ALASKA STATE LEGISLATURE
SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
March 12, 2024
3:32 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 CONCURRENT RESOLUTION NO. 9
Recognizing the need for parity in the provision of mental health and substance use disorder medical assistance benefits in the state; and urging the Department of Health to adopt regulations that ensure parity in the provision of mental health and substance use disorder medical assistance benefits in the state.

- HEARD & HELD

SENATE BILL NO. 27
"An Act relating to insurance coverage for contraceptives and related services; relating to medical assistance coverage for contraceptives and related services; and providing for an effective date."

- HEARD & HELD

SENATE BILL NO. 240
"An Act relating to medical assistance coverage for rehabilitative, mandatory, and optional services furnished or paid for by a school district on behalf of certain children."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: SCR 9
SHORT TITLE: MENTAL HEALTH/SUBSTANCE ASSISTANCE PARITY
SPONSOR(s): SENATOR(s) DUNBAR

02/19/24	(S)	READ THE FIRST TIME - REFERRALS
02/19/24	(S)	HSS
03/12/24	(S)	HSS AT 3:30 PM BUTROVICH 205

BILL: SB 27
SHORT TITLE: CONTRACEPTIVES COVERAGE:INSURE;MED ASSIST
SPONSOR(s): SENATOR(s) TOBIN

01/18/23	(S)	PREFILE RELEASED 1/9/23
01/18/23	(S)	READ THE FIRST TIME - REFERRALS
01/18/23	(S)	HSS, L&C
01/20/23	(S)	PRIME SPONSOR CHANGED: TOBIN REPLACED CLAMAN
03/12/24	(S)	HSS AT 3:30 PM BUTROVICH 205

BILL: SB 240
SHORT TITLE: SCHOOL DISTRICT MEDICAL ASSISTANCE
SPONSOR(s): RULES BY REQUEST OF THE GOVERNOR

02/19/24	(S)	READ THE FIRST TIME - REFERRALS
02/19/24	(S)	HSS
02/27/24	(S)	HSS AT 3:30 PM BUTROVICH 205
02/27/24	(S)	Heard & Held
02/27/24	(S)	MINUTE(HSS)
03/12/24	(S)	HSS AT 3:30 PM BUTROVICH 205

WITNESS REGISTER

SENATOR FORREST DUNBAR, District J
Alaska State Legislature, Juneau, Alaska
POSITION STATEMENT: Sponsor of SCR 9.

JOHN SOLOMON, CEO
Alaska Behavioral Health Association
Eagle River, Alaska
POSITION STATEMENT: Invited Testimony for SCR 9.

CODY CHIPP, Ph.D., Social Project Support
Alaska Behavioral Health Association
Anchorage, Alaska
POSITION STATEMENT: Invited testimony for SCR 9.

DARCI NEVZUROFF, Director of Operations

Behavioral Services Division
Southcentral Foundation
Anchorage, Alaska
POSITION STATEMENT: Testified in support of SCR 9.

RONTO RONEY, Director of Behavioral Health
Manilliq Corporation
Kotzebue, Alaska
POSITION STATEMENT: Testified in support of SCR 9.

LANCE JOHNSON, COO
Alaska Behavioral Health Association
Eagle River, Alaska
POSITION STATEMENT: Testified in support of SCR 9.

DAN BIGLEY, CEO
Denali Family Services
Anchorage, Alaska
POSITION STATEMENT: Testified in support of SCR 9.

TRACY DOMPELING, Director
Division of Behavioral Health
Department of Health
Juneau, Alaska
POSITION STATEMENT: Testified on SCR 9.

MICHAEL MASON, Staff
Senator Löki Tobin
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Provided the sectional analysis for SB 27.

LORI WING-HEIER, Director
Division of Insurance
Department of Commerce, Community & Economic Development
Juneau, Alaska
POSITION STATEMENT: Answered questions on SB 27.

ROBIN HOLMES, Ph.D., representing self
Homer, Alaska
POSITION STATEMENT: Invited testimony for SB 27.

INGRID JOHNSON, representing self
Anchorage, Alaska
POSITION STATEMENT: Invited testimony for SB 27.

MAUREEN O'HANLON, representing self

Sitka, Alaska
POSITION STATEMENT: Testified in support of SB 27.

OLIVIA LYNN, representing self
Fairbanks, Alaska
POSITION STATEMENT: Testified in support of SB 27.

NANCY SCHEETZ-FREYMILLER, representing self
Anchorage, Alaska
POSITION STATEMENT: Testified in support of SB 27.

LEAH VAN KIRK, Healthcare Policy Advisor
Department of Health
Juneau, Alaska
POSITION STATEMENT: Answered questions on SB 240.

ACTION NARRATIVE

3:32:36 PM
CHAIR DAVID WILSON called the Senate Health and Social Services Standing Committee meeting to order at 3:32 p.m. Present at the call to order were Senators Tobin, Kaufman, Dunbar, Giessel and Chair Wilson.

SCR 9-MENTAL HEALTH/SUBSTANCE ASSISTANCE PARITY

3:33:36 PM
CHAIR WILSON announced the consideration of SENATE CONCURRENT RESOLUTION NO. 9 Recognizing the need for parity in the provision of mental health and substance use disorder medical assistance benefits in the state; and urging the Department of Health to adopt regulations that ensure parity in the provision of mental health and substance use disorder medical assistance benefits in the state.

3:33:51 PM
SENATOR FORREST DUNBAR, District J, Alaska State Legislature, Juneau, Alaska, sponsor of SCR 9 gave the following statement:

> Senate Concurrent Resolution (SCR) 9 emphasizes the importance of behavioral health care within our health systems and calls for Alaska to adopt national parity standards. These standards ensure that behavioral health services receive fair and equal access and coverage compared to other medical treatments. By following these guidelines, we can remove barriers

that prevent individuals from accessing necessary care and ensure treatment for behavioral health issues receives equitable treatment, just like treatment for any other health issues.

SENATOR DUNBAR acknowledged the committee's strong commitment to behavioral health issues. He noted that the resolution includes discussion of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as well as non-quantitative treatment limitations (NQTLs). Instead of elaborating further on SCR 9, he asked to defer to the invited testimony, starting with Mr. John Solomon from the Eagle Health Association.

3:35:21 PM
CHAIR WILSON announced invited testimony on SCR 9.

3:35:35 PM
JOHN SOLOMON, CEO, Alaska Behavioral Health Association, Eagle River, Alaska, stated that he represents the Alaska Behavioral Health Association, a member organization for approximately 90 provider organizations across the state. These providers range from large hospital systems to small regional providers, primarily in the behavioral health field. He added that the association also includes Federally Qualified Health Centers (FQHCs)

MR. SOLOMON shared that he is a licensed professional counselor who initially came to Alaska to provide behavioral health care in rural villages. He later became a quality assurance supervisor, responsible for training therapists and ensuring quality care that met accreditation standards. He then advanced to director of behavioral health, where he designed programs, managed funds, and worked to expand access to behavioral health care in the Northwest Arctic.

MR. SOLOMON also shared his personal story of being in long-term recovery for over 13 years, having previously struggled with substance use, including methamphetamine and alcohol, and facing homelessness and legal issues. Additionally, he revealed that he has bipolar I disorder, which, as he explained, has both behavioral and medical implications, requiring lifelong treatment. He emphasized that access to behavioral health care is crucial to him, both professionally and personally.

3:37:44 PM

MR. SOLOMON moved to slide 2 of the presentation Behavioral Health Parity and explained that he would discuss parity in the context of SCR 9, noting that the term can be misunderstood or conflated with other issues. In healthcare and legislative terms, parity refers to ensuring that behavioral health treatment receives the same access and coverage as medical and surgical treatments. He clarified that the resolution aligns with national standards and would direct the state to remove barriers, ensuring that behavioral health care is treated under the same terms and conditions, regardless of diagnosis, severity, or cause.

3:38:35 PM
MR. SOLOMON moved to slides 3 and explained that barriers to behavioral health care can take many forms, often stemming from outdated regulations based on past clinical practices. He noted that when clinical care is written into regulations, they require updates, which hasn't always happened in the behavioral health field—a relatively newer area of healthcare. He highlighted that some regulations involve extensive paperwork and administrative burdens, which may reflect the stigma around being a behavioral health provider. He pointed out that behavioral health providers are sometimes scrutinized in ways that physical health providers are not. He stated these examples of barriers need addressing.

3:39:22 PM
MR. SOLOMON moved to slide 4 and explained parity from a client's perspective. He gave the example of visiting a community health center for elbow pain, where in one appointment, a patient can get an intake, a brief assessment, immediate treatment for symptoms, and a plan for further care, including potential referrals. This efficient process is common in physical health care.

3:40:04 PM
MR. SOLOMON moved to slide 5 and contrasted this with the experience at community behavioral health centers. A client seeking behavioral health care would first go through an intake and screening, then schedule a second appointment for a full biopsychosocial assessment, which could take hours. The third appointment would involve creating an ongoing treatment plan. This process, often taking months, delays treatment. While there is faster access during a crisis, the system currently offers two extremes: crisis care or a lengthy wait for treatment. He stressed that this structure doesn't address the urgency for

those needing behavioral health care before reaching a crisis point.

3:41:10 PM
MR. SOLOMON moved to slide 6 and stated that community behavioral health centers handle many Medicaid enrollments, claims adjudication, and documentation standards, which are necessary but applied more strictly than in physical health care. This leads to longer wait times, providers moving to private pay, organizations refusing Medicaid due to workflow differences, and rising service costs from increased administrative time. He expressed concern that budgets are shifting towards hiring more administrative staff instead of clinical staff, which was discouraging as a director. He emphasized the need to focus on outcomes rather than audits when building behavioral health systems.

3:42:09 PM
MR. SOLOMON moved to slide 7 a matrix of non-qualitative treatment limiters regarding enrollment and said explained that the Behavioral Health Association examined national standards and parity legislation, seeking a resolution to meet these parity standards. The goal is to ask the Department of Health and its division to address the different burdens and barriers between healthcare and behavioral health. He mentioned they created a matrix to highlight these issues, starting with Medicaid enrollments, noting that community behavioral health often requires 18 different enrollments compared to just one or two in primary care settings like pediatricians.

3:42:59 PM
MR. SOLOMON moved to slide 8-9 a matrix of non-qualitative treatment limiters regarding Medicaid claims adjudication processes, documentation standards, reporting requirements, accreditation requirements, state departmental review requirements, rate setting methodologies and service authorizations. He emphasized that community behavioral health follows healthcare documentation standards, which consist of one page of regulations, but adds an extra seven pages specific to behavioral health, along with hundreds of pages in the administrative service manuals, which are entered into regulation. This complexity increases audit risk for providers. He shared that even errors, such as typos in service manuals, have left providers in difficult situations, where they must choose between proper clinical care or adhering to a mistake in regulation, knowing audits could hold them accountable. He proposed creating a committee to review standards and

regulations to ensure behavioral health is as accessible as healthcare, while allowing for necessary differences in a thoughtful manner.

3:44:32 PM
MR. SOLOMON moved to slide 10 on parity legislation that ensures access and discussed the Mental Health Parity and Addiction Equity Act, passed in 2008 and updated in 2022, noting that 37 states follow it. He explained that states are allowed to pass their own legislation or match parity standards. He mentioned that Wyoming was the most recent state to pass parity legislation in 2019.

3:45:04 PM
MR. SOLOMON moved to slide 11 on real world outcomes the Alaska solution. He explained that the proposed resolution aims to align Alaska Medicaid regulations with federal standards and involve the Department of Health, the division, the Alaska Behavioral Health Association (ABHA), and partners in primary and hospital care. The group would work collaboratively to identify areas for improvement and support the division in enhancing care. He highlighted the importance of acting now, citing strong leadership and shared vision within the department. By building a solid framework for behavioral health in Alaska, he anticipated more efficient care, reduced reliance on emergency rooms and correctional facilities, and shorter wait times. He noted that hospitals and primary care often struggle to transfer patients to community behavioral health, particularly those with higher acuity needs.

3:47:08 PM
MR. SOLOMON moved to slide 12 on legislation. He stated that SCR 9 emphasizes the importance of parity legislation and references non-quantitative treatment limiters (NQTLs). He explained that NQTLs refer to regulatory and system barriers preventing easy access to care. The resolution highlights these issues and reinforces legislative support for improving behavioral health care access by aligning with federal standards. Solomon stressed the need for collaboration with providers to establish a strong foundation for the future of behavioral health care in Alaska.

3:48:27 PM
SENATOR TOBIN expressed curiosity about the absence of a call for parity in travel access within the resolution, despite its relevance to a 2018 Disability Law Center case. She asked for clarification on whether this issue falls under the purview of

the resolution or if it was unintentionally overlooked in the materials she reviewed.

3:49:04 PM
MR. SOLOMON responded by noting that one of the non-quantitative treatment limiters (NQTLs) involves barriers to care created by regional differences. He explained that the inability to access care due to location is a barrier the parity standards aim to address. He emphasized that the resolution is a collaborative effort with the Department and the division to find solutions together, rather than imposing them. Issues like travel would be included as part of the NQTLs addressed through this partnership.

3:49:58 PM
At ease

3:50:06 PM
CHAIR WILSON reconvened the meeting.

3:51:10 PM
CODY CHIPP, Ph.D., Social Project Support, Alaska Behavioral Health Association, Anchorage, Alaska, shared that while states cannot weaken federal parity laws, they can strengthen them, which is an important consideration. He noted that Alaska's Medicaid plan is exempt from federal parity requirements because it operates as a fee-for-service state. The resolution is not calling for legislation but seeks to partner with the Department of Health and Division of Behavioral Health to address non-quantitative treatment limiters (NQTLs), which create barriers to care. One significant example is the inefficiency of written treatment plans, which differ from medical counterparts who can adjust care plans at each appointment. In behavioral health, changes to treatment plans require amending multiple documents, which could be a warning sign of not meeting federal parity requirements. He also acknowledged the need to address travel barriers, particularly for emergency and non-emergency behavioral health services, as a priority in collaboration with the department and other partners if the resolution moves forward.

3:54:36 PM
CHAIR WILSON concluded invited testimony and opened public testimony on SCR 9.

3:55:09 PM

DARCI NEVZUROFF, Director of Operations, Behavioral Services Division, Southcentral Foundation, Anchorage, Alaska, testified in support of SCR 9. She stated that Southcentral Foundation (SCF), a tribal health organization serving over 70,000 Alaskans, is one of the largest behavioral health providers in the state, offering over 20 behavioral health and substance use programs. She highlighted the significant administrative and clinical documentation burdens for behavioral health providers, which contribute to long waitlists and hinder access to care. Intake, assessment, and treatment plans for billing purposes can take three to eight non-clinical hours, preventing providers from delivering care. She compared this to medical doctors who do not face similar burdens for longstanding diagnoses like type 2 diabetes, questioning why behavioral health should be treated differently. She urged support for the resolution to align behavioral health care with other healthcare providers and to meet the goals of the 1115 [Behavioral Health Medicaid] Waiver in improving access and quality of care for Alaskans.

3:57:14 PM
RONTO RONEY, Director of Behavioral Health, Manilliq Corporation, Kotzebue, Alaska, testified in support of SCR 9. He said he represents tribal health and emphasized the need for parity in behavioral health care access. He noted that while Alaska has made progress in reducing stigma, excessive paperwork still prevents immediate access to care. He called for prioritizing treatment when individuals seek help, handling documentation later, and compared this to how primary care for his children is delivered without delay. He stressed that reducing bureaucracy, especially for youth, will improve access to timely and effective care and urged the committee to streamline the process for all Alaskans.

3:59:30 PM
LANCE JOHNSON, COO, Alaska Behavioral Health Association, Eagle River, Alaska, testified in support of SCR 9. He expressed strong support for the initiative and gratitude for the testimony shared. He noted that efforts to improve access to behavioral health services have been ongoing for over 30 years in Alaska and emphasized that now is the time for action. He highlighted the opportunity to collaborate effectively with the Department and Division of Behavioral Health to improve access, pointing out that many people in need are currently accessing services through jails, emergency rooms, and crisis centers. He stressed the importance of providing easier and immediate access to treatment, similar to primary care.

4:00:50 PM
DAN BIGLEY, CEO, Denali Family Services, Anchorage, Alaska, testified in support of SCR 9. He stated that in the 21 years he has worked in the behavioral health field he has not seen Non-Quantitative Treatment Limitations (NQTLs) provide a benefit to youth and families. The use of NQTLs creates barriers to care, burdens providers with administrative tasks, and leads to burnout. He expressed concern that these limitations reduce provider willingness to accept Medicaid, increasing strain on those seeking services. He opined that regulations should not dictate care; rather, best practices in training and education should guide care. He looked forward to quality assurance departments focusing on care quality and evidence-based practices instead of regulatory compliance.

4:03:13 PM
CHAIR WILSON closed public testimony on SCR 9.

MR. WILSON asked if the department is already working on implementing regulations to reduce burdens and paperwork while increasing parity in medical services. He requested clarification on what actions the department is currently taking and what future plans exist regarding this issue.

4:04:09 PM
TRACY DOMPELING, Director, Division of Behavioral Health, Department of Health, Juneau, Alaska, stated that the Department of Health has been working on reducing administrative burdens since she took her position last June. Prior efforts were already underway, especially under the leadership of the commissioner and deputy commissioner. The department used the public health emergency to temporarily suspend service authorizations for the state plan and 1115 services. On February 2, the 1115 regulation package went into effect, eliminating most service authorizations and limits for outpatient treatment.

4:04:57 PM
MS. DOMPELING noted that the department held listening sessions with providers to discuss eliminating service authorizations for outpatient behavioral health services under the state plan, with hopes of finalizing those changes before the public health emergency ends in May. The department has worked closely with the Alaska Behavioral Health Association to identify regulatory changes to improve parity. She added that the division recently reallocated a position to the regulations section, increasing the team from one to three people to focus on regulatory work

and other tasks. She emphasized that while much has been accomplished, significant work remains.

4:06:18 PM
SENATOR DUNBAR thanked the previous testifiers and the director, expressing his belief that great progress is being made in the department. He stated that the department is moving in the right direction, which is why he supports a resolution encouraging continued efforts, rather than pursuing a complex statutory or regulatory fix. He commended the department for its work and expressed hope that the resolution would pass, benefiting the Behavioral Health Association.

CHAIR WILSON [held SCR 9 in committee.]
4:07:00 PM
At ease

SB 27-CONTRACEPTIVES COVERAGE:INSURE;MED ASSIST

4:08:51 PM
CHAIR WILSON announced the consideration of SENATE BILL NO. 27 "An Act relating to insurance coverage for contraceptives and related services; relating to medical assistance coverage for contraceptives and related services; and providing for an effective date."

4:09:02 PM
SENATOR LÖKI TOBIN, District I, Alaska State Legislature, Juneau, Alaska, speaking as sponsor of SB 27, introduced herself.

4:09:21 PM
SENATOR TOBIN emphasized that SB 27 is critical contraceptive legislation. She cited a 2020 report by the Joint Economic Committee of the U.S. Senate. The report highlights the importance of access to birth control, noting its impact on women's economic outcomes, including higher education attainment, income, better health, reduced poverty, narrowing the gender pay gap, and increasing labor force participation. She pointed out that while birth control is constitutionally protected, many women in Alaska still face barriers to access, particularly due to pharmacy closures and vacancies in U.S. Postal Service offices, which affect timely delivery of contraceptives by up to 12 weeks. She expressed concern about how extreme weather and lack of access to pharmacies further impede the ability to obtain birth control. She highlighted the broader societal benefits of family planning, including reduced

child poverty and improved educational outcomes for children. She mentioned the Affordable Care Act's role in reducing out-of-pocket costs for women by $483 million in one year and noted that a 2014 study included in the 2020 Joint Economic Committee Report showed that preventing unplanned pregnancies has saved $15.2 billion in Medicaid maternity and child related costs. In addition, there was an associated miscarriage Medicaid cost savings of $409 million. She stated that SB 27 is essential for expanding contraception coverage in Alaska by requiring insurers to cover up to a 12-month supply at once. SB 27 includes exemptions for religious employers that meet specific requirements. SB 27 will also help ensure both public and private healthcare insurers cover a 12-month supply of contraceptives.

4:14:23 PM
MICHAEL MASON, Staff, Senator Löki Tobin, Alaska State Legislature, Juneau, Alaska, Provided the sectional analysis for SB 27.

[Original punctuation provided.]

Senate Bill 27
"Insurance Coverage for Contraceptives and Related Services" Sectional Analysis
Version: 33-LS0241\A

Section 1 AS 21.42.427 Adds a new section that (1) requires a health care insurer to provide coverage for prescription contraceptives and medical services necessary for those products or devices (including over-the counter emergency contraception that was obtained without a prescription); (2) requires reimbursement to a health care provider or dispensing entity for dispensing prescription contraceptives intended to last for a 12-month period for subsequent dispensing; (3) prevents an insurer from offsetting the costs of compliance; (4) prevents an insurer from restricting or delaying coverage for contraceptives; (5) if the provider recommends a particular service or FDA-approved item based on a determination of medical necessity, the plan or issuer must cover that service or item without cost sharing; and (6) exempts religious employers if certain criteria are met.

Section 2 AS 29.10.200 Amends AS 29.10.200 by adding a provision applying to home rule municipalities.

Section 3 AS 29.20.420 Amends AS 29.20 by adding a new section clarifying that municipal health care insurance plans that are self-insured are subject to the requirements of sec. 1.

Section 4 AS 39.39.090(a) Clarifies that a group health insurance policy covering employees of a participating governmental unit is subject to the requirements of sec. 1.

Section 5 AS 39.30.091 Clarifies that a self-insured group medical plan covering active state employee provided under this section is subject to the requirements of sec. 1.

Section 6 AS 47.07.065 Requires the Department of Health and Social Services to pay for prescription contraceptives intended to last for a 12-month period for subsequent dispensing for eligible recipients of medical assistance, if prescribed to and requested by the recipient, as well as medical services necessary for those products or devices. The Department of Health and Social Services must also provide coverage for over-the-counter emergency contraception that was obtained without a prescription.

Section 7 Uncodified Law Requires the Department of Health to immediately amend and submit for federal approval a state plan for medical assistance coverage consistent with sec. 6 of this Act.

Section 8 Uncodified Law Makes sec. 6 of the Act conditional on the approval required under sec. 7 of the Act.

Section 9 Uncodified Law If, under sec. 8 of this Act, sec. 6 of this Act takes effect, it takes effect on the day after the date the United States Department of Health and Human Services approves the state plan amendment or determines an amendment is not necessary

4:17:47 PM
SENATOR TOBIN acknowledged that concerns raised by the Division of Insurance exist and stated that the committee is open to potential amendments to the legislation. She expressed the

intent to clarify any outstanding issues through these adjustments to ensure SB 27 addresses all concerns effectively.

4:18:26 PM
CHAIR WILSON referenced SB 27, page 2, line 13 [Section 1 (2)(c)], which states, "Except as provided in (d) of this section, a health care insurer may not offset the costs of compliance with (a)...". He asked how SB 27 would ensure that insurers do not pass the costs of compliance onto plan holders.

4:19:10 PM
SENATOR TOBIN deferred the question.

4:19:39 PM
LORI WING-HEIER, Director, Division of Insurance, Department of Commerce, Community & Economic Development, Juneau, Alaska, replied that SB 27 has an indeterminate fiscal note likely for three relatively small changes. She explained that when the state adopted the Affordable Care Act (ACA) essential health benefits benchmark plan it agreed on what would be presented in the individual market. If the state strays outside of the agreement, the Centers for Medicare and Medicaid (CMS) can ask the state to defray the cost. The Division of Insurance suggested changing three provisions in SB 27 that might trigger such an action. Asking an insurer to let go of co-pays is one of the three triggers. Therefore, the division suggests deleting (c) and replacing it with, "except for as provided in (d)", which should alleviate the concern of the co-pays referenced in (c). She said the second concern is use of "over the counter" because the ACA does not ask insurers to pay for over-the-counter drugs on emergency contraceptives. The third possible trigger is on page 2, lines 20 - 29 concerning medical management techniques. The division recommends deleting (e) and replacing it with, "the health care insurer that applies the medical management techniques, such as step therapy or prior authorization must provide for a simple and easy to understand exception."

4:21:26 PM
MS. WING-HEIER expressed hope that these suggestions are not seen as offensive and do not change the bill's intent. She noted that while CMS could fine the state, it is not a certainty. She emphasized that the changes do not significantly alter SB 27's intent and offered to work with the sponsor on further ideas.

4:22:13 PM
CHAIR WILSON announced invited testimony on SB 27.

4:22:31 PM
SENATOR TOBIN acknowledged that she serves on a non-profit board that provides operational support to Kachemak Bay Family Planning and stated her desire to have the conflict of interest on record.

4:22:45 PM
ROBIN HOLMES, Ph.D., representing self, Homer, Alaska, described her work as a family medicine physician and emphasized how SB 27 will improve access to contraceptive methods. She explained that the bill would require insurance to cover a year's supply of birth control at once and allow patients and providers full control over the choice of contraception without arbitrary limits. She noted that barriers to accessing contraception, including insurance denials and restrictions, negatively impact her patients, 30 percent of whom miss doses due to refill issues. She highlighted challenges faced by patients in school, commercial fishing, or college, who struggle to get timely refills, often relying on family members for assistance.

4:25:11 PM
DR. HOLMES discussed the challenges faced by individuals with disabilities, whose insurance plans often deny access to certain contraceptives, forcing them to go through ineffective stepwise methods. She noted that patients working multiple jobs or caring for families also struggle to get prescriptions on time. She emphasized that contraceptive decisions should be private and made between a patient and their healthcare provider, with providers trained to prescribe safely and adjust quantity when necessary. She highlighted the importance of continuous access to birth control, particularly for medical conditions like polycystic ovarian syndrome and endometriosis, where missing doses can lead to serious health impacts. She added that expanding access to a 12-month supply of contraception has proven effective in areas outside of Alaska.

4:27:27 PM
DR. HOLMES stated that the Centers for Disease Control and Prevention (CDC) recognized birth control as one of the top 10 health achievements of the past century, crediting it for contributing to women's societal, educational, and economic gains. She explained that when women have access to a full year of birth control rather than the current one to three-month supply in Alaska, the odds of unintended pregnancy decrease by 30 percent, and abortion rates fall by 46 percent. She emphasized the importance of addressing loopholes in insurance

practices through state laws to reduce income- and geography-based disparities in unintended pregnancy rates and access to medically necessary treatments. She noted that 26 other states, including Washington, DC, have enacted similar policies, and Alaska must recognize the racial disparities in health outcomes, particularly for Alaska Native and American Indian women who face systemic and geographic barriers to accessing reproductive health care, including contraception. Alaska has a 20 percent Native population and should lead the charge in reducing the barriers they face. She concluded by urging support for SB 27 to expand access to contraception, positioning Alaska alongside other states pursuing financially sound solutions.

4:30:14 PM
INGRID JOHNSON, representing self, Anchorage, Alaska, introduced herself as an associate professor at the University of Alaska Anchorage, clarifying that she holds a PhD and is a criminologist, not a medical doctor. She said her research focuses on victimization, particularly intimate partner and sexual violence, and how victims seek help and services. She emphasized her expertise in rural-urban dynamics and her role as the principal investigator for the Alaska Victimization Survey (AVS). She referenced a handout provided, which includes data from the 2020 AVS and other sources, highlighting statistics relevant to her testimony.

4:32:06 PM
MS. JOHNSON discussed the connection between birth control access and intimate partner abuse, noting that requiring regular trips to pharmacies or medical providers disproportionately impacts those in abusive relationships and their risk for homicide victimization. She shared that 48.3 percent of Alaskan women have had controlling partners, which makes it difficult to regularly seek medical care. These controlling behaviors can include monitoring their activities, restricting access to money, and reproductive control, complicating efforts to obtain contraception. She emphasized that this figure is a representative, weighted estimate from a randomized sample of Alaskan women.

4:34:18 PM
MS. JOHNSON noted that almost one in five Alaskan women, or 18.8 percent, have experienced reproductive control in their lifetime, underscoring the importance of easy access to contraceptives to reduce unintended pregnancies. She explained that the Alaska Victimization Survey (AVS) uses two measures for reproductive control: partners attempting to get women pregnant

against their will or trying to prevent them from using birth control, and partners refusing to use a condom when requested. This reproductive control affects one in five women in Alaska, illustrating the significance of this issue.

4:35:00 PM
MS. JOHNSON referred to the third bullet point in her handout, explaining that it is not a generalizable estimate but comes from a large sample of about 13,000 women who participated in the Alaska Victimization Survey (AVS). This sample includes data from the 2010, 2015, and 2020 statewide surveys, along with regional surveys conducted between 2011 and 2015. While not generalizable, it closely represents the population. The data shows that 18 percent of Alaskan women have experienced sexual assault by an intimate partner. She highlighted that separate reports provide generalizable rates of sexual assault for adult Alaskan women. She said one fifth of adult Alaskan women experience sexual assault by an intimate partner and emphasized that this underscores the importance of access to birth control in abusive relationships.

4:36:15 PM
MS. JOHNSON stated that the last bullet point, with two sub-bullet points, comes from non-Alaska Victimization Survey (AVS) data sources, which are cited in her handout. She explained that pregnancy increases the risk of violent victimization for women, especially those in abusive relationships. Qualitative research shows that abusive partners sometimes intentionally try to impregnate their partners to prevent them from leaving. Additionally, extensive research indicates that pregnancy raises a woman's risk of homicide, a critical concern in Alaska, where the rate of women killed by men is nearly double the national average.

4:37:03 PM
SENATOR DUNBAR highlighted how the connection between extended contraceptive coverage and violence prevention is an important point often overlooked when discussing bills like SB 27. He acknowledged that this concept resonates with policymakers familiar with the issue. He noted that her testimony was particularly timely, referencing that many people in the building were wearing purple in recognition of Ashley Johnson-Barr Day, which focuses on violence against children, as well as sexual violence and violence against women. He emphasized that her testimony demonstrated a concrete action that could help address these issues and expressed his gratitude.

4:38:10 PM
CHAIR WILSON opened public testimony on SB 27.

4:38:39 PM
MAUREEN O'HANLON, representing self, Sitka, Alaska, testified in support of SB 27. She said the SB 27 matters to her because her quality of life depends on access to birth control pills. She explained that she has endometriosis, a painful condition with no cure, and that birth control pills help manage its symptoms and progression. She highlighted the inconvenience of only receiving a one- to three-month supply, especially for those in Alaska who work seasonal jobs or live in remote areas. She emphasized that birth control has no overdose risk or street value and urged elected officials to support SB 27 for her health and safety.

4:39:52 PM
OLIVIA LYNN, representing self, Fairbanks, Alaska, testified in support of SB 27. She stated that birth control is essential for her to remain competitive in her job as a single, childless union journeyman electrician. She explained that without it, her work performance would suffer due to endometriosis, but with birth control, she can manage these symptoms every three months and schedule time off without negative consequences. It is not possible to overdose on birth control so there is no street value. She emphasized that all Alaskans deserve the opportunity to be more competitive in their careers and improve their standard of living. Consistent access to birth control is key to ensuring this opportunity for everyone.

4:41:06 PM
NANCY SCHEETZ-FREYMILLER, representing self, Anchorage, Alaska, testified in support of SB 27. She said she is retired but served on the Council of Domestic Violence and Sexual Assault and has been involved with other women's issues for many years. She expressed gratitude to the committee for addressing the topic and supporting women’s full participation in Alaska's economy and society. She acknowledged the challenges of creating equal access for all Alaskans and felt that earlier testimony addressed solutions to the issues raised. She emphasized that, while SB 27 may seem small, it has the potential to make a significant impact on Alaska's future.

4:42:29 PM
At ease

4:42:34 PM

CHAIR WILSON reconvened the meeting.

4:42:58 PM
CHAIR WILSON closed public testimony on SB 27.

4:43:09 PM
SENATOR GIESSEL noted that SB 27 was offered more than a year ago. She expressed appreciation for Senator Tobin's efforts in bringing it forward.

4:43:23 PM
SENATOR TOBIN shared that during her time in the Peace Corps, she had access to 12 months of birth control, though she didn't fully grasp the complications she might face if she had unintentionally become pregnant. When she and her husband decided to have a child, she was grateful to be near a major medical facility, which she credits for her being here today.

4:44:03 PM
CHAIR WILSON held SB 27 in committee.

SB 240-SCHOOL DISTRICT MEDICAL ASSISTANCE

4:44:16 PM
CHAIR WILSON announced the consideration of SENATE BILL NO. 240 "An Act relating to medical assistance coverage for rehabilitative, mandatory, and optional services furnished or paid for by a school district on behalf of certain children."

4:45:17 PM
CHAIR WILSON found there were no questions for the sponsor of SB 240.

4:45:27 PM
CHAIR WILSON solicited a motion.

4:45:29 PM
SENATOR GIESSEL moved to adopt Amendment 1, work order 33-GS2369\A.2, to SB 240:

33-GS2369\A.2
Bergerud
3/4/24

AMENDMENT 1

OFFERED IN THE SENATE BY SENATOR GIESSEL

TO: SB 240

Page 1, line 1, following "**Act**":

Insert "**allowing minors 16 years of age or older to consent to behavioral health and mental health services; authorizing school personnel to recommend a behavioral health or mental health professional to a child 16 years of age or older;**"

Page 1, following line 3:

Insert new bill sections to read:

"*** Section 1.** AS 14.30.171 is amended by adding a new subsection to read:

(c) Notwithstanding (a) of this section, school personnel may recommend a behavioral health professional or mental health professional to a child who is 16 years of age or older. In this subsection,

(1) "behavioral health professional" has the meaning given in AS 14.30.174(b);

(2) "mental health professional" has the meaning given in AS 47.30.915.

*** Sec. 2.** AS 14.30.174(a) is amended to read:

(a) Notwithstanding AS 14.30.171(a)(3) and (5), a behavioral or mental health professional working within a public school system may, in compliance with federal education law or applicable state law,

(1) recommend, but not require, a psychiatric or behavioral health evaluation of a child; [AND]

(2) recommend, but not require, psychiatric, psychological, or behavioral treatment for a child**; and**

(3) obtain informed consent from and provide behavioral or mental health services to a child who is 16 years of age or older.

*** Sec. 3.** AS 25.20.025(a) is amended to read:

(a) Except as prohibited under AS 18.16.010(a)(3),

(1) a minor who is living apart from the minor's parents or legal guardian and who is managing the minor's own financial affairs, regardless of the source or extent of income, may give consent for medical and dental services for the minor;

(2) a minor may give consent for medical and dental services if the parent or legal guardian of the minor cannot be contacted or, if contacted, is unwilling either to grant or **to** withhold consent; however, **if** [WHERE] the parent or legal guardian cannot be contacted or, **when** [IF] contacted, is unwilling either to grant or to withhold consent, the provider of medical or dental services shall counsel the minor keeping in mind not only the valid interests of the minor but also the valid interests of the parent or guardian and the family unit as best the provider presumes them;

(3) a minor who is the parent of a child may give consent to medical and dental services for the minor or the child;

(4) a minor may give consent for diagnosis, prevention**,** or treatment of pregnancy, and for diagnosis and treatment of venereal disease;

(5) **a minor who is 16 years of age or older may give consent to receive outpatient behavioral or mental health services from a behavioral health professional or mental health professional; a behavioral health professional or mental health professional may not prescribe medication to a minor receiving services under this paragraph without the consent of the minor's parent or guardian; during the course of treatment, the behavioral health professional or mental health professional shall contact the minor's parents and offer to provide services to the family, unless there are clear clinical indications that doing so would be harmful to the minor receiving services, in which case the behavioral health provider or mental health provider shall document those concerns in the counseling record; in this paragraph,**

(A) "behavioral health professional" has the meaning given in AS 14.30.174(b);

(B) "mental health professional" has the meaning given in AS 47.30.915 [THE PARENT OR GUARDIAN OF THE MINOR IS RELIEVED OF ALL FINANCIAL OBLIGATION TO THE PROVIDER OF THE SERVICE UNDER THIS SECTION].

*** Sec. 4.** AS 25.20.025 is amended by adding a new subsection to read:

(d) The parent or guardian of a minor is relieved of all financial obligation to the provider of a service under this section."

Page 1, line 4:
Delete "**Section 1**"
Insert "**Sec. 5**"

4:45:33 PM
CHAIR WILSON objected for purposes of discussion.

4:45:36 PM
SENATOR GIESSEL introduced Amendment 1, which would allow minors aged 16 or older to consent to behavioral and mental health services and permit school personnel to recommend these services. She explained that, in her experience as a nurse practitioner in school-based clinics, many students face significant mental health challenges, such as depression, anxiety, and suicidal thoughts, but parental consent often prevents them from accessing help. She shared reasons why parents or guardians do not reply or offer consent for their child to receive care when the child has expressed a desire. She stressed the importance of increasing access to care for these students by lowering the age of consent to 16 and noted that 33 states have already implemented similar policies.

4:48:41 PM
SENATOR GIESSEL cited widespread agreement from multiple organizations she has spoken with over the past two years. She referenced reports from the U.S. Surgeon General and the Alaska Department of Health, highlighting the prevalence of adverse childhood experiences (ACEs) such as parental divorce and financial hardship, which are common among Alaska's youth. She shared personal stories from her work, where students face significant challenges at home and are often left in charge of siblings, leading to anxiety and depression. She argued that lowering the age of consent to 16 for behavioral health services would allow earlier intervention. While 33 states have lowered the age of consent to 16, three have lowered the age to 12. She also clarified that while Section 3 allows minors to access therapy, it restricts the prescription of medication without parental consent and encourages family involvement in the treatment process.
4:54:07 PM

SENATOR GIESSEL said commonly, it is family issues that cause the behavioral health issues that young people experience. Therefore, family therapy is critical to treating a young person. Services are offered to the family unless there are clear clinical indications that doing so would be harmful to the minor receiving services, in which case the behavioral health provider or mental health provider shall document the concerns. She offered Amendment 1 to increase access to care for young people, particularly through school sites, which are well-suited for reaching students. She said schools are safe spaces for many kids and ideal locations for accessing behavioral health services.

4:55:39 PM
CHAIR WILSON asked who is responsible for paying service and assessment costs.

4:55:53 PM
SENATOR GIESSEL replied that Section 4 of Amendment 1 states that the parent or guardian of a minor is relieved of all financial obligations to the provider of services. She noted that many young people she sees have private insurance, but the majority are Medicaid beneficiaries, and Medicaid would be billed for the services.

4:56:26 PM
CHAIR WILSON asked whether insurance companies would be relieved of financial obligations or if only state Medicaid would be responsible for paying medical providers.

4:56:40 PM
SENATOR GIESSEL replied that it would depend on the type of insurance the young person has, but Amendment 1 allows them to consent to services.

4:56:50 PM
CHAIR WILSON noted that a similar amendment had already been addressed in HB 40 [HB 60], which is currently in Senate Rules. He acknowledged that SB 240 does a good job of providing educational services and increasing school-based services but expressed concerns about parental consent. He pointed out that in cases where clear clinical indicators suggest a child's parent should not be notified, there are usually deeper issues that care takers and mandated reporters would address with the proper authorities. He shared his concern that SB 240 may linger in Rules, like HB 40 [HB 60]. He wondered if the department held

a position on the matter and suggested moving forward with a vote.

4:58:00 PM
SENATOR DUNBAR opined that the amendment seems different from the one offered last year, noting that it appears to include compromise language addressing concerns from the original version. He asked if this observation was correct.

4:58:26 PM
SENATOR GIESSEL said it was correct that this amendment is not the same as the previous, broader amendment. She explained that Amendment 1 is limited to behavioral and mental health services, defines the age, and specifically outlines who the healthcare providers are.

4:58:51 PM
SENATOR DUNBAR expressed support for Amendment 1, acknowledging the chair's concerns about SB 240 potentially being held in Rules. He stated his belief that if SB 240 were held in rules Amendment 1 would not be the reason. He emphasized that SB 240 should still have strong support with the amendment and looked forward to voting for the overall bill on the floor.

4:59:24 PM
SENATOR KAUFMAN said supporting information included a table showing the ages of students in other states. He asked whether there was anecdotal or aggregate data on how other states managed financial responsibility when a minor incurred an obligation that might be borne by the parent or another entity.

4:59:53 PM
SENATOR GIESSEL replied she did not have that information.

5:00:05 PM
SENATOR TOBIN stated her support, noting a 14 percent increase in houseless and homeless youth over the past year. She emphasized that educators often identify issues with young people but may sometimes suspend or give negative recommendations when wraparound services are needed instead. She said family support services are crucial and that the amendment addresses the core issues faced by many young people. She concluded that Amendment 1 would give educators the opportunity to recommend behavioral and mental health support to students who need interventions but are unaware of available resources.

5:01:03 PM

CHAIR WILSON asked whether the department had a position on Amendment 1.

5:01:13 PM
LEAH VAN KIRK, Healthcare Policy Advisor, Department of Health, Juneau, Alaska, stated the department is still evaluating Amendment 1 and has not taken a position.

5:01:24 PM
CHAIR WILSON asked whether the amendment would have a fiscal note attached. He referred to the statement regarding children on Medicaid, noting that they make up approximately half of the population of children under 18 in the state. He mentioned that the state is responsible for paying for these services unless parental involvement leads to the use of private insurance. He inquired if there were associated costs with this responsibility.

5:01:56 PM
MS. VAN KIRK replied that the department would need to evaluate the information more closely before responding to the committee.

5:02:06 PM
CHAIR WILSON expressed concern about the financial strain placed on local behavioral health care providers who operate on thin margins and may not continue offering free assessments for children due to costs. He acknowledged the possibility of charities covering the costs but remained uncertain. His concern stems from the underlying aspect of SB 240, which reminded him of another bill that was held in Rules for a year. He said that despite his concern he was willing to vote on SB 240.

5:02:43 PM
SENATOR GIESSEL stated that the avoided cost should be considered more than the immediate cost. She emphasized the importance of avoiding costs related to suicide, drug addiction in emerging adults, and incarceration.

5:03:09 PM
CHAIR WILSON found the objection was maintained and asked for a roll call vote.

A roll call vote was taken. Senators Giessel, Dunbar, and Tobin voted in favor of Amendment 1 (A.2) and Senators Kaufman, and Wilson voted against it. The vote was 3:2.

5:03:30 PM

CHAIR WILSON announced that Amendment 1 (A.2) was adopted on a vote of 3 yeas and 2 nays.

5:03:33 PM
CHAIR WILSON asked if the department had any closing comments.

5:03:38 PM
MS. VAN KIRK thanked the committee for considering SB 240.

CHAIR WILSON asked if there was a date the department would have a completed analysis on SB 240, as amended.

MS. VAN KIRK stated the department would follow up with a date.

5:04:01 PM
CHAIR WILSON held SB 240, as amended, in committee.

5:04:12 PM
There being no further business to come before the committee, Chair Wilson adjourned the Senate Health and Social Services Standing Committee meeting at 5:04 p.m.