



Alaska Health Care Commission 2013 Voting Record

December 6, 2013 Meeting

9 Voting Members Present: Ward Hurlburt, Keith Campbell (via teleconference), Valerie Davidson, Jeff Davis, Emily Ennis, Thomas Harrell, David Morgan, Lawrence Stinson, Robert Urata
Absent: Allen Hippler; **Resigned** (seat vacant): Patrick Branco

Motion	Vote
Adopt the draft Finding & Recommendation Statements regarding evidence-based medicine, as revised in the draft dated 12-4-13 (pgs. 4-6), as final for the Commission's 2013 report.	Moved by Dr. Urata; seconded by Col. Harrell The motion passed unanimously.
Adopt the draft Finding & Recommendation Statements regarding employer engagement as revised in the draft dated 12-4-13 (pgs. 7-12), with the final bullet of Finding E (pg. 8) replaced with the recommended wording offered by Mr. Puckett*, as final for the Commission's 2013 report.	Moved by Mr. Davis; seconded by Dr. Urata The motion passed unanimously.
Adopt the draft Finding & Recommendation Statements regarding transparency and the health information infrastructure as revised in the draft dated 12-4-13 (pgs. 13-14) as final for the Commission's 2013 report.	Moved by Mr. Davis; seconded by Dr. Stinson The motion passed unanimously.
Adopt the draft Commission Plans for 2014 reflected in the draft dated 12-4-13 (pgs. 15), with the inclusion of a new bullet under Section II to continue studying the current condition of the behavioral health system, as final for the Commission's 2013 report.	Moved by Mr. Davis; seconded by Dr. Urata The motion passed unanimously.

* *"The State of Alaska, Department of Administration, has 62,000 covered lives in the AlaskaCare retiree health plan. This population consists of 16,000 under 65 retirees, 22,000 Medicare and 24,000 dependents. The non-diminishment clause of the Alaska State Constitution and subsequent decisions of the Alaska Supreme Court limits changes to the retiree health plan. Four billion dollars of the retirement systems' unfunded liability is attributed to retiree health care costs. Due to this unfunded liability any changes that add to retiree health plan expenses must be balanced with cost-saving measures."*



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November 1-6 electronic vote (via e-mail)

Vote to release the 10-31-13 Draft 2013 Findings & Recommendations for public comment
7 Voting Members Voting in Favor: Ward Hurlburt, Keith Campbell, Thomas Harrell, David Morgan, Lawrence Stinson, Robert Urata, Emily Ennis

1 Voting Member Voting in Favor with Exceptions: Allen Hippler, taking exception with Recommendation 4.b. under the Employer's Role, regarding restriction of reimbursement for repackaged pharmaceuticals.

2 Voting Members Abstaining (no response): Jeff Davis, Valerie Davidson

October 11, 2013 Meeting

10 Voting Members Present: Ward Hurlburt, Keith Campbell, Valerie Davidson, Jeff Davis, Emily Ennis, Thomas Harrell, Allen Hippler, David Morgan, Lawrence Stinson, Robert Urata
Resigned (seat vacant): Patrick Branco

Motion	Vote
Include in the Commission's 2013 draft Finding & Recommendation Statements for release for public comment a recommendation that continuing medical education on over-prescription of opioids and how to spot potential abusers be required for licensure/re-licensure of clinicians with prescription authority.	Moved by Dr. Urata; seconded by Dr. Stinson The motion passed unanimously.
Include in the Commission's 2013 draft Finding & Recommendation Statements for release for public comment a recommendation that the state adopt maximum opioid prescription dosage policies in state programs responsible for purchase of medical services.	Moved by Mr. Hippler; seconded by Mr. Morgan The motion passed unanimously.
Include in the Commission's 2013 draft Finding & Recommendation Statements for release for public comment, a recommendation that the state establish and support a real-time prescription opioid registry.	Moved by Mr. Davis; seconded by Dr. Stinson The motion passed on a vote of 9 to 1. <u>Voting in Favor:</u> Mr. Davis, Mr. Stinson, Mr. Morgan, Ms. Ennis, Dr. Urata, Mr. Campbell, Dr. Hurlburt, Col. Harrell, Ms. Davidson <u>Voting Opposed:</u> Mr. Hippler



Alaska Health Care Commission 2013 Voting Record

Motion	Vote
<p>Include the issue regarding the Division of Insurance UCR (usual and customary rate) regulation (3 AAC 26.110) on the Commission's 2014 agenda for further analysis.</p>	<p>Moved by Ms. Davidson; seconded by Dr. Stinson</p> <p>The motion failed on a vote of 6 to 3.</p> <p><u>Voting in Favor:</u> Ms. Davidson, Dr. Stinson <u>Voting Opposed:</u> Mr. Davis, Mr. Hippler, Dr. Urata, Mr. Campbell, Dr. Hurlburt, Col. Harrell <u>Recused for potential conflict:</u> Mr. Morgan (vote counted as "yea") <u>Absent for vote:</u> Ms. Ennis</p>
<p>Include in the Commission's 2013 draft Finding & Recommendation Statements for release for public comment, a recommendation that the Division of Insurance consider modifying the current UCR (usual and customary rate) regulation (3 AAC 26.110) to eliminate the unintended adverse pricing consequence.</p>	<p>Moved by Mr. Davis; seconded by Mr. Hippler</p> <p>The motion passed on a vote of 8 to 2.</p> <p><u>Voting in Favor:</u> Mr. Davis, Mr. Hippler, Ms. Ennis, Dr. Urata, Mr. Campbell, Dr. Hurlburt, Col. Harrell <u>Voting Opposed:</u> Ms. Davidson, Dr. Stinson <u>Recused for potential conflict:</u> Mr. Morgan (vote counted as "yea")</p>

June 21, 2013 Meeting

9 Voting Members Present: Ward Hurlburt, Patrick Branco, Keith Campbell, Jeff Davis, Thomas Harrell, Allen Hippler, David Morgan, Lawrence Stinson, Robert Urata

Absent: Valerie Davidson, Emily Ennis

Motion	Vote
<p>To adopt changes to the Alaska Health Care Commission By-Laws as noted in the 02-21-13 amended version and reviewed during the 03-08-13 meeting.</p>	<p>Moved by Mr. Morgan; seconded by Dr. Urata</p> <p>The motion passed on a vote of 8 to 1.</p> <p><u>Voting in Favor:</u> Mr. Davis, Col. Harrell, Mr. Campbell, Mr. Branco, Mr. Morgan, Dr. Hurlburt, Dr. Urata, Dr. Stinson <u>Voting Opposed:</u> Mr. Hippler</p>



Alaska Health Care Commission 2013 Voting Record

Motion	Vote
<p>To recommend a mandatory hospital discharge database for the purpose of providing data that will lead to health care policy decisions that will improve the health of Alaskans, and to provide price and quality transparency.</p> <ul style="list-style-type: none"> ▶ Amendment #1, offered by Mr. Branco, accepted by Dr. Urata: include additional facilities, including ambulatory surgery centers and imaging centers, and encourage federal facility participation. ▶ Amendment #2, offered by Mr. Branco, accepted by Dr. Urata: Remove the 1st amendment, and delete from the motion “and to provide price and quality transparency.” ▶ Amendment #3, offered by Mr. Branco, accepted by Dr. Urata: include additional facilities, including ambulatory surgery centers and imaging centers. ▶ Amendment #4, offered by Mr. Branco, accepted by Dr. Urata: include and encourage federal facility participation. <p>Final motion, as amended: To recommend a mandatory hospital discharge database for the purpose of providing data that will lead to health care policy decisions that will improve the health of Alaskans, and to encourage federal facility participation in that database.</p>	<p>Moved by Dr. Urata; seconded by Mr. Branco</p> <p><i>No vote taken – withdrawn by 2nd Amendment</i></p> <p>2nd Amendment passed unanimously</p> <p>3rd Amendment failed on a vote of 5 to 4. <u>Voting in Favor:</u> Mr. Davis, Dr. Urata, Mr. Campbell, Mr. Branco <u>Voting Opposed:</u> Col. Harrell, Dr. Stinson, Dr. Hurlburt, Mr. Hippler, Mr. Morgan</p> <p>4th Amendment passed unanimously.</p> <p>The motion as amended passed on a vote of 7 to 2. <u>Voting in Favor:</u> Mr. Davis, Col. Harrell, Mr. Campbell, Mr. Morgan, Dr. Hurlburt, Dr. Urata, Dr. Stinson <u>Voting Opposed:</u> Mr. Branco, Mr. Hippler</p>



Alaska Health Care Commission 2013 Voting Record

Motion	Vote
<p>To recommend the state immediately proceed with caution to establish an APCD and take a phased approach to developing an APCD, and include in the process:</p> <ul style="list-style-type: none">▶ Engage stakeholders in the planning and establishing parameters▶ Establish ground rules for data governance▶ Ensure appropriate analytical support to turn data into information and support appropriate use▶ Focus on consumer decision support as a first deliverable▶ Start with Commercial, Medicaid and Medicare first, then collaborate with other federal payers▶ Address privacy and security concerns	<p>Moved by Mr. Hippler Seconded by Mr. Campbell</p> <p>The motion passed unanimously.</p>

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: PATRICK J. BRANCO

MAILING ADDRESS: 218 RASBERRY LN. KETCHIKAN, AK 99901
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): (907)617-2275 Fax: 907-228-8563

E-MAIL: pbranco@kpunet.net

SPOUSE / DOMESTIC PARTNER: VICKI K. BRANCO

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):

JOSEPH P. BRANCO
MICHAEL J. BRANCO

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: PEACEHEALTH

Address: 3100 TONGASS AVE, KETCHIKAN, AK 99901

DESCRIPTION of WORK PERFORMED: HOSPITAL CEO

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

**ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT**

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

**ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT**

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: 

PATRICK J. BRANCO
NAME of FILER

6/24/13
DATE & PLACE SIGNED / FILED

*Alaska Health Care Commission members are solely responsible
for filing complete, accurate and truthful statements.*

THIS IS A PUBLIC DOCUMENT

ALASKA HEALTH CARE COMMISSION
3601 C Street, Suite 902
Anchorage, AK 99503-5923
907-334-2474
Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
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FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

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THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: C. Keith Campbell

MAILING ADDRESS: Box 722 Seward AK 99664
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 224-5631 - 362-1624-C Fax: _____

E-MAIL: KeithCampbell@aci.net

SPOUSE / DOMESTIC PARTNER: Jackie Campbell

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):
Daniel Campbell, David Campbell, Douglas Campbell

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
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SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT

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SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

**ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT**

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

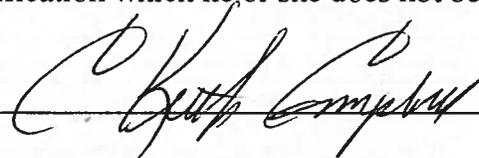
List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE:



NAME of FILER

C. Keith Campbell

6-20-13

DATE & PLACE SIGNED / FILED

*Alaska Health Care Commission members are solely responsible
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THIS IS A PUBLIC DOCUMENT

ALASKA HEALTH CARE COMMISSION

3601 C Street, Suite 902
Anchorage, AK 99503-5923
907-334-2474
Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
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THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: Valerie Davidson c/o ANTHC
4000 Ambassadors Dr.
Anchorage, AK 99508

MAILING ADDRESS: ~~4000 Ambassadors Dr. Anchorage, AK 99508~~
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 907-350-0572 Fax: 907-729-1901

E-MAIL: vdavidson@anthc.org

SPOUSE / DOMESTIC PARTNER: N/A

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):
Kylie Negale
Atara Negale

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: Alaska Native Tribal Health Consortium

Address: 4000 Ambassadors Drive, Anchorage, AK 99508

DESCRIPTION of WORK PERFORMED: Legal & Intergovernmental Affairs

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT

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SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
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SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

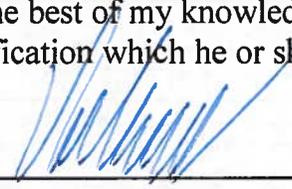
List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: _____



Valerie Davidson

NAME of FILER

8/21/13

DATE & PLACE SIGNED / FILED

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THIS IS A PUBLIC DOCUMENT

ALASKA HEALTH CARE COMMISSION
 3601 C Street, Suite 902
 Anchorage, AK 99503-5923
 907-334-2474
 Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
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FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: Jeffrey W. Davis

MAILING ADDRESS: 2550 Denali St, #1404
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 907-677-2404 Fax: _____

E-MAIL: jeff.davis@premera.com

SPOUSE / DOMESTIC PARTNER: Suzanne K. Davis

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):
Christopher, Nicholas, Blake

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: Premier Blue Cross

Address: 2550 Denali St, #1404

DESCRIPTION of WORK PERFORMED: Health Insurance Executive

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: University of Arizona Medical Center

Address: _____

DESCRIPTION of WORK PERFORMED: Resident physician in
Emergency Medicine

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
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SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

**ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT**

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE:

Jeffrey W. Davis

Jeffrey W. Davis

NAME of FILER

6/21/13 Anch AK

DATE & PLACE SIGNED/ FILED

*Alaska Health Care Commission members are solely responsible
for filing complete, accurate and truthful statements.*

THIS IS A PUBLIC DOCUMENT

ALASKA HEALTH CARE COMMISSION

3601 C Street, Suite 902
Anchorage, AK 99503-5923
907-334-2474
Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: Emily F. Ennis

MAILING ADDRESS: 1188 W. Chena Hills Dr., Fairbanks 99709
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 907-479-4371 Fax: _____

E-MAIL: emily@fra-alaska.net

SPOUSE / DOMESTIC PARTNER: Lawrence A. Gooding

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):

Alison Gifford
Megan Gooding

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: Fairbanks Resource Agency

Address: 805 Airport Way, Fairbanks 99701

DESCRIPTION of WORK PERFORMED: Executive Director

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT *page 1*

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: Magellan EAP

Business/Client/Customer address: 14100 Magellan Plaza, Maryland Heights MO 63043

DESCRIPTION of services provided: Psychological Therapy

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: TriWest

Business/Client/Customer address: PO Box 77028, Madison, WI 53707

DESCRIPTION of services provided: Psychological Therapy

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: Menitain Health

Business/Client/Customer address: 1405 Xenium Lane North #140, Minneapolis, MN 55441

DESCRIPTION of services provided: Psychological Therapy

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: Adult Learning Programs of Alaska

Business/Client/Customer address: 60 Hall Street, Fairbanks, AK 99701

DESCRIPTION of services provided: Psychological Therapy

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input checked="" type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: Emily F. Ennis

Emily F. Ennis
NAME of FILER

8/8/13 Anchorage
DATE & PLACE SIGNED / FILED

*Alaska Health Care Commission members are solely responsible
for filing complete, accurate and truthful statements.*

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ALASKA HEALTH CARE COMMISSION
3601 C Street, Suite 902
Anchorage, AK 99503-5923
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ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT *page 2 continued* NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.
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EARNED BY: Filer / Spouse/domestic partner / Child
Business/Client/Customer name: Premera Blue Cross BlueShield of Alaska
Business/Client/Customer address: PO Box 240609, Anchorage, AK 99524
DESCRIPTION of services provided: Psychological Therapy

EARNED BY: Filer / Spouse/domestic partner / Child
Business/Client/Customer name: Welfare and Pension (WPAS)
Business/Client/Customer address: PO Box 34840, Seattle, WA 98124
DESCRIPTION of services provided: Psychological Therapy

EARNED BY: Filer / Spouse/domestic partner / Child
Business/Client/Customer name: Cigna EAP
Business/Client/Customer address: PO Box 188022, Chattanooga, TN 37422
DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child
Business/Client/Customer name: ComPsych EAP
Business/Client/Customer address: PO Box 8379, Chicago, IL 60680
DESCRIPTION of services provided: Psychological Therapy

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

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RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: Emily F Ennis

Emily F Ennis
NAME of FILER

8/8/13 Anchorage
DATE & PLACE SIGNED / FILED

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ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: Thomas Harrell

MAILING ADDRESS: 7448 Quesada Ave JBER, AK 99506
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 580-3006 223-6251 Fax: _____

E-MAIL: thomas.harrell@us.af.mil

SPOUSE / DOMESTIC PARTNER: Caryse (Carol)

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):
Brent, Chad, Krista

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: USAF

Address: 5955 Zenger Ave JBER, AK 99506

DESCRIPTION of WORK PERFORMED: Hospital Commander/Cardiologist

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

**ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT**

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: HARRELL.THOMAS.W.1186848396

Digitally signed by HARRELL.THOMAS.W.1186848396
DN: c=US, o=U.S. Government, ou=DoD, ou=PKI, ou=USAF,
cn=HARRELL.THOMAS.W.1186848396
Date: 2013.08.31 16:46:46 -08'00'

NAME of FILER

DATE & PLACE SIGNED / FILED

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ALASKA HEALTH CARE COMMISSION

3601 C Street, Suite 902
Anchorage, AK 99503-5923
907-334-2474
Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: Allen Hippler

MAILING ADDRESS: 6730 CROOKED TREE CIR ANCHORAGE AK 99507
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 907 344 2522 Fax: 344 2836

E-MAIL: allen@faulknerwalsh.com

SPOUSE / DOMESTIC PARTNER: Christine Hippler

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):

Allen, Aaron, Perpetua, Rosalie, Andrew, Aidan, Alexander.
~~All~~ All last name Hippler

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

**ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT**

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: Allen Hippler

Allen Hippler
NAME of FILER

Anchorage, AK
6-17-13
DATE & PLACE SIGNED / FILED

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for filing complete, accurate and truthful statements.*

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ALASKA HEALTH CARE COMMISSION

3601 C Street, Suite 902
Anchorage, AK 99503-5923
907-334-2474
Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: WARD B. HURLBURT

MAILING ADDRESS: 17901 SPAIN DR, ANCHORAGE, AK, 99516
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 907 269 6670 Fax: _____

E-MAIL: ward.hurlburt@alaska.gov

SPOUSE / DOMESTIC PARTNER: Jesperus T. Hurlburt

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):
Ward's Hurlburt IV
Cypher E. Decker

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT

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SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: STATE OF ALASKA

Address: 3601 C STREET, SUITE 156, ANCHORAGE AK 99503

DESCRIPTION of WORK PERFORMED: CHIEF MEDICAL OFFICER
DEPARTMENT OF HEALTH & SOCIAL SERVICES
(currently 80% part time full time employee)

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT

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SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

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EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

**ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT**

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SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

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RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: Ward B Hurlbert

WARD B HURLBERT

NAME of FILER

Anchorage, AK
6/19/13

DATE & PLACE SIGNED / FILED

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Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: David Morgan

MAILING ADDRESS: 2170 Stanford Drive, Anchorage, Alaska 99508
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): (907) 317-5724 (or) (907) 563-4812 Fax: N/A

E-MAIL: MorganDavidConnie@gmail.com

SPOUSE / DOMESTIC PARTNER: Connie Morgan

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):

Arron Morgan and Paul Morgan

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: Southcentral Foundation

Address: 4201 Tudor Center Drive, Suite 320 - Anchorage, Alaska 99508

DESCRIPTION of WORK PERFORMED: Cost Based Reimbursement - Medicare/Medicaid Cost Report, CHC Costs/LOS Reports, and Provider Enrollment (Medicare, Medicaid, and TRICARE)

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

**ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT**

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: David Morgan

David Morgan
NAME of FILER

6/17/2013 - 4201 Tudor Center Drive
DATE & PLACE SIGNED / FILED

*Alaska Health Care Commission members are solely responsible
for filing complete, accurate and truthful statements.*

THIS IS A PUBLIC DOCUMENT

ALASKA HEALTH CARE COMMISSION

3601 C Street, Suite 902
Anchorage, AK 99503-5923
907-334-2474
Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: LAWRENCE STINSON

MAILING ADDRESS: 1917 Abbott Rd, Anchorage, AK 99507
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 907 278-2741 Fax: _____

E-MAIL: _____

SPOUSE / DOMESTIC PARTNER: ELIZABETH

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home): LAWRENCE, JAMES, SARAH, MATTHEW

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: Advanced Pain Centers of Alaska

Address: 1917 Abbott Rd, Suite 100, Anchorage, AK 99507

DESCRIPTION of WORK PERFORMED: Physician

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: South Anchorage Surgery Center

Address: 1917 Abbott Rd, Anchorage, AK 99507

DESCRIPTION of WORK PERFORMED: Physician

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: Pioneer Peak Surgery Center

Address: No longer active

DESCRIPTION of WORK PERFORMED: Physician

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

**ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT**

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

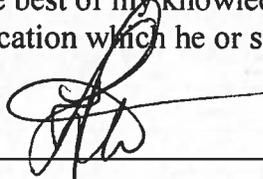
List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: _____



NAME of FILER

LAWRENCE STINSON

DATE & PLACE SIGNED / FILED

6-20-13 Anchorage AK

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for filing complete, accurate and truthful statements.*

THIS IS A PUBLIC DOCUMENT

ALASKA HEALTH CARE COMMISSION

3601 C Street, Suite 902
Anchorage, AK 99503-5923
907-334-2474
Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: Robert Urata

MAILING ADDRESS: 3250 Glacier Hwy Juneau, AK 99801
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 907 223 4144 Fax: 907 5862434

E-MAIL: bcurata@gei.net

SPOUSE / DOMESTIC PARTNER: Christie

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):
Kari Pipolo, Kiel Urata, Kimiko Urata

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2013 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2012– Dec. 31, 2012

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: Valley Medical Care

Business/Client/Customer address: 1801 Salmon Creek Lane Juneau AK 99801

DESCRIPTION of services provided: Family Medicine -

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: ~~Pacific~~ ^{Pacific} Mountain ^{or} Quality Health

Business/Client/Customer address: They are in Montana I believe

DESCRIPTION of services provided: Review charts for whether patients in hospital are discharged or not, (for CMS) appropriately,

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: Dept Federal Occupational Health Clinic

Business/Client/Customer address: Juneau Federal Building Juneau, AK 99801

DESCRIPTION of services provided: Occupational Health Clinic -
Do Occupational health evaluations -

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: Wrangell Medical Center

Business/Client/Customer address: Wrangell Alaska 99429

DESCRIPTION of services provided: Sort of a medical Director + provide peer review. Done mostly by phone. I don't practice in Wrangell



THE STATE
of **ALASKA**

GOVERNOR SEAN PARNELL

**Department of
Health and Social Services**

Alaska Health Care Commission

3601 C Street, Suite 902
Anchorage, Alaska 99503-5924

Main: 907.269.7800

Fax: 907.269.0060

MEMORANDUM

DATE: October 2, 2013

TO: Angie White, Litigation Assistant
Department of Law
Opinions, Appeals, & Ethics Section

FROM: Ward Hurlburt, MD, MPH, Chair
Alaska Health Care Commission
Department of Health & Social Services

A handwritten signature in blue ink, appearing to read "Ward Hurlburt".

SUBJECT: Executive Branch Ethics Act, AS 39.52 Quarterly Report:
July 1 – September 30, 2013

As designated ethics supervisor and chair for the Alaska Health Care Commission, I wish to advise you that I have received no notifications of potential violations or requests for ethics determinations under the Ethics Act (AS 39.52) and have made no written determinations for this quarter.

No other commissioner disclosed a potential conflict of interest at a recorded public meeting during this quarter.

Ethics Supervisor Quarterly Statistical Summary*

Reporting Period July 1-September 30, 2013

Alaska Health Care Commission

Reporting Agency, Board, Commission or Public Corporation

<u>Type of Disclosure</u>	<u>Number Reviewed</u>
---------------------------	------------------------

All agencies, boards, commissions and public corporations:

Notices of Potential Violation	<u>0</u>
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Requests for Ethics Determination	<u>0</u>
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Gifts	<u>0</u>
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Gifts from Other Governments	<u>0</u>
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Interests in Contracts, Grants, Leases, Loans	<u>0</u>
---	----------

Agencies only:

Outside Employment or Services	<u>0</u>
--------------------------------	----------

Boards, commissions and public corporations only:

Conflicts of Interest stated orally at board/commission meetings	<u>0</u>
---	----------

** Please report the total number of written disclosures in each category, regardless of disposition. You need not report informal oral or email contacts, only those disclosures submitted on ethics disclosure forms.*

** Attach this summary to your regular quarterly report.*



THE STATE
of **ALASKA**
GOVERNOR SEAN PARNELL

**Department of
Health and Social Services**

Alaska Health Care Commission

3601 C Street, Suite 902
Anchorage, Alaska 99503-5924
Main: 907.269.7800
Fax: 907.269.0060

MEMORANDUM

DATE: July 2, 2013

TO: Angie White, Litigation Assistant
Opinions, Appeals, & Ethics Section
Department of Law

FROM: Ward Hurlburt, MD, MPH, Chair *WH*
Alaska Health Care Commission
Department of Health & Social Services

SUBJECT: Executive Branch Ethics Act, AS 39.52 Quarterly Report: April 1 – June 30, 2013

As designated ethics supervisor and chair for the Alaska Health Care Commission, I wish to advise you that I have received no notifications of potential violations or requests for ethics determinations under the Ethics Act (AS 39.52) and have made no written determinations for this quarter.

No other commissioner disclosed a potential conflict of interest at a recorded public meeting during this quarter.

Ethics Supervisor Quarterly Statistical Summary*

Reporting Period April 1 - June 30, 2013

Alaska Health Care Commission

Reporting Agency, Board, Commission or Public Corporation

<u>Type of Disclosure</u>	<u>Number Reviewed</u>
---------------------------	------------------------

All agencies, boards, commissions and public corporations:

Notices of Potential Violation	<u>0</u>
--------------------------------	----------

Requests for Ethics Determination	<u>0</u>
-----------------------------------	----------

Gifts	<u>0</u>
-------	----------

Gifts from Other Governments	<u>0</u>
------------------------------	----------

Interests in Contracts, Grants, Leases, Loans	<u>0</u>
---	----------

Agencies only:

Outside Employment or Services	<u>0</u>
--------------------------------	----------

Boards, commissions and public corporations only:

Conflicts of Interest stated orally at board/commission meetings	<u>0</u>
---	----------

* Please report the total number of written disclosures in each category, regardless of disposition. You need not report informal oral or email contacts, only those disclosures submitted on ethics disclosure forms.

* Attach this summary to your regular quarterly report.



THE STATE
of **ALASKA**
GOVERNOR SEAN PARNELL

**Department of
Health and Social Services**

Alaska Health Care Commission

3601 C Street, Suite 902
Anchorage, Alaska 99503-5924
Main: 907.269.7800
Fax: 907.269.0060

MEMORANDUM

DATE: April 4, 2013

TO: Angie White, Litigation Assistant
Opinions, Appeals, & Ethics Section
Department of Law

FROM: Ward Hurlburt, MD, MPH, Chair
Alaska Health Care Commission
Department of Health & Social Services 

SUBJECT: Executive Branch Ethics Act, AS 39.52 Quarterly Report: January – March, 2013

As designated ethics supervisor and chair for the Alaska Health Care Commission, I wish to advise you that I have received no notifications of potential violations or requests for ethics determinations under the Ethics Act (AS 39.52) and have made no written determinations for this quarter.

No other commissioner disclosed a potential conflict of interest at a recorded public meeting during this quarter.

Ethics Supervisor Quarterly Statistical Summary*

Reporting Period January 1-March 31, 2013

Alaska Health Care Commission

Reporting Agency, Board, Commission or Public Corporation

<u>Type of Disclosure</u>	<u>Number Reviewed</u>
---------------------------	------------------------

All agencies, boards, commissions and public corporations:

Notices of Potential Violation	<u>0</u>
--------------------------------	----------

Requests for Ethics Determination	<u>0</u>
-----------------------------------	----------

Gifts	<u>0</u>
-------	----------

Gifts from Other Governments	<u>0</u>
------------------------------	----------

Interests in Contracts, Grants, Leases, Loans	<u>0</u>
---	----------

Agencies only:

Outside Employment or Services	<u>0</u>
--------------------------------	----------

Boards, commissions and public corporations only:

Conflicts of Interest stated orally at board/commission meetings	<u>0</u>
---	----------

** Please report the total number of written disclosures in each category, regardless of disposition. You need not report informal oral or email contacts, only those disclosures submitted on ethics disclosure forms.*

** Attach this summary to your regular quarterly report.*