

**SENATE BILL NO. 3**

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-THIRD LEGISLATURE - FIRST SESSION

BY SENATOR HUGHES

Introduced: 1/9/23

Referred: Prefiled

**A BILL**

**FOR AN ACT ENTITLED**

1   **"An Act relating to direct health care agreements; relating to a health care insurance**  
2   **policy incentive program; relating to health care services; relating to unfair trade**  
3   **practices; and providing for an effective date."**

4   **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5    \* **Section 1.** AS 18.23 is amended by adding a new section to read:

6                   **Article 5. Direct Health Care Agreements.**

7                   **Sec. 18.23.500. Direct health care agreements.** (a) A direct health care  
8                   agreement is a written health care agreement between a health care provider and a  
9                   government entity, an individual patient, or the employer of a patient to provide health  
10                  care services in exchange for payment of an annual fee. The health care provider shall  
11                  disclose the services to be provided under the agreement to the patient and to the  
12                  person paying the fee. The health care provider may not assess charges or receive  
13                  compensation other than the annual fee for health care services and additional fees  
14                  specified in the agreement. However, a patient may submit a health care insurance

claim and the health care provider may assess charges or receive compensation for health care services not included in the agreement. A direct health care agreement must

(1) describe the health care services to be provided by the health care provider;

(2) specify the annual fee for the health care services and additional fees that the health care provider may charge in addition to the annual fee;

(3) prominently state that the agreement is not health insurance and does not meet an individual or other health insurance mandate that may be required by federal law;

(4) prominently state that the patient is not entitled to the protections under AS 21.07 (Patient Protections Under Health Care Insurance Policies) or AS 21.36 (Trade Practices and Frauds);

(5) identify and include contact information for the person responsible for receiving and addressing a complaint made by a patient; and

(6) state that the annual fee under the agreement for services

(A) must be comparable to the annual fee for comparable services provided by the health care provider to other patients under the provider's other direct health care agreements; and

(B) may not be based solely on the patient's health status or sex.

(b) A direct health care agreement between a health care provider and a patient must allow a patient to terminate the agreement in writing within 30 days after entering into the agreement. If a patient terminates an agreement under this subsection, the provider shall, not later than 30 days after the patient terminates the agreement, refund to the patient payments made under the agreement, less payments made for services the provider has already performed. The provider may charge a nominal termination fee for termination of an agreement under this subsection.

(c) A direct health care agreement between a health care provider and a patient must allow a party to terminate the agreement in writing after at least 30 days' notice and in accordance with the agreement. The agreement may provide for a refund, a

1 nominal termination penalty, or a nominal termination fee for termination of an  
2 agreement under this subsection.

3 (d) A direct health care agreement between a health care provider and a  
4 government entity or the employer of a patient may be terminated in accordance with  
5 the agreement. An agreement may provide for a refund, a nominal termination penalty,  
6 or a nominal termination fee.

7 (e) The parties to a direct health care agreement may modify or renew the  
8 agreement by written agreement of the parties and in a manner consistent with this  
9 section. A health care provider may not change the annual fee under the agreement  
10 more than once a year, and shall provide at least 45 days' written notice of a change in  
11 the annual fee.

12 (f) A direct health care agreement and health care services provided under a  
13 direct health care agreement are not subject to AS 21.07 (Patient Protections Under  
14 Health Care Insurance Policies) or AS 21.36 (Trade Practices and Frauds), but are  
15 subject to other consumer protection statutes and regulations, including AS 45.45.915.

16 (g) A person may not make, publish, or disseminate an assertion,  
17 representation, or statement with respect to the business of direct health care  
18 agreements, or with respect to a person in the conduct of the person's direct health care  
19 agreement business, that is untrue, deceptive, or misleading, and may not

20 (1) misrepresent the benefits, advantages, conditions, sponsorship,  
21 source, or terms of a direct health care agreement;

22 (2) use a name or title of a direct health care agreement  
23 misrepresenting its true nature; or

24 (3) make a false or misleading statement as to a direct health care  
25 agreement.

26 (h) Offering or executing a direct health care agreement does not constitute  
27 engaging in the business of insurance or underwriting in this state, and a direct health  
28 care agreement and health care services provided under a direct health care agreement  
29 are exempt from regulation by the division of insurance, Department of Commerce,  
30 Community, and Economic Development. A health care provider is not a health  
31 maintenance organization, insurer, or insurance producer by virtue of the offering or

1 execution of a direct health care agreement or the provision of health care services  
 2 under a direct health care agreement. A certificate of authority or license to market,  
 3 sell, or offer to sell a direct health care agreement or health care services under a direct  
 4 health care agreement is not required to offer or execute a direct health care agreement  
 5 or provide health care services under a direct health care agreement.

6 (i) In this section,

7 (1) "health care provider" means a firm, corporation, association,  
 8 institution, or other person licensed or otherwise authorized in this state to provide  
 9 health care services;

10 (2) "health care service" means a health care service or procedure,  
 11 other than a health care service or procedure that is immediately necessary to prevent  
 12 the death or serious impairment of the health of the patient, that is provided in person  
 13 or remotely by telemedicine or other means by a health care provider for the care,  
 14 prevention, diagnosis, or treatment of a physical or mental illness, health condition,  
 15 disease, or injury.

16 \* **Sec. 2.** AS 21.06.110 is amended to read:

17 **Sec. 21.06.110. Director's annual report.** As early in each calendar year as is  
 18 reasonably possible, the director shall prepare and deliver an annual report to the  
 19 commissioner, who shall notify the legislature that the report is available, showing,  
 20 with respect to the preceding calendar year,

21 (1) a list of the authorized insurers transacting insurance in this state,  
 22 with a summary of their financial statement as the director considers appropriate;

23 (2) the name of each insurer whose certificate of authority was  
 24 surrendered, suspended, or revoked during the year and the cause of surrender,  
 25 suspension, or revocation;

26 (3) the name of each insurer authorized to do business in this state  
 27 against which delinquency or similar proceedings were instituted and, if against an  
 28 insurer domiciled in this state, a concise statement of the facts with respect to each  
 29 proceeding and its present status;

30 (4) a statement in regard to examination of rating organizations,  
 31 advisory organizations, joint underwriters, and joint reinsurers as required by

1 AS 21.39.120;

2 (5) the receipts [RECEIPT] and expenses of the division for the year;

3 (6) recommendations of the director as to amendments or  
4 supplementation of laws affecting insurance or the office of the director;

5 (7) statistical information regarding health insurance, including the  
6 number of individual and group policies sold or terminated in the state; this paragraph  
7 does not authorize the director to require an insurer to release proprietary information;

8 (8) the annual percentage of health claims paid in the state that meet  
9 [MEETS] the requirements of AS 21.36.495(a) and (d);

10 (9) the total amount of contributions reported and the total amount of  
11 credit claimed under AS 21.96.070;

12 (10) the total number of public comments received and the director's  
13 efforts, to the extent allowable by law, to improve or maintain public access to  
14 information on individual health insurance rate filings before they become effective;  
15 [AND]

16 (11) the most recent incentive program report compiled under  
17 AS 21.96.260; and

18 (12) other pertinent information and matters the director considers  
19 proper.

20 \* **Sec. 3.** AS 21.36.100 is amended to read:

21 **Sec. 21.36.100. Rebates.** Except as provided in AS 21.96.220 or otherwise  
22 expressly provided by law, a person may not knowingly permit or offer to make or  
23 make a contract of life insurance, life annuity or health insurance, or agreement under  
24 the contract other than as plainly expressed in the contract, or pay, allow, give or offer  
25 to pay, allow, or give, directly or indirectly, as inducement to the insurance, or  
26 annuity, a rebate of premiums payable on the contract, or a special favor or advantage  
27 in the dividends or other benefits, or paid employment or contract for services of any  
28 kind, or any valuable consideration or inducement whatever not specified in the  
29 contract; or directly or indirectly give, sell, purchase or offer to agree to give, sell,  
30 purchase, or allow as inducement to the insurance or annuity or in connection  
31 therewith, whether or not to be specified in the policy or contract, an agreement of any

form or nature promising returns, profits, stocks, bonds, or other securities, or interest present or contingent in the contract or as measured by the contract, of an insurance company or other corporation, association, or partnership, or dividends or profits accrued or to accrue under the contract; or offer, promise, or give anything of value that is not specified in the contract.

\* **Sec. 4.** AS 21.96 is amended by adding new sections to read:

**Article 2. Health Care Insurance Policy Incentive Program.**

**Sec. 21.96.210. Access to payment information.** A health care insurer that offers a health care insurance policy in the group or individual market shall provide comprehensive comparison guidance by telephone and make available on the Internet website of the insurer a price comparison tool that, to the extent practicable, allows an individual enrolled in or covered under a health care insurance policy to compare the amount of cost sharing that the individual would be responsible for paying under the policy for a specific item or service provided in the same policy year and geographic region by each provider participating in the policy. At a minimum, the health care insurer shall comply with 42 U.S.C. 300gg-114.

**Sec. 21.96.220. Incentive program.** (a) A health care insurer that offers a health care insurance policy in the group or individual market shall develop and implement a program that provides a monetary incentive for a covered person enrolled in a health care insurance policy to elect to receive a covered health care service under the health care insurance policy from a health care provider that charges less than the median contracted rate recognized by the health care insurer for that health care service.

(b) A health care insurer that offers a health care insurance policy in the group or individual market shall provide an incentive payment to a covered person as provided in this subsection. An incentive may be calculated as a percentage of the difference in price as a flat dollar amount or by another reasonable methodology adopted by the director by regulation. Except as provided in (e) of this section, the total amount of incentive payments a health care insurer provides to a covered person in a calendar year under this subsection may not exceed the amount of the covered person's cost sharing in the calendar year by more than five percent. A health care

insurer is not required to provide an incentive payment to a covered person if the cost saved by the health care insurer is \$200 or less.

(c) If a covered person receives coverage under a group health care insurance policy offered by an employer, a health care insurer shall provide the covered person with an incentive as provided in this subsection. Except as provided in this subsection and (e) of this section, the incentive a health care insurer provides the covered person must be at least 33.4 percent of the costs saved by the health care insurer resulting from the covered person's election to receive a health care service from a health care provider that charges less than the median of the contracted rates recognized by the health care insurer for that health care service. Except as provided in (e) of this section, the incentive a health care insurer provides to a covered person in a calendar year under this subsection may not exceed the amount of the covered person's cost sharing in the calendar year. The health care insurer shall provide the employer with at least 33.3 percent of the costs saved by the health care insurer resulting from the covered person's election.

(d) If a covered person receives coverage under a health care insurance policy offered in the individual market, a health care insurer shall provide the covered person with an incentive of at least 50 percent of the costs saved by the health care insurer resulting from the covered person's election.

(e) For a dental insurance policy or a vision insurance policy, the incentives a health care insurer provides to a covered person in a calendar year may not exceed the amount of the dental benefits or vision benefits provided to the covered person under the dental insurance policy or the vision insurance policy.

(f) An incentive payment to a covered person under this section is not

- (1) a violation of AS 21.36.100; or
- (2) an administrative expense of the health care insurer for rate development or rate filing purposes.

**Sec. 21.96.230. Availability of program; notice.** A health care insurer that offers a health care insurance policy in the group or individual market shall make an incentive program under AS 21.96.220 available as a component of a health care insurance policy offered in this state. Annually, at enrollment or renewal, a health care

insurer shall provide notice about the availability of the program to a person covered under a health care insurance policy eligible for the program.

**Sec. 21.96.240. Filing requirements.** Before offering an incentive program under AS 21.96.220, a health care insurer that offers a health care insurance policy in the group or individual market shall file a description of the program with the director in the manner determined by the director. The director may review the filing to determine whether the incentive program complies with the requirements of AS 21.96.210 - 21.96.300.

**Sec. 21.96.250. Out-of-network health care providers.** If a covered person participates in an incentive program under AS 21.96.220 and elects to receive a health care service under AS 21.96.220(a) from an out-of-network health care provider that results in a savings for the health care insurer, the health care insurer shall apply the amount paid for the health care service toward the cost sharing owed by the covered person as specified in the applicable health care insurance policy as if the health care services were provided by an in-network health care provider.

**Sec. 21.96.260. Reporting requirements.** (a) A health care insurer shall, at the request of the director, annually provide information to the director relating to an incentive program under AS 21.96.220 for the most recent calendar year that includes

- (1) the total number of incentive payments;
- (2) information on the use of the incentive program by category of service;
- (3) the total amount of incentive payments;
- (4) the average amount of each incentive payment for each category of service;
- (5) the total savings achieved below the average price of the health care service in each category of service; and
- (6) the total number and percentage of covered persons who participated in the incentive program.

(b) The director shall include the information provided under this section in the director's annual report under AS 21.06.110 and shall submit the annual report to the chairs of the committee in each house of the legislature with jurisdiction over labor



1 and commerce.

2 **Sec. 21.96.270. Applicability.** (a) Except as provided in (b) of this section,  
3 AS 21.96.210 - 21.96.300 apply to a health care insurance policy or contract but do  
4 not apply to excepted benefits.

5 (b) AS 21.96.210 - 21.96.300 apply to excepted benefits provided under a  
6 dental insurance policy or a vision insurance policy.

7 (c) In this section, "excepted benefits" has the meaning given in AS 21.54.160.

8 **Sec. 21.96.300. Definitions.** In AS 21.96.210 - 21.96.300,

9 (1) "cost sharing" means a deductible, coinsurance, copayment, or  
10 similar expense owed by a covered person under the terms of the covered person's  
11 health care insurance policy;

12 (2) "health care insurance" has the meaning given in AS 21.12.050;

13 (3) "health care insurer" has the meaning given in AS 21.54.500;

14 (4) "health care provider" has the meaning given in AS 18.23.400(n);

15 (5) "health care service" has the meaning given in AS 18.23.400(n);

16 (6) "policy" has the meaning given in AS 21.97.900.

17 \* **Sec. 5.** AS 29.10.200 is amended by adding a new paragraph to read:

18 (68) AS 29.35.142 (disclosure and reporting of health care services and  
19 price information).

20 \* **Sec. 6.** AS 29.35 is amended by adding a new section to read:

21 **Sec. 29.35.142. Regulation of disclosure and reporting of health care**  
22 **services and price information.** (a) The authority to regulate the disclosure or  
23 reporting of price information for health care services by health care providers, health  
24 care facilities, or health care insurers is reserved to the state, and, except as  
25 specifically provided by statute, a municipality may not enact or enforce an ordinance  
26 regulating the disclosure or reporting of price information for health care services by  
27 health care providers, health care facilities, or health care insurers.

28 (b) This section applies to home rule and general law municipalities.

29 (c) In this section,

30 (1) "health care facility" has the meaning given in AS 18.23.400(n);

31 (2) "health care insurer" has the meaning given in AS 21.54.500;

(3) "health care provider" has the meaning given in AS 18.23.400(n);

(4) "health care service" has the meaning given in AS 18.23.400(n).

\* **Sec. 7.** AS 45.45 is amended by adding a new section to read:

**Sec. 45.45.915. Direct health care agreements.** (a) A health care provider may not decline to enter into a direct health care agreement with a new patient or terminate a direct health care agreement with an existing patient solely because of the patient's race, religion, color, national origin, age, sex, physical or mental disability, marital status, change in marital status, pregnancy, parenthood, or any other characteristic of a class of persons protected by federal or state laws that prohibit discrimination.

(b) A health care provider may decline to enter into a direct health care agreement with a new patient or terminate a direct health care agreement with an existing patient based on the patient's health status only if the health care provider is unable to provide to the patient the level or type of care the patient requires for a medical condition. Before terminating a direct health care agreement with an existing patient, a health care provider shall ensure that the patient is transferred to a health care provider who

(1) is able to provide the level or type of care the patient requires; and

(2) agrees to provide to the patient the level or type of care the patient requires.

(c) In this section,

(1) "direct health care agreement" means an agreement described in AS 18.23.500;

(2) "health care provider" has the meaning given in AS 18.23.500.

\* **Sec. 8.** AS 45.50.471(b) is amended by adding new paragraphs to read:

(59) violating AS 18.23.500 (direct health care agreements);

(60) violating AS 45.45.915 (direct health care agreements).

\* **Sec. 9.** The uncodified law of the State of Alaska is amended by adding a new section to read:

DEPARTMENT OF ADMINISTRATION ANALYSIS; REPORT TO LEGISLATURE. The Department of Administration shall analyze whether the state or

1 employees covered by a group health care insurance policy for a participating governmental  
2 unit would benefit if a group health care insurance policy obtained or provided under  
3 AS 39.30.090 or 39.30.091 were required to comply with the provisions of AS 21.96.210 -  
4 21.96.300, added by sec. 4 of this Act. The Department of Administration shall complete the  
5 analysis and compile the information into a report to the legislature, submit the report to the  
6 senate secretary and chief clerk of the house of representatives before January 31, 2024, and  
7 notify the legislature that the report is available.

8 \* **Sec. 10.** The uncodified law of the State of Alaska is amended by adding a new section to  
9 read:

10 TRANSITION: REGULATIONS. The director of the division of insurance may adopt  
11 regulations necessary to implement this Act. The regulations take effect under AS 44.62  
12 (Administrative Procedure Act), but not before the effective date of the law implemented by  
13 the regulation.

14 \* **Sec. 11.** Sections 9 and 10 of this Act take effect immediately under AS 01.10.070(c).

15 \* **Sec. 12.** Except as provided in sec. 11 of this Act, this Act takes effect January 1, 2024.