

ALASKA STATE LEGISLATURE
SENATE LABOR AND COMMERCE STANDING COMMITTEE

February 28, 2024

1:34 p.m.

MEMBERS PRESENT

Senator Jesse Bjorkman, Chair
Senator Click Bishop, Vice Chair
Senator Elvi Gray-Jackson
Senator Kelly Merrick
Senator Forrest Dunbar

MEMBERS ABSENT

All members present

OTHER LEGISLATORS PRESENT

Representative Justin Ruffridge
Senator Löki Tobin

COMMITTEE CALENDAR

SPONSOR SUBSTITUTE FOR SENATE BILL NO. 121

"An Act relating to the Board of Pharmacy; relating to insurance; relating to pharmacies; relating to pharmacists; relating to pharmacy benefits managers; relating to patient choice of pharmacy; and providing for an effective date."

- HEARD & HELD

SENATE BILL NO. 115

"An Act relating to physician assistants; relating to physicians; and relating to health care insurance policies."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: SB 121

SHORT TITLE: PHARMACIES/PHARMACISTS/BENEFITS MANAGERS

SPONSOR(S): SENATOR(S) GIESSEL BY REQUEST

03/31/23	(S)	READ THE FIRST TIME - REFERRALS
03/31/23	(S)	L&C, FIN

02/08/24 (S) SPONSOR SUBSTITUTE INTRODUCED-REFERRALS
02/08/24 (S) L&C, FIN
02/28/24 (S) L&C AT 1:30 PM BELTZ 105 (TSBldg)

BILL: SB 115

SHORT TITLE: PHYSICIAN ASSISTANT SCOPE OF PRACTICE

SPONSOR(s): SENATOR(s) TOBIN BY REQUEST

03/27/23 (S) READ THE FIRST TIME - REFERRALS
03/27/23 (S) HSS, L&C
01/23/24 (S) HSS AT 3:30 PM BUTROVICH 205
01/23/24 (S) Heard & Held
01/23/24 (S) MINUTE(HSS)
02/06/24 (S) HSS AT 3:30 PM BUTROVICH 205
02/06/24 (S) Heard & Held
02/06/24 (S) MINUTE(HSS)
02/15/24 (S) HSS AT 3:30 PM BUTROVICH 205
02/15/24 (S) Moved CSSB 115(HSS) Out of Committee
02/15/24 (S) MINUTE(HSS)
02/19/24 (S) HSS RPT CS 3DP 2AM SAME TITLE
02/19/24 (S) DP: WILSON, KAUFMAN, DUNBAR
02/19/24 (S) AM: TOBIN, GIESSEL
02/28/24 (S) L&C AT 1:30 PM BELTZ 105 (TSBldg)

WITNESS REGISTER

SENATOR CATHY GIESSEL, District E
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Sponsor of SB 121.

BRANDY SEIGNEMARTIN, Executive Director
Alaska Pharmacy Association
Anchorage, Alaska

POSITION STATEMENT: Testified by invitation on SB 121.

PALMER WETZELL III, Deputy Director
Chief Andrew Isaac Health Center
Fairbanks, Alaska

POSITION STATEMENT: Testified by invitation on SB 121.

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

POSITION STATEMENT: Answered questions on SB 121.

ASHLEY SCHABER, Chair
Alaska Board of Pharmacy
Anchorage, Alaska

POSITION STATEMENT: Testified by invitation SB 121.

BARRY CHRISTENSEN, Pharmacist
Island Pharmacy
Ketchikan, Alaska

POSITION STATEMENT: Testified by invitation on SB 121.

DIRK WHITE, Owner
White's Pharmacy
Sitka, Alaska

POSITION STATEMENT: Testified by invitation on SB 121.

PATRICK SHIER, Alaska Membership Representative
Pacific Health Coalition
Wasilla, Alaska

POSITION STATEMENT: Testified in opposition to SB 121.

BRENDA SNYDER, Lead Director
State Government Affairs
CVS Health

Seattle Washington

POSITION STATEMENT: Testified in opposition to SB 121.

TONIA NEAL, Senior Director
Pharmaceutic Case Management Association
Shelton, Washington

POSITION STATEMENT: Testified in opposition to SB 121.

DESIREE MOLINA, representing self
Palmer, Alaska

POSITION STATEMENT: Testified in support of SB 121.

HARRY ROGERS, representing self
Petersburg, Alaska

POSITION STATEMENT: Testified in support of SB 121.

DELILAH BERNALDO, representing self
Petersburg, Alaska

POSITION STATEMENT: Testified in support of SB 121.

CATHERINE KOWALSKI, representing self
Petersburg, Alaska

POSITION STATEMENT: Testified in support of SB 121.

GREG LOUDON Consultant
Employee Benefits
Parker, Smith and Feek Insurance
Anchorage, Alaska

POSITION STATEMENT: Testified in opposition to SB 121.

MARY STOLL, Legal Counsel
Pacific Health Coalition
Seattle, Washington

POSITION STATEMENT: Testified in opposition to SB 121.

LUCY LAUBE, Manager
State Government Relations
National Psoriasis Foundation
Portland, Oregon

POSITION STATEMENT: Testified in support of SB 121.

THOMAS WADSWORTH, representing self
Anchorage, Alaska

POSITION STATEMENT: Testified in support of SB 121.

KAREN MILLER, Director
Denali Pharmacy
Fairbanks Memorial Hospital
Fairbanks, Alaska

POSITION STATEMENT: Testified in support of SB 121.

GARY STRANNIGAN, Vice President
Congressional and Legislative Affairs
Premera Blue Cross Blue Shield of Alaska
Seattle, Washington

POSITION STATEMENT: Testified in opposition to SB 121.

SENATOR LÖKI TOBIN, District I
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Sponsor of SB 115 by request.

MACKENZIE POPE, Staff
Senator Löki Tobin
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Provided the sectional analysis for SB 115.

JENNIFER FAYETTE, Co-Chair
Legislative Committee
Alaska Academy of Physician Assistants

Anchorage, Alaska

POSITION STATEMENT: Testified by invitation on SB 115.

CHRISTI FROILAND, representing self

Anchorage, Alaska

POSITION STATEMENT: Testified by invitation on SB 115.

WENDY SMITH, representing self

Juneau, Alaska

POSITION STATEMENT: Testified in support of SB 115.

MEGHAN HALL, representing self

Anchorage, Alaska

POSITION STATEMENT: Testified in support of SB 115.

ACTION NARRATIVE

[1:34:05 PM](#)

CHAIR JESSE BJORKMAN called the Senate Labor and Commerce Standing Committee meeting to order at 1:34 p.m. Present at the call to order were Senators Gray-Jackson, Merrick, Dunbar, Bishop, and Chair Bjorkman.

SSSB 121-PHARMACIES/PHARMACISTS/BENEFITS MANAGERS

[1:35:05 PM](#)

CHAIR BJORKMAN announced the consideration of SPONSOR SUBSTITUTE FOR SENATE BILL NO. 121, "An Act relating to the Board of Pharmacy; relating to insurance; relating to pharmacies; relating to pharmacists; relating to pharmacy benefits managers; relating to patient choice of pharmacy; and providing for an effective date."

[1:35:22 PM](#)

SENATOR CATHY GIESSEL, District E, Alaska State Legislature, Juneau, Alaska, sponsor of SB 121. She stated that this legislation addresses a very complex subject and highlighted the secretive - yet dangerous - nature of the work done by Pharmacy Benefit Managers (PBM). PBMs are employed by pharmaceutical drug chains. She said that PBMs significantly affect the cost of prescription medications - and these effects are not transparent. She stated that she has been working with various agencies to put forth the best legislation possible. She explained that the Department of Law became involved when they unsuccessfully attempted to access details of "secret" contracts between the PBMs and the State of Alaska. There is a companion

bill. She commented that former Senator Egan worked on similar legislation many years ago.

[1:38:11 PM](#)

SENATOR GIESSEL said that in 2018, she worked with former Representative Guttenberg to pass the first pharmaceutical transparency legislation; this removed a gag rule that had prevented pharmacists from sharing information about lower cost alternatives to prescribed medications. She explained that the intention of SB 121 is transparency in pricing and freedom of choice for patients. She said that the largest three PBMs take in more than \$300 billion per year. She added that this money comes from customer pockets - and from the State of Alaska. She noted that Congress is attempting to address this as are many individual states. She drew attention to a bibliography in members' packets that provides additional information.

[1:41:00 PM](#)

CHAIR BJORKMAN announced Representative Ruffridge joined the meeting at 1:35 p.m.

[1:41:24 PM](#)

BRANDY SEIGNEMARTIN, Executive Director Alaska Pharmacy Association, Anchorage, Alaska, testified by invitation on SB 121. She said that she is a pharmacist and teaches with the UAA Doctor of Pharmacy ~~program~~. She said that the current system has allowed a few PBMs to monopolize the marketplace and drive local brick and mortar pharmacies out of business. She then gave a presentation titled: SB 121: Transparency in Prescription Pricing & Patient Freedom of Pharmacy Choice. She moved to slide 2 and discussed the role of Pharmacy Benefit Managers (PBM):

[Original punctuation provided.]

What is a Pharmacy Benefit Manager (PBM)?

- Third party companies that act as intermediaries between insurance companies, drug manufacturers, pharmacies, & patients
- Originally created to help insurers control drug spend, but have become perversely incentivized to increase drug spend

- **Why are they incentivized to increase drug spend?**
 - Create and manage formularies
 - Negotiate rebates
 - Process claims

- Manage pharmacy networks
- Operate mail-order and "specialty" pharmacies

MS. SEIGNEMARTIN said that PBMs only exist in the United States and suggested that this is one reason pharmaceuticals are more expensive in this country. She stated that PBMs take advantage of rebate systems, increasing the cost of brand name pharmaceuticals as they negotiate rebates. She acknowledged that many employers depend on the rebates to offset their costs and pointed out that rebates are not addressed in SB 121. She stated that PBMs also operate their own low-cost mail-order pharmacies and they demand and/or coerce Alaskan patients to use these pharmacies.

[1:44:10 PM](#)

MS. SEIGNEMARTIN read from a letter from the National Association of Attorneys General:

[Original punctuation provided.]

RE: Support for Reforming Pharmacy Benefit Managers

Dear Speaker Johnson, Majority Leader Schumer,
Minority Leader Jeffries, Minority Leader McConnell,

In recent years, our offices and other offices of state attorneys general have worked to hold Pharmacy Benefit Managers (PBMs) accountable.

The PBMs' original purpose was to protect and negotiate on behalf of employers and consumers after pharmaceutical manufacturers were criticized for overpricing medications. Unfortunately, in recent years, the PBMs have only made the pharmaceutical market more opaque and have been a cause of rising drug prices.

A small number of PBMs hold significant market power and are reaping abundant profits at the expense of the patients, employers, and government payors the PBMs are supposed to help. Pharmaceutical buyers and sellers have little choice but to employ PBMs, allowing them to extract both monopoly profits from individuals and monopsony profits from the market. Moreover, PBMs often dictate reimbursement rates and rules to independent pharmacies, making it difficult for many to survive.

Our offices and other state attorneys general are very concerned about actions taken by PBMs that have unduly raised drug prices for consumers, and we are engaging on the issue on a number of fronts, including investigation, litigation, and advocating for legislative and policy reforms.

Further, state legislatures have taken action to regulate PBMs with new and amended state laws that are often more stringent than federal law. For example, in 2018 and 2019, respectively, Ohio and Arkansas passed legislation prohibiting spread pricing, in which a PBM charges payors such as Medicare more than they pay the pharmacies supplying the medication, keeping the difference for the PBM. The U.S. House of Representatives also passed legislation barring spread pricing for Medicaid just this month, but it is still awaiting a vote in the Senate.

While state law can provide the basis for oversight of and lawsuits against PBMs, States often face arguments by PBMs that federal jurisdiction and preemption limit states' authority to regulate PBMs. For instance, in response to early State efforts to regulate PBM pricing, a PBM trade association launched a barrage of litigation across the country arguing such regulations were preempted by the Employee Retirement Income Security Act of 1974 and those efforts largely succeeded until, years later, the Supreme Court unanimously rejected that argument in *Rutledge v. PCMA*, 592 U.S. 80 (2020). And now, PBMs routinely try to evade state law and obstruct state regulatory efforts by refusing to disclose data to state regulators as well as their own clients (i.e., health plans operated by employers and the government).

Thus, the FTC and Congress must act to ensure fulsome regulation of PBMs nationwide. Such legislation should reform PBM practices to curtail their ability to unreasonably raise the price of drugs and to require greater transparency. Such transparency should, among other things, require PBMs to produce pricing data to health plans and federal and state regulators in a standardized format. This will enable health plans to negotiate better deals with PBMs and will allow regulators to better hold PBMs accountable.

Proposed legislation to combat high healthcare costs is before Congress and deserves debate and inclusion in much needed reforms. The DRUG Act (S1542/HR6283), Protecting Patients Against PBM Abuses Act (HR2880) and The Lower Costs, More Transparency Act (HR5378), which is in the Senate following recent House passage, are three such bills; and we believe several of the proposals they convey would be an important step toward reforming this industry. With stronger federal law, state and federal regulators can work together to better meet their shared responsibility to hold PBMs accountable and improve the country's health care system overall.

[1:45:35 PM](#)

MS. SEIGNEMARTIN moved to slide 3 and discussed how PBMs impact healthcare costs:

[Original punctuation provided.]

How PBMs Impact Healthcare Costs

- **How do they increase drug costs?**
 - **Rebates and fees** demanded of manufacturers for formulary placement - responsible for 42% of every dollar spent on brand medicines in the commercial market
 - **Incentivize spend on higher-cost drugs** in order to maximize profit margin
 - **Reimburse self-owned pharmacies at higher rates** than other pharmacies
 - **Invented the fallacy of "specialty" pharmacy** as a guise to increase spend on higher-profit margin prescriptions that they steer to their owned pharmacies
 - **Spread pricing** - charging the plans more for a claim than they reimburse the pharmacies

MS. SEIGNEMARTIN said that the three big PBMs control the flow of commerce and data in the prescription marketplace. She shared a story of her experience working as a pharmacist and being required to offer a higher cost medication to a patient when a cheaper option was available.

[1:47:40 PM](#)

MS. SEIGNEMARTIN stated that PBM audits do not include the action of the PBM side of the claim. She gave an example of "spread pricing."

[1:49:54 PM](#)

SENATOR BISHOP asked if spread pricing is real.

MS. SEIGNEMARTIN replied yes. She added that there are many reports detailing the scale and scope of this issue and offered two examples, one in Ohio and one in Utah. She commented that Alaska may not be able to access the full data to determine how much this is occurring in the state, as this is often kept as proprietary data.

SENATOR BISHOP said that as a union member this is alarming.

MS. SEIGNEMARTIN agreed and stated that many pharmacies have closed and/or have business disrupted as a result of these practices.

[1:52:31 PM](#)

MS. SEIGNEMARTIN moved to slide 4:

[Original punctuation provided.]

PBMs are Harming Alaskans

- Pharmacies across Alaska are closing - crumbling public health infrastructure due to deceptive practices by Pharmacy Benefit Managers
- 25 percent of independent pharmacies have closed since 2018, even more chain and independent pharmacies limited staffing and hours. Tribal health systems feel the impact on overall care.
- **Recently closed or closing soon:** Ron's Apothecary (Juneau), Foodland Drug (Juneau), Medical Center Pharmacy (Fairbanks), Infusion pharmacies x2 (Anchorage), Geneva Woods (Anchorage and Wasilla)
- **Limited services:** Walgreens (rolling closures at various locations), Fred Meyer break with Express Scripts, Most have limited hours / staffing in some form
- **At risk of limited services or closing this year:** Tribal health organizations, 35 percent of surviving independent and chain pharmacies

MS. SEIGNEMARTIN noted that chain pharmacies support SB 121. She emphasized that this is a broken reimbursement model and that PBMs monopoly power must be broken.

[1:54:20 PM](#)

SENATOR DUNBAR questioned where the monopoly power comes from. He expressed his understanding that it does not come from access to the drugs but from reimbursements.

MS. SEIGNEMARTIN replied yes and advanced to slide 5 to show how the monopoly power works. She stated that PBMs have not been regulated before now. They are considered third-party administrators and are therefore not beholden to any rules and regulations (at the state or federal level) that insurance plans are. As a result, they have profited greatly from the system they have created. Referring to the slide, she explained the role of vertical integration and noted that the stars on the slide indicate fortune 500 companies and their placement.

[1:56:07 PM](#)

MS. SEIGNEMARTIN moved to slide 13, showing how three large PBMs monopolize 79 percent of the marketplace. This includes CVS (33 percent), Express Scripts (24 percent) and OptumRx (22 percent). She asserted that, as a result of this power imbalance, pharmacies have zero negotiating power. She pointed out that there are very few state laws governing the contracts and added that more laws would put guardrails around the system and allow more fair trade to occur. She said that if pharmacists go against the PBM contracts, the contracts can be pulled. These "big three" PBMs are under investigation by Congress and the Federal Trade Commission (FTC). According to the FTC, PBM are stonewalling requests for information.

[1:57:24 PM](#)

SENATOR DUNBAR asked what "pull the contract" means. He asked for clarification that the contract is between the pharmacy and the insurance company.

MS. SEIGNEMARTIN returned to slide 5 and explained that the contract is between the pharmacy and the PBMs. She reiterated that the direct contracting is vastly unregulated and expressed concern that SB 121 would not go into effect until 2025-2026, allowing time for many more pharmacies to go out of business. She then scrolled through headlines of Alaska news that show the limiting of medications and pharmacy closures. She returned to slide 5 and explained that the companies shown are PBMs and companies abusing the system. She surmised that any testimony

against SB 121 would be directly from PBMs or from companies concerned (as a result of bullying from PBMs) that this would increase costs. She emphasized that this is not the case. She noted that other states have passed similar legislation and have not seen an increase in costs.

[1:59:42 PM](#)

MS. SEIGNEMARTIN returned to slide 13 and discussed the vertical integration and stonewalling that is occurring. She emphasized that this is indicative of a pattern of questionable actions and stonewalling by PBMs.

[2:00:20 PM](#)

SENATOR GRAY-JACKSON commented that this is alarming and asked if PBMs make more money through mail order versus when prescriptions are filled at local pharmacies.

MS. SEIGNEMARTIN replied that patients are steered to PBM mail order partners and in doing so the PBMs increase their profit.

[2:01:30 PM](#)

MS. SEIGNEMARTIN moved to slide 14 and discussed spread pricing:

[Original punctuation provided.]

Spread Pricing

- Harms Alaskan employers, patients, and pharmacies!
- Alaska Employer Example
- Alaska Care
- In other states, investigations have found that PBMs were overcharging their plans by millions of dollars
 - o \$223.7 million in Ohio in one year
 - o Utah uncovered \$8 per prescription average spread

MS. SEIGNEMARTIN stated that spread pricing is rampant and ubiquitous. She declared that this practice must cease immediately. She noted that Congress is slowly working toward change but insisted that the state Legislature must take immediate action. She then shared an example of a pharmacy where spread pricing was discovered related to an employee's prescription. When they began to investigate, the pharmacist was told to cease and desist their investigation and sharing of proprietary information, or they would have all contracts

pulled. She emphasized that this hurts Alaskans. She also shared examples from the state of Ohio.

[2:04:18 PM](#)

SENATOR BISHOP asked if the PBMs in Ohio made changes once this was discovered.

MS. SEIGNEMARTIN replied that Ohio has taken extensive legislative action to change PBMs behavior.

[2:04:46 PM](#)

CHAIR BJORKMAN announced Senator Tobin joined the meeting.

MS. SEIGNEMARTIN moved to slide 15:

[Original punctuation provided.]

Anti-competitive, unfair trade practices

- Monopolistic practices lead to artificially inflated drug costs because PBMs control the flow of pharmacy commerce, reap the benefits by driving business to themselves
- Anti-competitive practices to discourage or squash competition:
 - Make ludicrous requirements and fees for pharmacies wanting to dispense "specialty" drugs to edge out competition
 - Contractually disallow local pharmacies from mailing prescriptions
- As PBMs grow in power and continue to have lack of oversight, they are crushing Alaska pharmacies with non-negotiable contracts and forcing them out of business
- Reports show that PBMs reimburse their affiliated pharmacies at much higher rates than local pharmacies

MS. SEIGNEMARTIN pointed out that pharmacists hold advanced degrees and have a depth of knowledge of all medications. She asserted that the reason PBMs have additional requirements for "specialty" medications is solely based on financial gain.

[2:07:05 PM](#)

MS. SEIGNEMARTIN advanced to slide 16, which showed a graph titled, "Brand Name Margin Over Acquisition Cost by Pharmacy Grouping in Top 6 MCOs, 2018-2019 (Excl. 340B)" and explained

that PBM-owned pharmacies show a much higher rate of reimbursement (~\$79-\$206) over the acquisition cost of the drug when compared to smaller pharmacies (~\$1-\$4). She asserted that this is wrong.

[2:08:25 PM](#)

MS. SEIGNEMARTIN moved to slide 17:

[Original punctuation provided.]

Patient Steering

PBMs steer patients to their own high-cost, low quality mail-order pharmacies

- Causes delays in patient care, poor outcomes, increased healthcare costs

Patients deserve the right to choose where they get their medications!

MS. SEIGNEMARTIN stated that steering patients to PBM-owned mail-order pharmacies causes many problems. She explained that often, patients show up in a panic because their medication did not arrive, or it froze in transit and is no longer useable. This causes delayed and fractured care, which leads to poor prognosis and poor patient outcomes, including hospitalization. With respect to clinician-administered drugs - a.k.a. "white-bagging" and "brown bagging" - she stated that the practice of mandatory patient steering creates a system that circumvents the federal Drug Supply Chain Security Act (DSCSA). This act ensures the safe and proper chain of custody for drug products. She explained that clinician-administered drugs are often used in situations such as chemotherapy for cancer treatment. She pointed out that chemotherapy medications need to be dosed and administered within a short time (often a single day) after the patient's lab work was done. She asserted that it is not possible for medications to arrive to Alaska from Florida within this timeframe. When the medication does not arrive in time, doctors must find a work-around. She reiterated that this often results in poor patient outcomes and increases the risk of medication errors. She emphasized that this is a dangerous situation.

[2:11:19 PM](#)

SENATOR BISHOP asked who is liable in these situations.

[2:11:25 PM](#)

MS. SEIGNEMARTIN replied that this is a great question. She explained that many healthcare systems in Alaska have disallowed the practice of white bagging and brown bagging, because the clinician is liable. She said that if the medication is sent to the mail room at the hospital or if it is brought by an individual - rather than being handled properly at the pharmacy - the pharmacist is responsible for ensuring that the patient is safe through this process. She stated that this puts a great deal of liability on the healthcare systems and pointed out that this is one reason why the Alaska Hospital and Healthcare Association (AHHA) is in support of SB 121.

[2:12:15 PM](#)

MS. SEIGNEMARTIN moved to slide 18 and discussed Tribal Health impacts:

[Original punctuation provided.]

Tribal Health Patient & Pharmacy Impacts

- Patients are often unable to fill prescriptions at Tribal Health Organization (THO) pharmacies
- THO pharmacies forced to either send prescriptions out to PBM-owned mail order pharmacies or "eat" 100% of the cost of what should be a covered prescription
- This is not only an issue for the private sector - THOs ability to provide care is impacted as well

MS. SEIGEMARTIN reiterated that PBMs are not beholden to insurance laws and explained how this impacts Tribal healthcare Organizations (THO). She stated that PBMs ignore the congressionally mandated payments required by the Indian Healthcare Improvement Act (IHICIA). She explained that IHICIA requires that if insurance covers a service in other locations, it must also cover the treatment at THOs. However, PBMs are able to control the flow of commerce away from THO pharmacies, which impacts patient care.

[2:13:19 PM](#)

MS. SEIGNEMARTIN moved to slide 19:

[Original punctuation provided.]

To whom are PBMs responsible?

- Currently, the big PBMs are only beholden to their shareholders
- Should PBMs have a responsibility to the health of Alaskans?

MS. SEIGNEMARTIN stated that SB 121 would extend this fiduciary responsibility to plan sponsors and to the state of Alaska, ensuring that patients and employers pay the lowest possible price. She opined that this is appropriate.

[2:13:51 PM](#)

At ease

[2:14:18 PM](#)

CHAIR BJORKMAN reconvened the meeting.

[2:14:34 PM](#)

MS. SEIGNEMARTIN moved to slide 20:

[Original punctuation provided.]

Impacts of PBM Practices on Alaskans

- Crumbling public health infrastructure
- Pharmacy closures and reduction in hours, staffing
- Increased healthcare costs for employers and patients
- Poor health outcomes
- Shipping delays, breaks in therapy, fractured care, lack of care coordination
- Disease progression and poor prognosis

MS. SEIGNEMARTIN stated that these negative impacts are heightened in patients with low health literacy and those who experience social determinants of health that make navigating the healthcare system difficult. She shared a story of a chemotherapy patient who was required to utilize a PBM mail-order pharmacy for medication - which resulted in a delay in treatment.

[2:16:04 PM](#)

MS. SEIGNEMARTIN moved to slide 21:

[Original punctuation provided.]

SB 121 / HB 226 Provisions

- Gives patients right to access medication at pharmacy of their choice
 - Bans patient steering to PBM-owned or affiliated pharmacies
- Ensures safe access to physician-administered medications
 - Bans PBM-required white bagging and brown bagging
- Requires a transparent reimbursement model
 - Saves money for patients and plan sponsors on prescription drug spend
 - Gets rid of complicated and opaque reimbursement methodologies
- How?
 - Bans spread pricing
 - Requires reimbursement floor of NADAC + dispensing fee
 - Requires payment parity between PBM-owned pharmacies and local pharmacies
 - Fiduciary responsibility from PBMs to plan sponsors

[2:18:49 PM](#)

SENATOR DUNBAR asked how the NADAC price is determined.

MS. SEIGNEMARTIN replied that the Centers for Medicare and Medicaid Services (CMS) sends out a weekly survey. The survey gathers information for various National Drug Codes (NDC) based on invoice prices.

[2:20:35 PM](#)

SENATOR DUNBAR commented that Alaska is a small state without much impact on the national price average. He asked if there is a regulatory agency that would limit the price increase if more states were to adopt similar legislation.

MS. SEIGNEMARTIN replied that the NADAC is based on the purchase price from wholesaler rather than on the reimbursement amount; therefore, it would not be affected.

[2:21:25 PM](#)

SENATOR DUNBAR asked if there are enough competitive prices amongst wholesalers to prevent the NADAC price from ratcheting up.

MS. SEIGNEMARTIN replied yes.

[2:22:03 PM](#)

MS. SEIGNEMARTIN NADAC continued her discussion of slide 21. She reiterated that the actual cost of drugs is not known, and NADAC is the only transparent pricing available. She said that overpayment to PBM-owned mail-order pharmacies needs to be disincentivized. This would be done by requiring payment parity between PBM pharmacies and local pharmacies. She said that the fiduciary responsibility between PMB and plan sponsors is necessary to ensure that the state health plan, plan beneficiaries, and other employers and employees in the state are at the heart of the contract.

MS. SEIGNEMARTIN clarified that SB 121 does not limit the sight of care for clinician administered drugs. She said that SB 121 only applies to where the drug is dispensed - PBMs would no longer be able to specify what pharmacy can be used. Additionally, SB 121 requires that a pharmacy become a network pharmacy and agree to network terms in order to participate in the network prior to serving patients. This includes price guarantees and ensures that pharmacies cannot demand higher payment for services than the network contract allows.

[2:24:14 PM](#)

MS. SEIGNEMARTIN moved to slide 22:

[Original punctuation provided.]

Supporters of SB 121

- Alaska Native Health Board & All Tribal Health Organizations
- Alaska Hospital and Healthcare Association
- Alaska Primary Care Association
- Alaska Medical Board
- Alaska Board of Pharmacy
- Alaskan Chain Drug Stores - National Association of Chain Drug Stores - Fred Meyer, Carr's/Albertsons, Walgreens, Costco
- Alaska Independent Pharmacies
- Patient Protection Groups

MS. SEIGNEMARTIN commented the, in effect, the entire Alaska health care system is in support of SB 121

[2:25:22 PM](#)

PALMER WETZELL III, Deputy Director, Chief Andrew Isaac Health Center, Fairbanks, Alaska, testified by invitation on SB 121. He continued the presentation. He moved to slide 23, titled "Alaska DRB 2022 Overall Rx Spend vs. SB121 Pricing (utilizing NADAC + \$13.36*)" and explained the potential fiscal impact of SB 121. He noted that if the formula included in SB 121 would have been in place in 2022, the state would have saved approximately \$4.3 million.

[2:26:20 PM](#)

MR. WETZEL moved to slide 24 and explained that the Division of Retirement and Benefits (DRB) could potentially save up to \$7.9 million.

MR. WETZEL moved to slide 25, and said it is based on 2019 Kaiser Family Foundation (KFF) prescription data utilized for data analysis for SB 121. He explained that, if claim numbers remain consistent and with a dispensing fee of \$13.36 for each claim, SB 121 would add close to \$50 million to the local economy with dispensing fees alone. He added that Alaskan employers would save money.

[2:27:22 PM](#)

MR. WETZEL moved to slide 26 and stated that Alaska employers overall cost savings potential is \$43.8 million.

MR. WETZEL moved to slide 27 and discussed an example of spread resulting from under-reimbursement. He explained the following data and stated that it is evidence of the urgent need for transparency:

Acquisition Cost: \$366,342.84

Reimbursed: \$16,207.98

Fair Reimbursement: \$832,980.20

[2:29:11 PM](#)

MR. WETZEL moved to slide 28 titled, "SB121/HB226 is Pro-Alaska economy by preventing forced mail order and patient steering/coercion." He explained how SB 121 would benefit patients by allowing them to fill prescriptions locally if they choose. Currently, pharmacies can only fill for 30 days and amounts over 30 days must be done by mail order. He said that this would potentially infuse \$34 million to \$36 million

annually into Alaska's local economy while saving employers money.

[2:31:31 PM](#)

SENATOR BJORKMAN referred to slide 23 commented that the cost savings to DRB would be about \$4.3 million and asked how much DRB would receive of the \$49.4 million on slide 25.

MR. WETZEL answered that this number is an extrapolation of the roughly 3.7 million claims for commercial Medicare. He explained that this number would be divided by the 668 thousand claims to reach this number, which he estimated to be around \$5.53 [million]. He surmised that the number of claims has likely increased since 2019 and therefore the total would be much more.

[2:32:58 PM](#)

SENATOR BISHOP asked if SB 121 would increase the time to 90 days in Anaktuvuk Pass.

MS. SEIGNEMARTIN replied yes and clarified that there would be no limitations.

SENATOR BISHOP commented that the recent cold spell in Fairbanks grounded flights for up to a week or more. He said that 30 days would be on the edge, while 90 days would provide extra padding.

[2:33:39 PM](#)

SENATOR DUNBAR referred to slide 21 and inquired about the enforcement mechanism for the provision.

[2:34:21 PM](#)

SENATOR GIESSEL replied that the Division of Insurance would be responsible for enforcement.

[2:34:33 PM](#)

SENATOR DUNBAR expressed curiosity about what enforcement would look like. He commented that the companies in question are some of the largest in the country and questioned how the Division of Insurance would get them to pay fines and cease these activities.

SENATOR GIESSEL differed to Lori Wing-Heier, Director of the Division of Insurance.

[2:35:27 PM](#)

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

answered questions on SB 121. She stated some of this (fines and penalties) would be addressed in regulations. She pointed out that SB 121 has a large fiscal note due to the added responsibilities required by SB 121. She added that this would include working with consultants and contractors to determine where a PBM has not met the intent of the law. She said that the Division of Insurance currently does this with market conduct.

[2:36:35 PM](#)

SENATOR DUNBAR asked about the effectiveness of the regulations created by other states.

MS. WING HEIR replied that Oklahoma and New Hampshire have spent a great deal of time enforcing regulations like those included in SB 121. Ohio has also had to hire additional enforcement staff.

[2:37:56 PM](#)

ASHLEY SCHABER, Chair, Alaska Board of Pharmacy, Anchorage, Alaska, testified by invitation on SB 121. She gave a brief history of her experience working on the issues addressed by SB 121. She said the goal of SB 121 is to ensure an adequate pharmacy infrastructure in Alaska. She stated that the Alaska Board of Pharmacy (ABP) unanimously supports this legislation. This legislation gives patients the right to access medication at the pharmacy of their choice, if their pharmacy is a willing provider and contracted with a PBM. Additionally, SB 121 provides a framework for transparency and fair reimbursement for pharmacies and patients and protects patient access to clinician-administered medication by restricting the practice of white-bagging and brown-bagging. She explained that the board updates its strategic plan yearly and noted that the FY2023 plan includes the goal of growing the Alaska economy while promoting community health and safety. The board believes this goal is met by SB 121. She said that the board's mission is to promote, preserve, and protect the public health, safety, and welfare by and through the effective control and regulation of the practice of pharmacy. She noted that over the last few years the board has received comment from the public, Alaska pharmacists, technicians, and organizations regarding the current practices limiting access to Alaskan pharmacies and compromising the safety of medications received in the state.

[2:40:10 PM](#)

MS. SCHABER stated that multiple community and infusion pharmacies have closed since efforts on SB 121 began, which severely limits access. She added that this legislation will

help to ensure that Alaska's pharmacies will continue to safely serve Alaskans.

2:40:36 PM

SENATOR BISHOP asked if passage of SB 121 would result in local pharmacies making a comeback.

MS. SCHABER stated her belief that it would encourage local pharmacies to return to business or start a business by decreasing barriers to providing services.

2:41:45 PM

BARRY CHRISTENSEN, Pharmacist, Island Pharmacy, Ketchikan, Alaska, testified by invitation on SB 121. He said that he is a 2nd generation pharmacist and added that his father opened their family pharmacy over 50 years ago. He said that the future of his pharmacy - and the patients he serves - is in jeopardy and requested support of SB 121. He explained that Island Pharmacy is the only pharmacy in Ketchikan that offers unique services such as compliance packaging and the compounding of commercially unavailable medications. He stated that if his pharmacy were to close, like 25 percent of individual pharmacies have, patients would suffer from lack of services. He pointed out that SB 121 impacts pharmacies across the state. He said that six years ago he testified in favor of the prescription benefit manager legislation. He explained that, at that time, opponents claimed that the resulting costs would be financially damaging to plan sponsors. However, it did not drive costs up. He shared his belief that SB 121 would allow plan sponsors to save money while providing relief to Alaska pharmacies and the patients they serve. He said his pharmacy currently employs 12 people - all Alaskans - and emphasized their dedication to serving their fellow Alaskans. He contrasted this with PBM employees, who are entirely out-of-state. He expressed gratitude and the hope that committee members would support this legislation.

2:43:44 PM

DIRK WHITE, Owner, White's Pharmacy, Sitka, Alaska, testified by invitation on SB 121. He said that he has a family of pharmacists and has run White's Pharmacy for 40 years. He has 35 employees. He said that he has witnessed the rise of PBMs and continued rise in pharmaceutical costs. He stated that PBMs claim to reduce costs - yet the US has the highest percentage of gross domestic product (GDP) spent on pharmaceuticals in the world. He expressed confusion at the promotion of this money-saving fallacy. He commented that PBMs take egregious actions to

steal money from community pharmacies - causing them to close or reduce services.

[2:45:13 PM](#)

MR. WHITE said that since 2020 payroll is up 40 percent (primarily due to the Covid-19 pandemic) and health insurance has gone up 17 percent. He shared that in the previous month, he paid \$17 thousand with 1-2 percent claim on the insurance. He stated that his workers' compensation insurance has gone up 45.5 percent - with zero claims, which he asserted is even worse. In response to an earlier question about pharmacy contracts, he explained that he must contract with the PBM, who then contracts with the insurance companies. He stated that reimbursements have gone down over the past four years on all these contracts and emphasized that they are required, non-negotiable contracts. He went on to say that, when questioned, PBMs claim that increased costs are a part of doing business. He reiterated that his costs have gone up while his reimbursements have gone down. He referenced a \$10 thousand audit from a PBM (not named for fear of retribution) and explained that the audit was for two medications for one patient. In this case, a single field was not properly filled in on the forms (although this information was on the prescription). He questioned why someone did not stop and request the information, which could have easily been supplied by the pharmacist. He shared a story about a patient who was told that her insulin was not covered. She was told to contact the PBM's mail order pharmacy, where it would likely be covered. He expressed hope that his pharmacy would be able to provide whatever the PBM requires in order for this patient to receive her insulin.

[2:50:45 PM](#)

CHAIR BJORKMAN opened public testimony on SSSB 121.

[2:51:09 PM](#)

PATRICK SHIER, Alaska Membership Representative, Pacific Health Coalition, Wasilla, Alaska, testified in opposition to SB 121. He briefly explained that the Pacific Health Coalition (PHC) represents individuals whose healthcare is paid for through health and welfare benefit trusts. He noted that the trusts are regulated by the Employee Retirement Income Security Act of 1974 (ERISA). He added that the penalty for falling short of ERISA requirements is jailtime and fines; therefore, most individuals are careful to meet these requirements. He said that the PHC trusts hire, fire, and manage PBMs. He explained that this is done on the advice of expert council and consultants who have been in the business for many years. This is done to maximize

pharmacy spend and efficacy and is based on the best available scientific and market knowledge. He said that PHC also offers a purchasing option called National Cooperative Rx - a nonprofit, member owned and operated organization that negotiates aggressively with PBMs to provide nation-leading benefits at the lowest possible price and best possible quality. He suggested SB 121 be held for further analysis due to the complexity of the issues addressed.

[2:54:23 PM](#)

BRENDA SNYDER, Lead Director, State Government Affairs, CVS Health, Seattle Washington, testified in opposition to SB 121. She said that CVS believes that access to care is paramount to improving health outcomes and supports policies that expand access to quality and affordable healthcare. However, she stated that SB 121 is a "cost driver" rather than a "cost saver". She asserted that this legislation would not increase access to healthcare in Alaska. She stated that employer insurance, insurance, and governments choose to hire PBMs to manage drug spend and drug portion of healthcare benefits. She said that PBMs offer a menu of options that plan sponsors can choose from - and SB 121 takes away the sponsor's ability to choose by creating mandates. She highlighted two cost drivers: the mandated dispensing fee and restrictions on pharmacy networks. She expressed concern about how SB 121 would effect the patient. She reiterated that her organization supports policies that increase access to care but added that it also needs to continue to be affordable.

[2:56:56 PM](#)

TONIA NEAL, Senior Director, Pharmaceutical Case Management Association, Shelten, Washington, testified in opposition to SB 121. She said Pharmaceutical Case Management (PCM) is the national association for PBMs. She stated that PCM has not been involved in any of the work sessions for SB 121. She indicated that the depiction of PBMs has been one-sided. She said that PBMs provide multiple services, from providing databases to pharmacies to negotiating with manufacturers and pharmacies for price. She explained that pharmacy negotiations occur through a Pharmacy Services Administrative Organization (PSAO) - which she said is the equivalent of a PBM. She clarified that during these negotiations, the insurance plans are represented by the PBM and the pharmacy is represented by the PSAO. She disagreed that PBMs maintain a monopoly. She said that PBMs want to be involved in these discussions. She stated that their goal is for the plans and patients to have the best access and price available.

[2:59:43 PM](#)

CHAIR BJORKMAN commented that he has made requests for data from various organizations but has not received a reply. He expressed willingness to meet and discuss these issues with those who have expressed concerns with the changes put forth by SB 121; however, he surmised that when requests for information are ignored, it is likely that the answers to those questions are not good.

[3:00:25 PM](#)

DESIREE MOLINA, representing self, Palmer, Alaska, testified in support of SB 121. She said she is a fourth-year student in the University of Alaska Anchorage (UAA)/Idaho State University (ISU) doctor of pharmacy program. She is currently employed as a pharmacist intern. She said that during the course of her study and work as an intern, she has seen firsthand how unethical PBM practices harm patients. She shared a story about a patient who needed to receive medication to treat a blood clot. The patient was unable to receive the medication due to restrictions set by their PBM. The patient was told they needed to use the PBMs mail-order pharmacy rather than the local pharmacy. When they attempted to opt-out, their co-pay made the medication cost-prohibitive and they were forced to go without. The patient returned to the hospital after several days. They were placed in intensive care and later died. She emphasized that this death was preventable and asserted that the lives of Alaskans should not be in the hands of PBMs. She drew attention to the number of pharmacies that have been forced to close. She stated that this is a health crisis that must be addressed.

[3:02:55 PM](#)

HARRY ROGERS, representing self, Petersburg, Alaska, testified in support of SB 121. He shared a personal story related to prescription medications. When he attempted to fill a prescription at the local pharmacy, he was told his medication would come through a specialty pharmacy located in Florida. His medication needed refrigeration, which would be provided for 48 hours; however, it is not possible for deliveries to reach Alaska in this amount of time. This prescription was then sent to a pharmacy in Seattle where again, shipment was not possible. He said he suggested gold streak; however, this was not an option. He explained that his local pharmacy was able to get the medication for him in the end - a month after the medication was prescribed.

[3:05:44 PM](#)

DELILAH BERNALDO, representing self, Petersburg, Alaska, testified in support of SB 121. She said she is a retired nurse. She expressed her belief that patients have a right to choose where they get their medications. She expressed satisfaction with her local pharmacy. She added that she has asked the PBM pharmacy not to call her and this request has been repeatedly ignored.

[3:06:59 PM](#)

CATHERINE KOWALSKI, representing self, Petersburg, Alaska, testified in support of SB 121. She said that she has been a pharmacist for 35 years and her family has operated a pharmacy for 55 years. She briefly detailed her experience in the industry and expressed support for the patient's right to use the pharmacy of their choice. She said that patients pay into a benefit and should not be coerced to use an out-of-state, specialty pharmacy or bombarded by phone calls from PBMs. She asserted that SB 121 makes economic sense by requiring transparency and accountability from PBMs. Additionally, money would stay in the state. She questioned how closing local pharmacies benefits healthcare or the economic viability of communities.

[3:09:49 PM](#)

GREG LOUDON, Consultant, Employee Benefits, Parker, Smith and Feek Insurance, Anchorage, Alaska, testified in opposition to SB 121. He said he works as a consultant for the Pacific Health Coalition (PHC). He spoke to the financial impact of SB 121. He said PHC has ten groups and 24,841 lives participating in PBM contracts that PHC has helped negotiate. He said PBMs act as a third-party administrator that helps the insurance plans purchase prescription drugs. He said that five of the ten groups use an exclusive specialty plan design. He offered a breakdown of the savings for various plans. He said that, using lower-end numbers, there would be a \$2.7 million increase in costs for the ten plans.

[3:11:43 PM](#)

MARY STOLL, Legal Counsel, Pacific Health Coalition, Seattle, Washington, testified in opposition to SB 121. She said that SB 121 seeks to regulate PBMs who serve as third-party vendors to ERISA health benefit plans. Regulating PBMs at a state level would force ERISA health plans in Alaska to redesign benefit plan provisions - including existing preferred and specialty pharmacy arrangements. She stated that this conflicts with federal laws regulating ERISA. She referred to PCMA v Mulready in Oklahoma and explained why this ruling would also apply to SB

121. She asserted that it is crucial to consider the legal challenges this legislation may face based on established precedent. She pointed out that ERISA was enacted 50 years ago to ensure a consistent nationwide framework for the administration of health and pension plans. Congress included a preemption clause to prevent conflicting state law that could impede plan administrators' ability to design benefits that are in the best interest of their participants. She suggested that stakeholders be engaged in meaningful dialogue to address the concerns while respecting ERISA guidelines and legal precedent.

[3:13:56 PM](#)

LUCY LAUBE, State Government Relations Manager, National Psoriasis Foundation, Portland, Oregon, testified in support of SB 121. She said that she takes medication that requires refrigeration and she empathized with those who are concerned about their life-saving medications on time. She explained that for individuals suffering from psoriatic arthritis, this can have irreversible, long-term effects. She said that the top three PBMs control 80 percent of the market - and regardless of whether this is considered a "monopoly," it is a power imbalance. She agreed that supporting local pharmaceutical businesses makes financial sense for Alaska and opined that it is common sense for insurance companies to reimburse local Alaskan pharmacies at the same rate as PBM mail-order and specialty pharmacies. She emphasized the danger and inconvenience and danger of steering patients to these pharmacies - medications that must come from out-of-state run the risk of arriving late and/or freezing in transit - both of which can be life-threatening. She surmised that the potential for inclement weather and long transit times impact Alaska more than other states. She said she has seen similar laws passed in other states and suggested that this issue deserves extra consideration in Alaska.

[3:16:36 PM](#)

THOMAS WADSWORTH, representing self, Anchorage, Alaska, testified in support of SB 121. He said that while he is the interim Dean of the University of Alaska Anchorage/Idaho State University (UAA/ISU) Doctor of Pharmacy program, he is speaking as a pharmacist and executive who operates a non-profit pharmacy that is loosely tied to UAA/ISU. He explained that the UAA/ISU pharmacy program began with the intent of creating a non-profit community pharmacy that would serve some of the more remote communities in Alaska. He emphasized that this pharmacy would be a not-for-profit with the mission of serving underserved communities. The pharmacy program has partnered closely with the

Board of Pharmacy and the Alaska Pharmacist Association in order to achieve this goal. With respect to the question of whether SB 121 would result in the return of local pharmacies, he shared his belief that this would absolutely happen. He explained that the system is currently "upside-down" - making a non-profit pharmacy untenable. He emphasized that the changes contained in this legislation would make it possible for the non-profit pharmacy to open. He said they will continue to pursue this goal and explained how the non-profit pharmacy would operate. He stated that many UAA/ISU pharmacy graduates would like to open local pharmacies; however, payment models preclude them from doing so.

[3:19:14 PM](#)

KAREN MILLER, Director, Denali Pharmacy, Fairbanks Memorial Hospital, Fairbanks, Alaska, testified in support of SB 121. She shared her belief that PBMs are hurting Alaskans. She added that PBMs are not lowering healthcare costs or drug prices for patients. She said that her job is to safely discharge patients from the hospital in a timely manner - and an extra day or two in the hospital drives up healthcare costs. She shared a story involving a patient with *Clostridioides difficile* (C. diff) and the medication required for treatment. She briefly explained the roadblocks to access that patients face.

[3:22:23 PM](#)

GARY STRANNIGAN, Vice President, Congressional and Legislative Affairs, Premera Blue Cross Blue Shield of Alaska, Seattle, Washington, testified in opposition to SB 121. He said that Premera is not owned and does not own a PBM. He added that Premera supports access to pharmacies and transparency for members. He requested that section 14 be removed. He expressed concern that this section could cause already high premiums to increase by as much as 10 percent. He pointed to the ban on spread pricing and the in-network versus out-of-network pay parity provision as particularly troubling. He said that the latter is anti-competitive. He stated that Premera also opposes the dispensing fee in section 9. He explained that the dispensing fee would insulate pharmacy services from competitive pressures and accountabilities and would have a negative impact on the cost and quality of members' pharmacy services. He commented that SB 121 is a complicated bill and suggested that careful consideration be given to this complex issue. He expressed concern that restrictions for PBMs and spread pricing are not equal for all players. He noted extreme prescription markups by hospitals. He emphasized that Premera depends on pharmacists to meet the needs of members and expressed the

importance of working together to meet these needs in a way that maintains the importance of quality, cost, and value. He asserted that with sections [9] and 14 included, SB 121 does not maintain this standard.

[3:24:57 PM](#)

CHAIR BJORKMAN held SSSB 121 in committee.

[3:25:01 PM](#)

At ease

SB 115-PHYSICIAN ASSISTANT SCOPE OF PRACTICE

[CSSB 115(EDC) was before the committee.]

[3:26:43 PM](#)

CHAIR BJORKMAN reconvened the meeting and announced the consideration of SENATE BILL NO. 115 "An Act relating to physician assistants; relating to physicians; and relating to health care insurance policies."

[3:27:06 PM](#)

SENATOR LÖKI TOBIN, District I, Alaska State Legislature, Juneau, Alaska, sponsor of SB 115 by request. She gave a brief overview of SB 115. She explained that SB 115 would allow physician assistants to provide care to patients without the direct oversight of a physician. She emphasized that SB 115 has clear stipulations about education requirements and time in active practice in collaboration with a physician. She commented that healthcare practitioners do not operate independently and often call upon one another with questions when dealing with complex issues. She said that currently, there is a limited number of physicians available to meet the demand of care in the state. She stated that 69 percent of primary care providers are located in urban areas, while more than 90 percent of Alaska's physician assistants (PA) operate in rural areas, where they provide basic, quality medical care. For these PAs, their collaborating physicians may be far away - which does not allow for direct oversight. She explained that SB 115 was amended by the Senate Health, Education and Social Services Standing Committee so that PAs with more than 4,000 hours would be able to operate independently. She noted that PAs have a great deal of professional and lived experience and added that, on average, PAs have over 3,000 hours of direct patient care prior to entering into an accredited PA program.

[3:29:35 PM](#)

SENATOR TOBIN said that accepted into a PA program, students learn via classroom and in a clinical setting often alongside other students for 27 months. She said that graduates must complete 100 continuing education hours every two years - and take a comprehensive exam every ten years. This is in addition to the required national certifying exam and licensing in SB. She clarified that, in spite of this education, PAs are not medical doctors. She pointed out that Alaskans face high needs and high costs for medical services - and the laws governing PAs are some of the most limiting in the country. She went on to explain that PAs are subject to the prescription drug monitoring program and must comply with the SB Drug Enforcement Agency. She noted that national laws grant PAs prescriptive privileges in states where pharmaceutical training standards are met. She reiterated that PAs play an important role in medical care and their work is broad in scope. She said that SB 115 would allow them to do so - as long as they receive adequate training and education.

[3:32:17 PM](#)

MACKENZIE POPE, Staff, Senator Löki Tobin, SB State Legislature, Juneau, SB, provided the sectional analysis for SB 115:

[Original punctuation provided.]

Senate Bill 115: Sectional Analysis

Section 1. Amends AS 08.64.107 by changing the term "regulation" to "licensure and scope of practice."

Section 2. Amends AS 08.64.107 by adding four new subsections:

Subsection (b) describes the procedures and evaluations physician assistants can perform, including their ability to: perform comprehensive health histories and physical examinations of patients; treat disease and injury; and prescribe, dispense, order, and administer schedule II, III, IV, or V controlled substance under federal law if the physician assistant has a valid federal Drug Enforcement Administration registration number.

[3:33:16 PM](#)

MS POPE continued the sectional analysis for SB 115:

[Original punctuation provided.]

Subsection (c) establishes that a physician assistant with less than 2,000 hours of practice may practice only under collaborative agreement with one (or more) physician to provide care in a hospital, clinic, or other clinical setting. These collaborative agreements must be in writing and describe how the collaboration will be executed between the physician and physician assistant.

Subsection (d) requires that a physician assistant in a collaborative agreement or the collaborating physician shall provide a copy of their collaborative agreement and relevant documentation to the State Medical Board upon request.

Subsection (e) defines collaborative agreement.

Section 3. Amends 08.64.170 to authorize a physician assistant to practice medicine independently, with those practicing with less than 2000 hours required to operate under a collaborative agreement as authorized in the previous section.

Section 4. Amends AS 11.71.900 to include physician assistants under the definition of "practitioner."

Section 5. Amends AS 21.07.010 to disallow a contract between a participating health care provider and health care insurer from including a provision that imposes a practice, education, or collaboration requirement on physician assistants which is inconsistent with or more restrictive than the requirements stipulated under AS 08.64.107.

Section 6. Removes the direct supervision requirement for physician assistants under the definition of "attending physician" as stated in AS 23.30.395, which allows employees to designate physician assistants as responsible for their care under the Alaska Workers Compensation Act.

[3:35:09 PM](#)

MS. POPE continued the sectional analysis for SB 115:

[Original punctuation provided.]

Section 7. Removes the direct supervision requirement for physician assistants under the definition of "health care provider" as stated in AS 33.30.901, which allows physician assistants to provide medical services as a health care provider within the Department of Corrections statute definition.

[3:35:31 PM](#)

SENATOR TOBIN stated she has many invited testifiers who can speak to the rigor of their academic performance, expertise, and answer questions.

[3:35:57 PM](#)

SENATOR BJORKMAN announced invited testimony.

[3:36:19 PM](#)

SENATOR BJORKMAN turned the gavel over to Senator Gray-Jackson.

[3:36:25 PM](#)

JENNIFER FAYETTE, Co-Chair, Legislative Committee, Alaska Academy of Physician Assistants, Anchorage, Alaska, testified by invitation on SB 115. She said she is a lifelong Alaskan and practicing PA in Anchorage. She stated that PAs provide essential, high-quality medical patient-centered care throughout the state. She surmised that all those present have a family member who has received treatment from a PA. She explained that PAs diagnose illnesses, develop and manage treatment plans, manage their own patient panels, and often serve as the patient's principal healthcare provider. The latter is particularly true in rural areas. She said that PAs hold a state medical license, medical liability insurance, and Drug Enforcement Administration (DEA) license. She stated that PAs are responsible for the care that they provide. She asserted that PAs are crucial to Alaska's healthcare system. She pointed out that healthcare worker shortages have long been an issue in the state and demand is increasing. She noted that Alaska is faced with unique challenges for access to - and delivery of - medical care. She said that these challenges occur in rural areas as well as urban specialty care clinics. She added that some patients will wait over nine months to see a medical specialist - this is a worsening problem. She said that state projections indicate that Alaska is expected to have the most significant shortages of any state moving forward. She stated that, since its creation in the 1960s, the primary goal of the PA program has been to increase access to care. She opined that Alaska would benefit from updating PA practice laws. She

suggested that this would make Alaska more appealing to local PA program graduates and providers from other states.

[3:38:29 PM](#)

[SENATOR GRAY-JACKSON returned the gavel to Chair Bjorkman.]

MS. FAYETTE stated that PAs are highly trained healthcare professionals whose broad generalist medical education allows them to adapt to the evolving needs of the healthcare system. She noted that there are 306 accredited PA programs in US, with only one independent accrediting body. The Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) includes representatives from a variety of medical organizations and ensures that these programs adhere to a high accreditation standard. She explained that PA curriculum is modeled after medical school curriculum and includes clinical rotations alongside other medical students. She noted that the average PA program applicant has over 3,000 hours of direct patient contact prior to applying. PAs must also complete specific prerequisites during their undergraduate education.

MS. FAYETTE detailed how students progress through the program. Graduates must complete a comprehensive national exam. The exam must be taken every ten years and PAs must complete 100 hours of continuing education each year, in addition to state requirements. She briefly shared her own education experience. She stated that PAs are not doctors and their education is not equivalent. However, they are well-trained medical providers who are capable of providing medical care to Alaskans. She said that PAs want to fill this role for Alaskans. She stated that as president of AK APA, she was contacted by clinics and asked to explain current state regulations and how to comply with them. She said she was often asked why anyone would hire a PA when it also involves securing an MD to supervise them. She explained that restrictive regulations impact patients and PAs. She said that research has shown that the most successful teams fully utilize the skills of each member and support efficient, patient-centered healthcare and added that collaborative care models have been modified in many states. These modifications allow PAs to fully utilize their education, training, and experience, and range from no requirement for post-graduate hours to 10,000 hours.

[3:42:08 PM](#)

MS. FAYETTE noted that the several branches of federal government, including military and native agencies, have removed or modernized the supervisory/collaboration requirements,

recognizing that PAs are capable of practicing autonomously. She referred to a recently published ten-year study that found that removing these restrictive requirements does not increase the risk to patients or rates of malpractice. She stated that many similar reports show the positive potential of PAs. She said that SB 115 would define the PA scope of practice, ensuring that Alaskans' access to care is not restricted. It would also remove the oversight requirements after a set amount of post-graduate clinical hours. Additionally, PAs would be recognized as practitioners alongside medical doctors. She opined that PAs are an essential part of the healthcare system and asserted that barriers to PA practice must be removed in order to meet the needs of the healthcare system in Alaska.

[3:43:55 PM](#)

CHRISTI FROILAND, representing self, Anchorage, Alaska, testified by invitation on SB 115. She said she is a PA with 16 years of experience in the area of medical dermatology. She said that medicine should be a collaborative practice. She shared a story about her experience as a PA working closely with doctors both as mentors and team members. She explained how her skills work alongside - and independently of - the doctors on her team. She explained how her broad skillset benefits doctors who specialize in a particular field of study. She shared her experience working as a PA in the dermatology field. She said that in addition to teaching at Providence Medical Center, she is a faculty member at the University of Washington, where she teaches dermatology to medical residents; however, to practice, she has to have a signed collaborative agreement. She said that when discussing collaborative agreements, she is often asked about her liability. She added that this seems to be doctors' main concern, in spite of her high level of experience.

[3:45:58 PM](#)

MS. FROILAND expressed frustration that she likely has more specialized experience doing in-office procedures than many practicing doctors - yet is continually asked this question. She asserted that her skills and education complement general medicine quite well. She shared a recent experience in which the liability of PAs was a concern - despite their having anywhere from 5 to 15 years of experience. She said that PAs have the education and training needed to do the jobs they are asked to do and are liable for the care that they provide.

[3:46:50 PM](#)

She stated that SB 115 defines the PA scope of practice and would recognize PAs alongside other medical practitioners. She expressed concern about the fees charged in collaborative

agreements and explained the various collaborative agreement scenarios and fees that impact PAs. In some cases, a doctor may take as much as 50 percent of collections, which she asserted is extortion. These high fees are prohibitive. She explained that a PA can hire a new doctor, mentor and train them, and the doctor can simultaneously supervise the PA. She asserted that this needs to change to reflect how PAs practice and serve Alaskans. She stated that SB 115 is about recognizing PAs as medical providers and recognizing their scope of practice at the statute level. She said that Alaska is one of the most difficult states for PA licensing, which decreases access to care.

[3:49:12 PM](#)

CHAIR BJORKMAN opened public testimony on SB 115.

[3:49:30 PM](#)

WENDY SMITH, representing self, Juneau, Alaska, testified in support of SB 115. She said she is a PA with over 20 years of experience and is currently working at Juneau Urgent and Family Care. She opined that one profession relying on another in order to do its job is ridiculous. She said that for over 60 years, PAs have been proving the safety and efficacy of their work and it is time to modernize, which is what SB 115 would do. She opined that being tied to one physician is archaic and there is no longer a financial benefit to making collaborative agreements. PAs are considered a liability as they do not bring financial benefit to physicians working as part of a system. She stated that access to care is important. She explained that when working for a small practice that is directed by one physician, the second collaborating physician must be outsourced. If this relationship dissolves, the PA is not able to continue working. She reiterated that the current statutory regulations limit her ability to provide excellent care.

[3:51:57 PM](#)

MEGHAN HALL, representing self, Anchorage, Alaska, testified in support of SB 115. She said she is a PA working in Anchorage and SB 115 would keep Alaska relevant in the increasingly competitive healthcare market for providers. She pointed out that the healthcare industry has evolved over the past 50 years. While PAs were initially intended to extend the reach of physicians in a primary care setting, they now work in every area of medicine. She said that this increases patients' access to vital care. She acknowledged that PA is a relatively new profession and is continually evolving and adapting to patient needs and the changing healthcare system. PAs are committed to patient safety and collaborative medicine. She said that SB 115

allows the profession to continue to grow and adapt. PAs have moved into specialty and subspecialty care in response to the demands for highly educated providers and treatment options that require expertise. She asserted that letters from specialists who oppose SB 115 is indicative of a move toward even greater specialization; however, a medical system cannot function with only specialist providers. She stated that PAs are trained as medical generalists and are thus able to efficiently fill gaps in care. She said that Alaska is struggling to recruit and retain healthcare providers and SB 115 would advance PA practice - and the healthcare system.

[3:54:01 PM](#)

CHAIR BJORKMAN held public testimony open.

[CHAIR BJORKMAN held SB 115 in committee.]

[3:55:04 PM](#)

There being no further business to come before the committee, Chair Bjorkman adjourned the Senate Labor and Commerce Standing Committee meeting at 3:55 p.m.