct health care agreements thereby improving the public's access to lower cost, high quality health care.

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SENATOR KAUFMAN arrived at the meeting.

[3:32:40 PM](#)

JASMIN MARTIN, Staff, Senator David Wilson, Alaska State Legislature, Juneau, Alaska, said Senate Bill 45 reduces barriers between patients and providers by clearly allowing direct health care agreements. A direct health care agreement is between a patient and a provider with no third-party intermediary profiting. Parties spell out the terms of the agreement in a contract. The patient pays a flat periodic fee in exchange for routine care, provider access, and other services, as spelled out in the contract. She stated that an oversimplified analogy of how a direct healthcare agreement works is a gym membership. A person pays to access a gym and

uses standard equipment, but extras like a tanning bed may not be in the contract and require an extra fee. Direct health care fees are about \$100. An employer can pay the fee but is not a party to the agreement. Direct health care has the following benefits:

- Reduced bureaucracy
- More appointment opportunities
- Longer patient visits
- Reliable care
- Higher doctor morale

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MS. MARTIN said Alaska has broadly drafted insurance laws, and the legality of direct healthcare agreements needs to be clarified. Currently, the official opinion of the Department of Commerce, Community and Economic Development is that insurance statutes would regulate the agreements. She reiterated that Alaska statute does not explicitly contemplate or prohibit these direct provider agreements. The agreements fall under the broad category of insurance as defined in Alaska law. SB 45 defines that direct health care agreements are not insurance. Direct health care agreements are different from insurance, health maintenance organizations, and medical services corporations for the following reasons:

- No third-party middleman
- No risk to the insurer
- Periodic fees are charged at the end of a period; no prepay

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MS. MARTIN provided the sectional analysis for SB 45 as follows:

[Original punctuation provided.]

**Section 1: Adds a new section (.025 Direct health care agreements) to AS 21 (Insurance) .03 (Scope of Code).**

**Section (a), page 1, line 5, through 11:** Defines a direct health care agreement (DHCA) as a written agreement between a patient (or representative) and a health care provider or business. This section also stipulates that Medicaid recipients under AS 47.47 and those receiving assistance for catastrophic illness and chronic or acute medical conditions under AS 47.08 are not eligible to enter a DHCA.

**Section (b), page 1, line 12, through page 2, line 19:** Specifies what a DHCA must contain.

(1) It must describe the services a patient is entitled to for payment of a periodic fee.

(2) It must specify: the amount of the periodic fee, the length of period the fee covers, any additional fees the provider or business may charge.

(3) It must include contact information for a representative of the provider or business that is responsible for patient complaints.

(4) It must state that the agreement is not health insurance.

(5) Prominently 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).

**Section (c), page 2, line 20, through 29:** Specifies that a patient may terminate an agreement within 30 days. Requires any fees and payments, less payments made for services the health care provider has already performed that are not included in the periodic fee. This section does allow the provider or business to charge a cancellation fee equal to no more than one month's cost of the periodic fee.

**Section (d), page 2, line 30, though page 3, line 8:** Specifies that a patient or provider can terminate an agreement after 30 days with at least 30 days' notice. The provider must prorate the periodic fee to the date of termination. The healthcare provider may charge a termination fee if the patient is the one to initiate the cancellation.

**Section (e), page 3, line 9, through 11:** Specifies that a provider may change the fee up to once a year, only with a written 45-day notice.

**Section (f), page 3, line 12, through 14:** Specifies that the patient is billed by the provider at the end of the period covered by the fee.

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At ease.

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CHAIR WILSON reconvened the meeting.

**Section (g), page 3, line 15, through 20:** Allows an employer to pay the periodic fee on behalf of an employee. This does not mean the employer is a health insurance provider or business.

**Section (h), page 3, line 21, through 31:** Sets terms by which a health care provider may immediately terminate a DHCA.

**Section (i), page 4, line 1, through 5:** Specifies that a patient or provider may terminate a DHCA if either party violates the terms of the agreement.

**Section (j), page 4, line 6, through 9:** Specifies that a DHCA is not subject to AS 21.07 (Patients Protections Under Health Care Insurance Policies) or AS 21.36 (Trade Practices and Frauds) but is subject to other consumer protections and regulations.

**Section (k), page 4, line 10, through 22:** Specifies that a DHCA is not insurance and is not regulated as such.

**Section (l), page 4, line 23, through page 5, line 8:** Defines: health care business, health care insurance, health care insurer, health care provider, health care service, health insurance, health maintenance organization, and medical services corporation.

**Section 2: Adds a new section (.915 Direct health care agreements) to AS 45 (Trade and Commerce) .45 (Trade Practices).**

**Section (a), page 5, line 11, through 17:** Specifies that a provider may not decline to enter or terminate a DHCA solely based on a patient's status within a protected class.

**Section (b), page 5, line 18, through 23:** Specifies that a provider may decline to enter an agreement if they are unable to provide the care the patient needs, or their practice is at capacity.

**Section (c), page 5, line 24, through 27:** Specifies that a provider may terminate a DHCA with a current

patient based on their health status only if the providers is not able to provide the services the patient requires or in accordance with AS 21.03.025 (section 1 of this legislation).

**Section (d), page 5, line 28, through page 6, line 2:** Defines: direct health care agreement, health care business, health care provider, and health care service.

**Section 3: Adds a new paragraph to AS 45 (Trade and Commerce) .45 (Trade Practices) .471 (Unlawful acts and practices).**

**Section (58), page 6, line 4:** Adds violations of AS 45.45.915 (section 2 of this legislation) 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.

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MS. MARTIN noted that SB 45 allows for direct health care agreements. Direct health care and direct primary care are similar terms, but not interchangeable, as primary care agreements only allow for contracts with primary care physicians. Some testifiers may use the term direct primary care agreements.

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SENATOR GIESSEL referred to SB 45, page 3, line 23, and asked what would constitute a failure to comply with a treatment.

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MS. MARTIN deferred the question to Mr. Diemer.

[3:45:47 PM](#)

CHAIR WILSON opened invited testimony on SB 45.

[3:46:00 PM](#)

PETER DIEMER, Partner, Clayton & Diemer LLC., Anchorage, Alaska, replied that he would briefly overview SB 45 and then respond to the question. He stated that SB 45 allows the legislature to make limited-scope amendments to Title 21 so that Alaska can fully embrace the direct healthcare service and payment model. Title 21 currently contains a broad definition for health care insurer, health care maintenance organization, and medical

service corporation. SB 45 creates a safe harbor for providers and patients who elect to engage in a qualified direct health care agreement while creating important patient and consumer protections. SB 45 does not change the relationship between a patient and their insurer. The Division of Insurance regulates insurance, health maintenance organizations, and medical service organizations. SB 45 does not change the exercise of independent clinical judgment by the provider or any existing regulations that apply to various licensed providers engaging in a direct health care agreement. In answer to Senator Giessel's question, he replied that Alaska administrative codes, promulgated by the American Medical Association (AMA), apply to all physicians. He stated that SB 45, Section 1, subsection (h), paragraphs (1-3) are consistent with the AMA's code of ethics and published guidance on terminating a physician-patient relationship.

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SENATOR GIESSEL commented that the language seems broad as patients routinely do not follow treatment plans.

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SENATOR TOBIN asked what would happen if a patient could not complete a treatment plan due to lacking personal funds.

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MR. DIEMER replied that direct health care agreements usually do not include prescriptions within the scope of services, as physicians generally only offer the services they can provide. Typically, physicians work with patients to obtain needed treatment. Standards for the termination of a patient relationship exist. A physician must use the AMA code to determine whether the relationship can continue. Termination is generally due to a lack of willingness to comply.

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SENATOR TOBIN suggested adding language to SB 45 to clarify that a doctor cannot arbitrarily drop a patient from an agreement.

[3:53:27 PM](#)

SENATOR GIESSEL agreed that medication is often more expensive than a physician's visit. She stated it would be prudent for a patient to carry health insurance.

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MR. DIEMER replied that direct health care agreements are complementary to insurance. Direct healthcare agreements are

often a good fit for individuals with high deductibles. Most providers recommend that patients maintain insurance.

[3:55:21 PM](#)

SENATOR GIESSEL responded that the cost of a medical visit and medication gets applied to a high deductible. She reasoned that direct health care agreements benefited the providers and asked how the agreements benefit patients.

[3:56:04 PM](#)

CHAIR WILSON stated that a direct service agreement could benefit an individual who does not elect employer vision or dental plans. Direct healthcare agreements provide more options to consumers.

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SENATOR TOBIN asked whether direct health care insurance could be equivalent to insurance.

CHAIR WILSON deferred the question to Ms. Wing-Heier.

[3:57:39 PM](#)

LORI WING-HEIER, Director, Division of Insurance, Department of Commerce, Community and Economic Development (DCCED) Juneau, Alaska, replied that the division does not consider direct health care agreements a substitute for health insurance. She explained that many families only benefit from their insurance plan if they reach their insurance plan's deductible. A low deductible for a family of four is \$7,000. A direct care agreement is a fixed amount that allows individuals and families to visit a provider as often as needed without paying extra. Many Alaskans desire the state to offer direct health care agreements. The agreements are beneficial when primary care physicians do not accept Medicare.

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SENATOR KAUFMAN said he knew of a doctor who could not keep up with insurance paperwork and decided to retire. He asked if direct health care agreements would help keep doctors in the workforce since they would not be bound to the documentary requirement of insurance companies and the government.

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MS. WING-HEIER replied that she could not speak for doctors. However, previous testimony indicated paperwork contributes to burnout, and many doctors like that direct health care

agreements would allow them to be effective in their community without burdensome billing.

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DR. JOSH UMBEHR, CEO, Atlas MD Clinics, Wichita, Kansas, said direct healthcare agreements help patients, doctors, and employers. He said his clinic had used the same model for 12 years and had never raised prices. The monthly charge for unlimited primary care is \$10 per child and \$50, \$75, or \$100 per adult. Primary care includes office visits, telemedicine, no copay, in-office procedures, and wholesale costs for medications and lab work, which is 95 percent cheaper. He opined that direct healthcare cost agreements reduce emergency room visits, provide better continuity of care, decrease specialty referrals, and lower insurance premiums for small employers between 30 - 60 percent. He said direct healthcare agreements create efficiency. Having enough doctors is not a problem in health care. The problem is that doctors spend 40 percent of their time doing non-clinical paperwork. He stated he had helped over 2,000 doctors open more than 800 - 900 clinics.

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SENATOR DUNBAR said SB 45 allows doctors to terminate an existing agreement if they cannot provide a service. He asked if a doctor could deny an initial contract based on health status. He wondered if Mr. Umbehr's clinic does screenings for very sick individuals.

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MR. UMBEHR replied that his clinic does not have any constraints on preexisting conditions. He has never seen a doctor refuse a patient for not taking medication. He reiterated that the American Medical Association (AMA) has an established standard that allows doctors to discontinue a relationship that is not healthy or productive, such as failure to pay, making staff feel unsafe, and personality conflicts. A doctor might not enter a contract if he does not provide a particular service that the patient wants, such as obstetrics.

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SENATOR DUNBAR restated his question and referred to SB 45, Section 2, subsection (a), which lists reasons a healthcare provider may not decline to enter a direct healthcare agreement. He asked whether adding preexisting conditions to the list would change the healthcare model.

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MR. UMBEHR replied that the direct health care model is similar to other models. It is a business decision that does not affect ethics. The rules that apply to insurance-based doctors apply to direct care. Financial arrangements do not affect ethics.

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SENATOR TOBIN asked whether a woman would have to pay a cancellation fee if she became pregnant and wanted to change to a doctor who did obstetrics.

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MR. UMBEHR replied that he could not speak to SB 45, but that is not how the business model functions; it is a month-to-month contract. Usually, a patient continues with their primary care doctor, who assists them in finding an obstetrician.

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MR. DIEMER referred to AS 45.45.915 (b) and said that a healthcare provider could decline to enter into a new healthcare agreement if the provider cannot provide the patient's required service. A physician can only take patients that they can serve. A patient would not have to cancel a direct health care agreement if a medical need arose that their physician could not fulfill. A direct health care agreement offers a menu of services, and the patient could continue to receive those services while seeing a specialized doctor for other services. He clarified that SB 45 contains a cancellation fee provision, not a mandate.

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DR. LEE GROSS, Direct Primary Care Provider, Patient Care Foundation, North Point, Florida, said he has been practicing under the direct care model since 2012. He noted that he has an office in the second poorest county in Florida. The hospital agreed to pay the membership fees for all employees that sign up for a direct health care agreement. The hospital structured its self-funded insurance plan around the direct health care model. It eliminated all copays and deductibles for hospital services, such as CAT scans and surgeries. His office and the hospital eliminated all financial barriers to accessing routine and unpredictable services. He said the arrangement with the hospital has been in place for four years. In the first year, the agreement reduced employee premiums by 20 percent, and employee premiums have not increased. The hospital has seen a sustained 55 percent reduction in its employee health plan cost, which has saved it millions of dollars. Rural health care has many obstacles, such as access. He described services and

situations where the direct health care model allowed his office to respond to crises faster and more efficiently than providers who bill insurance companies. Rural hospitals are struggling to stay open, but the hospital he works with had one of the best financial years in its history.

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CHAIR WILSON asked if SB 45 could help enhance rural hospitals' business models.

DR. GROSS replied that his business is a four-year proof of concept. He opined that the concept applies to more than just rural hospitals. Various socio-economic areas are practicing it. The variability and flexibility of the direct care model make it a very powerful tool.

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SENATOR GIESSEL asked whether Medicare prevents patients from paying for their healthcare. She stated her understanding that providers could only accept what Medicare pays.

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MS. WING-HEIER responded that a direct health care agreement is not insurance, and it is not Medicare. A consumer can participate in an agreement and receive primary care while not impacting Medicare. She stated that the department thoroughly explored this question two years ago.

[4:20:00 PM](#)

SENATOR GIESSEL said this could benefit Medicare beneficiaries who can afford to enter into an agreement.

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SENATOR DUNBAR asked why a person on Medicaid cannot enter into a direct health care agreement as stated in SB 45, page 1, Section 1.

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MS. MARTIN replied that Medicaid is a payer of last resort, which complicates direct health care agreements. Therefore, it was requested to be omitted from participation.

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SENATOR DUNBAR requested the sponsor provide a more substantive reason for excluding Medicaid as he is concerned that the agreements will target healthier and wealthier people and harm lower-income individuals indirectly.

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CHAIR WILSON said SB 45 is primarily to help underinsured individuals who never reach their high deductible.

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MS. WING-HEIER said a payer of last resort is the final insurance to pay on a claim. For example, an Aetna policy would pay first, and Medicaid would pay second. If a direct health care agreement covered an individual's needs, there would be no secondary payment.

[4:23:29 PM](#)

SENATOR DUNBAR responded that direct health care agreements are not insurance and wondered why Medicaid would be implicated.

[4:23:38 PM](#)

MS. WING-HEIER replied that the Department of Health would need to respond.

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CHAIR WILSON asked if Mr. Diemar had any comment.

[4:24:04 PM](#)

MR. DIEMER said SB 45 excluded Medicaid for two reasons. First, direct healthcare agreements deliver healthcare services. Medicaid's complex rules require compulsory billing and payment according to its schedules for receipt of healthcare services for a Medicaid beneficiary, which is then in tension with a healthcare agreement. Some states have explored Medicaid pilot programs where Medicaid enters into a direct health care agreement with providers. Those agreements were between the state and the providers of defined services. The Department of Health asked to exclude Medicaid beneficiaries because they will receive a greater scope of care and services under Medicaid than through a direct health care agreement.

[4:25:35 PM](#)

SENATOR DUNBAR asked if there was a reduction in the number of physicians accepting Medicaid in the states allowing direct health care agreements.

[4:25:49 PM](#)

CHAIR WILSON stated he was unaware of any studies indicating a reduction in physicians accepting Medicaid due to direct health care agreements.

[4:25:58 PM](#)

MR. UMBEHR replied that he had not seen any significant drop in physicians accepting Medicaid. Instead, there has been an uptake in the number of Medicaid patients able to receive care. He stated that fewer than one in 11 Kansas doctors were taking new Medicaid patients a few years ago. He opined that being able to have a contract with a doctor outside of Medicaid unburdens the system in ways such as no copays, free telemedicine, and decreased travel responsibility. He compared it to being able to use food stamps not only at the grocery store but at McDonald's. He opined that direct healthcare practices result in a net gain for Medicaid.

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DR. GROSS stated that direct healthcare providers in Florida could see Medicaid patients. He said he understood the concern regarding the complexity of Medicaid but suggested the focus should be on the improved access Medicaid patients experience due to direct healthcare agreements. In Florida doctors that previously did not accept Medicaid began accepting Medicaid patients. He stated that the direct healthcare model does not create healthcare access obstacles for people experiencing poverty; it improves it. He said that people who do not have insurance or frequently need to be seen by a doctor travel many hours to his clinic and are glad they can be seen for \$80 per month for an adult and \$15 per month for a child.

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SENATOR GIESSEL asked what the distinction is between Medicare and Medicaid as payers of last resort.

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MS. WING-HEIER replied that she would speak with the Department of Health and respond to the committee.

[4:29:22 PM](#)

SENATOR KAUFMAN asked if direct health care agreements prevent doctors from working pro bono.

[4:29:46 PM](#)

MR. UMBEHR answered no; doctors are more likely to offer scholarships or discounts to patients because, in a typical insurance setting, over and under-billing is considered fraud. The direct healthcare model frees doctors up for charity work and medical student mentoring. It is a net gain for at-risk people.

[4:31:12 PM](#)

SENATOR TOBIN referenced SB 45, page 3, line 9, and asked if there is a provision for a patient to decline a continuation of an agreement if there is a fee increase.

MS. MARTIN replied that there is no such provision in SB 45.

SENATOR TOBIN suggested adding a provision.

[4:31:58 PM](#)

SENATOR TOBIN asked what recourse patients with direct health care agreements would have if mistreated.

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MS. MARTIN replied that the recourse for unfair treatment would be through the Attorney General's Office under acts of unfair trade practices.

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CHAIR WILSON opened public testimony on SB 45; finding none, he closed public testimony.

[4:33:47 PM](#)

SENATOR GIESSEL asked if the Department of Health (DOH) would come before the committee to discuss the differences between Medicaid and Medicare as payers of last resort.

CHAIR WILSON replied that he would ask DOH to prepare a response when they next meet with the committee.

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CHAIR WILSON held SB 45 in committee.

[4:35:21 PM](#)

There being no further business to come before the committee, Chair Wilson adjourned the Senate Health and Social Services Standing Committee meeting at 4:35 p.m.