HEARTBEAT

THE BIMONTHLY NEWSLETTER OF THE ALASKA STATE MEDICAL ASSOCIATION June 2024

PRESIDENT'S COLUMN

ASMA members

I wanted to take a few minutes to introduce myself as the incoming President of ASMA and let you know some of the issues I'm paying close attention to this year.

Kristin Mitchell, MD

As a child, I loved a tiny sealskin doll my grandmother brought me from a trip to Nome, and I dreamed of visiting the Great Land. I finally got here for the first time on a third year medical student rotation at Kanakanak Hospital in Dillingham and fell in love with the landscape, the people of Alaska, and the breadth and challenge of medical practice. After finishing Internal Medicine residency at the University of Washington, I packed everything including my dog and new husband into a Subaru and took the ferry north to join three internists in Soldotna. It's been 25 years of deeply fulfilling practice and medical education. I have raised two kids and buried one, hosted foreign exchange students and innumerable visitors, fostered puppies, learned to row and lost track of the number of rhubarb pies I have baked.

Compton Continued Page 5

State Medical Board Update

The medical board held a special meeting on June 13th. Among other business, the board:

Agreed to monthly meetings in between their quarterly meetings with the prime purpose of considering medical license applications in a timelier manner.

Gave the executive administrator the authority to issue licenses when there are no "yes" answers to questions on the license application.

Is moving forward on regulation changes reducing duplicative requirements on initial medical license applications.

Agreed to resurrect the working group to update the physician assistant regulations. The working group never met due to pending activity on SB 115 that would have given PAs independent practice in Alaska. Since SB 115 was not passed by the legislature, the working group was directed to meet with two new physician representatives replacing the previous physicians who no longer had sufficient time available for the project.

Drs. Richard Wein and Maria Freeman did not seek reappointment to the medical board when their terms expired March 1, 2024. Two new physician appointees have filled those vacancies: Eric Nimmo, MD, family physician from Wasilla, and Brent Taylor, MD, gastrointestinal surgeon in the Mat-Su Valley.

ASMA Website Info:

- For those that have not logged in yet, the site did not carry over your password. You **WILL** need to reset it in order to login.
- If you don't have an address in the "personal" field you will not receive mailings. Please login to update your profile.
- Physician images were **not** imported to the new site so please be sure you log in and upload a new photo for the OMD (Online Medical Directory).
- The system currently does not support Company Admin's uploading individual physician photos. You may email photos to Cjeanes@asmadocs.org, but please include the physician name and company so that we can be sure we're uploading to the proper profile.

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Mitchell continued from Page 1

I first joined ASMA when the physician directory was only in print and available to members; mine was annotated with back office phone numbers and notes about responses to referrals. I've come to appreciate that ASMA continues to be valuable for connecting newly arrived and well-established physicians and other medical providers, and I've learned that ASMA does much more than provide a useful directory.

As I have grown in my clinical practice, I have come to realize that individual actions in the exam room, while powerful, are not sufficient to make the meaningful system-level changes needed to support our patients' health and our professional lives. With this in mind, I've been grateful to ASMA for teaching me about legislative advocacy in Juneau, and about leadership through the FAMLI leadership program. We expect there to be another class of leadership training in 2025 - more about this program in a future issue.

This legislative session in Juneau was a busy one. As usual, many bills were introduced and did not make it through the process to a vote. ASMA provided testimony about two bills that would have expanded scope of practice - one regarding Naturopaths, and another regarding PAs.

PA members proposed a bill that would have reduced administrative overhead and also granted independent practice after a number of hours of work experience. Physician members of ASMA and other Physician specialty groups from around the state testified before the legislature that we don't believe PA training prepares a person for independent practice. The bill did not pass, and ASMA is actively working to collaborate with PA colleagues to craft a better legislative remedy for some of the challenges to PA practice in Alaska.

ASMA also supports efforts to expand the healthcare workforce in Alaska. We have supported WWAMI and the newly established, first of its kind in the nation, Alaska Internal Medicine Rural Residency Program - more on this in a future issue.

ASMA is leading a new effort to ensure Network Adequacy for insured patients in Alaska. Narrow networks limit access to essential care for many patients. ASMA wants to be sure Alaska protects access to care for Alaskans and joins the 38 states who have Network Adequacy rules or legislation. More on this elsewhere in this issue.

National HPV Vaccination Roundtable

APRIL 2022

HPV Vaccination at 9-12 Years of Age

What's Known

Adolescent vaccination coverage is improving, but gaps remain between HPV and other adolescent vaccines, and on-time series completion is especially low.

- Adolescent (13-17 years) HPV vaccine coverage, as assessed in 2020, has continued to increase in the United States (75% having received at least 1 HPV vaccine dose, compared to 72% in 2019; 59% up-to-date, compared to 54% in 2019), but still trails coverage of Tdap vaccine (90%) and quadrivalent meningococcal conjugate vaccine (89%).[1]
- A study published in 2019, using the 2016 National Immunization Survey-Teen data, found that while 60.4% of adolescents had initiated HPV vaccination by ages 13-17 years, only 15.8% were fully up-to-date prior to their 13th birthday.[2]
- Benchmarks for quality improvement, including HEDIS measures, assess vaccination at 13 years of age.[3] Initiating HPV vaccination at the first opportunity (e.g., 9 years of age) can help achieve these QI goals.

HPV vaccination is recommended for ages 9-12, but specific recommendations related to age differ by organization.

- The American Academy of Pediatrics and the American Cancer Society recommend HPV vaccination between 9-12 years of age.[4,5]
- The Advisory Committee on Immunization Practices recommends starting the HPV vaccine series at 11-12 years of age and indicates that vaccination can be started as early as 9.[6,7]

Implementing HPV vaccination at the earliest opportunity produces a strong immune response.

- HPV vaccination at younger ages (e.g., less than 15 years) yields higher antibody titers compared to vaccination later in adolescence, even with a reduced 2-dose schedule.[8,9]

What's New

Efforts to improve HPV vaccination at the first opportunity help improve overall vaccine uptake.

- Adolescents initiating HPV vaccination at 9-10 years were more likely to be fully up-to-date by 13.5 years of age compared to those initiating at 11 to 12 years (97.5% versus 78%, respectively).[10]
- QI initiatives, including changing electronic medical record prompts to alert providers of the need for HPV vaccination starting at 9 years rather than 11 years, led to an 8-fold increase in vaccination prior to 11 years of age (4.6% to 35.7%).[11]
- A provider-focused multi-level intervention in pediatric offices that agreed to initiate HPV vaccination at 9-10 years of age resulted in a 13 percentage point increase in vaccination among 9-10-year-olds, which was not only sustained but increased in the post-intervention period (27 percentage point increase).[12]
- A 2021 survey of over 1,000 U.S. primary care professionals found that about one-fifth (21%) were routinely recommending the HPV vaccine at age 9-10. Another 48% were somewhat or more willing to adopt the practice of recommending the HPV vaccine at age 9.[13]

Initiating HPV vaccination at 9-10 years of age is acceptable to both parents and health care providers.

- Attendance at care visits decreases in older adolescence. Therefore initiating the series younger provides more opportunities to complete the vaccine series on time.[14] For example, this allows providers to give the two HPV vaccine doses 12 months apart at annual well-child visits at 9 and 10 years of age, with Tdap and MCV4 vaccination given at 11 years of age.
- Providers find conversations are easier as sexual activity is not a focus.[15]
- The opportunity to receive fewer vaccines per visit is appealing to parents, adolescents, and clinicians.[15,16]

What's Next

There are a number of gaps in our ability to widely implement HPV vaccination at the first opportunity that need to be addressed.

Data gaps:

- Rather than reporting vaccinations received by a particular age, more granular data analysis (e.g., NIS-Teen, state-level IIS) by age at vaccination and birth cohorts can better identify missed opportunities for HPV vaccination.
- The impact of the COVID-19 pandemic on adolescent vaccination needs to be better understood. The 2020 NIS-Teen data[1] did not fully reflect the impacts of the COVID-19 pandemic on adolescent vaccination[17], as adolescents may have been vaccinated prior to the pandemic but assessed in 2020.

Dissemination and implementation gaps:

- Aside from research-based projects showing vaccination gains with recommendations at 9-10 years, most evidence of implementation success has been limited in scope. Larger implementation studies are needed.
- For practices having success at bundling HPV, Tdap, and MCV4 at 11 years of age, the bundling efforts should be continued and supported. Where success has been more difficult to come by, HPV vaccination at the first opportunity (e.g., 9 years of age) may be an option to improve coverage.
- Communications tools need to be developed to reassure pediatricians that it is safe and effective to give HPV vaccine starting at 9 years and that parents are accepting of vaccination at that age.

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Alaska State Medical Association

Meeting of the General Assembly

May 1, 2024

Minutes of meeting held at the BP Energy Center and on Zoom

Call to Order: The meeting was called to order at 5:01 pm by President Dr. Compton.

Board of Trustees in attendance: Drs Roberts, Foland, Johnson, Colescott, Mitchell, Sheufelt, and PA Froiland.

Staff present: Jardell, Holmes and Ventgen.

Members Present: Carolyn V. Brown, Jean Tsigonis, Stephen ?, Ed Hall, Steve Markewich, Kathy Young, Matt Guess, Barb Doty, Betsy Douds, Christy Toumi, Jeff Demain, Lenny Dunikoski, Emily Olsen, Joe Roth, Jody Butto, Camila Sulak, Jenny Fayette, Peter Lawrason, John Finley, Megan Hall, Wendy Cruz, Eric Miknich, Mary Klix, Jim O'Malley, Alexander von Hafften

Guests Present: Jeff Davis, Consultant; and Dr. Joann Schafer and Charlie Engle from Anonymous Health.

Minutes: The minutes of the May 13, 2023, General Assembly Meeting were approved after a motion by Klix that was seconded by Lawrason.

Anonymous Health: Dr. Joann Schafer and Charlie Engle introduced Anonymous Health addiction recovery, a telehealth treatment platform, as an option that physicians can offer patients interested in recovering from various forms of addiction. Their providers are licensed in Alaska, services are covered by most insurance companies and it provides one more tool available to persons across the state.

Election of Officers: By unanimous vote the following slate of officers was elected.
President: Kristin Mitchell, MD
President Elect: Rhene Merkouris, MD
Secretary/Treasurer: Mary Klix, MD
AMA Delegate: Alex Malter, MD
AMA Alternate Delegate: Rhene Merkouris, MD
Trustee for the 2nd and 4th Districts: Jessica Panko, MD
Trustee for 3rd District: Christy Tuomi, MD
Physician Assistant Representative: Christi Froiland, PA-C

Committee Reports:

Physician Health Committee – Dr. Foland reported that the PHC continues to be busy. After years of work, the professional fitness questions on initial and renewal licensing applications are finally being updated to one question: "Are you currently suffering from any condition, mental or physical, that impairs your judgement or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?" All forms should be updated before the fall renewal cycle.

Network Adequacy:

Dr. Compton gave a recap on the 80th percentile litigation. The state has asked for mediation. After studying options and discussions at the Board of Trustees, the board has agreed to move forward with a Network Adequacy project. Insurance companies currently have all the claims data while physicians and practices are prohibited from discussing fees with each other, leading to an asymmetry of information. ASMA has worked to support the All Payer Claims Database in Alaska. One way insurers in the Lower 48 are controlling health care costs is to limit local networks. Insurer strategy is to have really narrow networks forcing many services

Meeting Minutes Continued Page 7

to be 'out of network' leading to more financial burden transferred to patients. Premera proposes to pay 175% of Medicare rates this year. The best way to protect patient access to adequate levels of care is by defining network adequacy. 37 states/territories have network adequacy language already in place. Alaska has a statute, but it is not well defined. Since physicians are the only ones advocating for patients in the state, the ASMA board believes this is the best way to protect patient access to care.

ASMA is contracting with Jeff Davis to develop this project. For the past 8 years, Jeff has been working on the provider side, mostly with radiation oncology groups. Prior to that he lived in Alaska and for 18 years was the CEO of Premera. He understands this issue from both sides and is uniquely qualified for this effort. Our plan is to customize language already approved by the National Association of Insurance Commissioners (NAIC) to define what constitutes an adequate network of providers. There will be a fundraising campaign to cover the cost of this effort.

Legislative Update:

Mr. Jardell reported that among the hundreds of bills that were introduced this session 60 bills dealt with health care in some way and were followed by ASMA. Only 15 bills have passed so far with just a few more days of the session remaining. A few bills consumed the most time and had the biggest impact on the medical community. These included naturopathic scope expansion, PA scope of practice, prior authorization, mammograms, lay midwives and the 80th percentile rule.

Naturopath scope of practice – This bill was moving through the House but stalled in House Finance. and is being held in Senate Labor and Commerce committee. There is significant need for physicians to contact their legislators during the interim to help educate the legislators on lack of naturopath training in prescribing medications and minor surgical procedures.

Physician Assistant Scope of Practice – both the medical association and the medical board had working groups with the physician assistant community to discuss their current regulations. This bill was brought to Senator Lora Reinbold by a constituent and would allow for PA independent practice. The bill moved rapidly through the Senate this year, the House is considering amendments to the bill

Prior Authorization – this bill adopts language similar to Texas' Gold Card program. The bill is progressing well and hopefully will pass this session.

Lay midwives – though very concerning to physicians this bill probably has low likelihood of passage due to many safety concerns.

Next meeting of the General Assembly will be on Wednesday, October 2nd, 2024, from 5 to 7:30 pm.

The meeting was adjourned at 6:50 pm.

Retired medical license in Alaska –

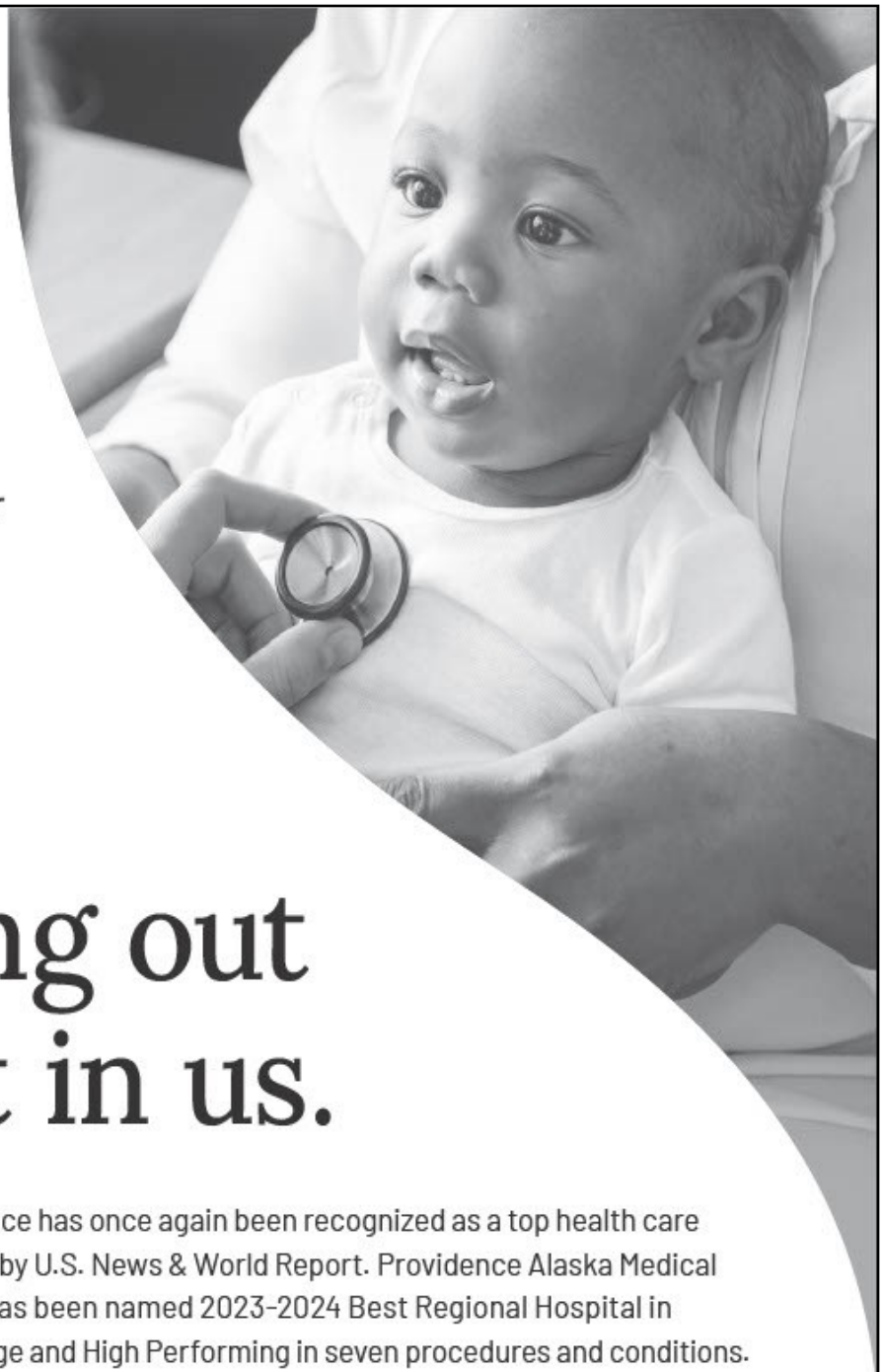
License renewal is coming up this fall. It's time to think about CME requirements (50 hours since January 1, 2023, two of which are "education in pain management and opioid use and addiction") unless you are thinking about converting to a retired status medical license.

Retired license: When retiring from practice in Alaska, you may convert your license to a retired status. There is a one-time fee for the remainder of the licensee's lifetime, and there is no CME requirement. A physician may not practice medicine with a retired license. In order to resume practice in Alaska, the retired status license must be reactivated. That requires submitting an application for reactivation, paying the required license fees, proof of meeting CME requirements, submittal of license verification and clearance documents, passing the SPEX exam, documentation of mental and physical competency to practice, and a full Board interview. You may wish to review the statutes and regulations regarding retired licenses; relevant sections include Alaska Statutes 08.64.276 and Professional Regulations 12 AAC 40.031.

Cost is $150

Sec. 08.64.276. Retired status license. (a) On retiring from practice and payment of an appropriate one-time fee, a licensee in good standing with the board may apply for the conversion of an active or inactive license to a retired status license. A person holding a retired status license may not practice medicine, osteopathy, or podiatry in the state. A retired status license is valid for the life of the license holder and does not require renewal. A person holding a retired status license is exempt from AS 08.64.312. (b) A person with a retired status license may apply for active licensure. Before issuing an active license under this subsection, the board may require the applicant to meet reasonable criteria as determined under regulations of the board, which may include submission of continuing medical education credits, reexamination requirements, physical and psychiatric examination requirements, an interview with the entire board, and review of information in the national data bank of the National Federation of State Medical Boards.

12 AAC 40.031. ACTIVATING A RETIRED STATUS LICENSE. (a) An applicant holding a retired status license under AS 08.64.276 will, in the board's discretion, be issued an active license to practice medicine, podiatry, or osteopathy in this state, as appropriate, if the applicant (1) submits a new and complete application as required by 12 AAC 40.010, documenting compliance with (A) AS 08.64.200 and 08.64.250, if a physician applicant; (B) AS 08.64.209 and 08.64.250, if a podiatry applicant; or (C) AS 08.64.205, if an osteopath applicant; (2) submits evidence of at least 50 hours of continuing medical education credits earned within the two years immediately before the date of application; (3) submits evidence of successful completion of the Special Purpose Examination (SPEX) prepared by the Federation of State Medical Boards; (4) submits, at the request of the board, physical and mental examination reports from practitioners approved by the board indicating that, at the time of the examination, the applicant is mentally and physically capable of practicing medicine, podiatry, or osteopathy safely; (5) submits information from the disciplinary data bank of the Federation of State Medical Boards; (6) is interviewed by a member of the board; and (7) pays the fees established in 12 AAC 02.250. (b) If the report required in (a)(5) of this section shows evidence of disciplinary action in this state or another licensing jurisdiction within the five years immediately before the date of application under (a)(1) of this section, the board will, in its discretion, deny an application for reactivation, if the evidence demonstrates that the applicant is not capable of practicing medicine, podiatry, or osteopathy safely or lawfully.



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Why Alaska Needs Health Network Adequacy

Lower 48 insurers implement narrow networks to the detriment of patients & providers alike!

AK has no specific network minimums

Lower 48 networks exclude as many as 80% of providers

Premera has publicly stated their goal of narrow AK networks with NO out-of-network benefits

Currently, providers can be excluded from networks at discretion of insurer without checks or balances

Adequacy is difficult for consumers to evaluate

Often leaves patients surprised by limited or no coverage for needed care

Requiring adequate network minimums will restore some market balance between insurers, patients and providers

Is there precedent for Network Adequacy Standards?

38 States and Territories have network adequacy standards

Patterned after model statutes/regulations from the National Association of Insurance Commissioners (NAIC)

Tailored to the needs of a specific geography, population and available providers

Washington, Montana, South Dakota and HI have standards in place

Premera and Moda must meet WA standards to conduct business there

NAIC Health Insurance and Managed Care Committee:

Considered network standards the top priority for 2023

Recognized rules as important to a well-functioning healthcare and insurance market

What's included in this Network Adequacy Project?

- Draft network adequacy standards for health insurance plans tailored to Alaska with specific standards for inclusion of specialists and primary care physicians
- Refine standards through discussions with the NAIC, State regulators, AK healthcare providers, Legislators, AK Division of Insurance, (DOI), and other relevant constituencies.
- Work with key health insurers to build support or minimize opposition to the proposed standards.
- Build support amongst stakeholders for the proposed standards
- Encourage the DOI to adopt the proposed standards as regulations under existing AK statute.
- If unsuccessful with the DOI, draft legislation and build support with key Legislators and other stakeholders and introduce network adequacy legislation in next Legislative session

Network Adequacy Continued on Page 11

Network Adequacy Continued

Project team will be led by Dr. Steve Compton under the direction of the ASMA Board, working closely with Kevin Jardell, ASMA's lobbyist, and Jeff Davis, consultant, to shepherd the bill through the process.

Glossary of Terms:

Narrow network – A provider network which does not include a significant portion of providers – in some instances in the Lower 48 up to 80% are excluded.

Adequate network – Contains sufficient breadth and depth of primary care and specialty providers to meet the expected healthcare needs of covered enrollees

Network minimums – Specific definition(s) of an adequate network based on geography, population and available providers

Out-of-network coverage – the level of payment an insurer provides when a consumer receives services from a provider not in the insurer's network

No out-of-network coverage – Zero payment from the insurer for services received from an out-of-network provider. No deductible or out of pocket maximum credit.

Market balance – when parties to a negotiation have equal influence over the outcome

National Association of Insurance Commissioners – Standard setting and regulatory support organization comprised of state insurance regulators from all 50 states, DC and five territories. Mission is to protect the public interest, promote competitive markets and improve state regulation of insurance.

Alaska Division of Insurance, (DOI) – State entity responsible for regulating the insurance industry to protect Alaskan consumers.

Model Statute/Regulations – Framework for the development and deployment of state specific solutions in either regulation (rules set by State agency) or Statute (laws enacted by the Legislature).

Jim Grazko, President Premera Blue Cross Blue Shield of Alaska, "One change that would help limit future spikes in the individual market is if the state could give insurers more flexibility in their plan design Grazko said. Currently, Alaska requires insurers to provide at least some coverage for services from providers even if they're outside the insurer's network, Grazko said. In Washington, Premera offers a plan with no out-of-network benefits that's 15% cheaper than an alternative plan with some out-of-network coverage. "That might be another way for consumers to have a choice of lower-cost options premium-wise, in exchange for maybe a narrower network or a little bit less choice on the provider side", he said." By Nathaniel Herz, Northern Journal, November 16, 2023

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