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ALASKA HEALTH CARE COMMISSION

3601 "C" STREET

SUITE 896

ANCHORAGE, ALASKA

OCTOBER 14, 2010

8:00 A.M.

VOLUME 1

PAGES 1 TO 247

1 Wasilla, and in Fairbanks. And my personal goals in my
2 practice, as well as goals of the Health Care Commission, are
3 how do you deliver the best care possible to the people at the
4 best and lowest economic cost to them, and I think that's
5 primarily what we're all trying to do.

6 COMMISSIONER KELLER: I'm Wes Keller, a state
7 representative from Wasilla and one of the ex officio members,
8 non-voting members of the Commission, and it's just a delight
9 to be here.

10 COMMISSIONER STEVENS: Good morning, Wayne Stevens,
11 President and CEO of the Alaska State Chamber of Commerce and
12 looking forward to the continuation of the great work we
13 wrapped up last year.

14 COMMISSIONER ERICKSON: Good morning, I'm Deb Erickson,
15 staff to the Commission and I'm very happy to see everybody
16 here this morning. Thank you.

17 COMMISSIONER LAUFER: Good morning, I'm Noah Laufer. I'm
18 a family doc in Anchorage. I'm actually President of a
19 private family practice called Medical Park Family Care.
20 We've been here about 40 years. I'm a second generation doc
21 at that practice. I practice right across the street from
22 where I went to junior high. I have strong biases about
23 primary care. I hear them parroted everywhere, but I haven't
24 seen a lot of action. I'm here for one year to see if I can
25 push things along. Thanks.

1 CHAIR HURLBURT: I'm Ward Hurlburt. I'm the Director of
2 the Public Health Division with the State here in Alaska and
3 Chief Medical Officer of the Department of Health and Social
4 Services.

5 SENATOR OLSON: And I'm Donald Olson, the doctor up in
6 Nome who is now serving the State Senate. It's pretty obvious
7 that we are in an upheaval as far as the health care delivery
8 system, and because of what's going on nationally as well as
9 statewide, we need to go ahead and have a handle on it. And
10 as a legislator and a non-voting member, I've been looking for
11 direction from the Commission on what kind of state
12 legislative fix we can try and put in place that would
13 facilitate as what Dr. Stinson had talked about.

14 COMMISSIONER MORGAN: I'm Dave Morgan. I'm representing
15 the 26 Community Health Center programs with 147 delivery
16 sites across the state. I have detailed instructions from the
17 Board of the Community Health Center Board listing issues and
18 concerns, and contrary to what Debby's expecting because we've
19 known each other a long time, I think I'll submit those in
20 writing and we'll move this right along. How's that?

21 COMMISSIONER DAVIDSON: Good morning. (Speaking Native
22 language), I'm Valerie Davidson. I am originally from Bethel.
23 My mom's family is from Guoyilok (sp), and my dad's family is
24 originally from Port Orchard, Washington. I worked at the
25 Alaska Native Tribal Health Consortium, and I think I'll save

1 my dreams and hopes for later on in the discussion.

2 COMMISSIONER ENNIS: Good morning, I'm Emily Ennis. I'm
3 from Fairbanks where I am Executive Director of Fairbanks
4 Resource Agency, a community-based service providing long term
5 care for individuals with developmental disabilities and
6 seniors with Alzheimer's disease and related disorders. Today
7 I'm here representing the Alaska Mental Trust and its four
8 beneficiary groups and I'm very pleased to be here.

9 COMMISSIONER BRANCO: Good morning, my name is Patrick
10 Branco. I'm the CEO and Chief Mission Officer of Ketchikan
11 General Hospital in the deep south. That's my accent here.
12 I've been there about nine years and really looking forward to
13 serving this Commission.

14 COMMISSIONER CAMPBELL: I'm Keith Campbell. I reside in
15 Seward. I was a Hospital Administrator there for 20 years,
16 and I've been doing other things for the last 20, volunteer
17 work primarily. But I am the Consumer Representative on the
18 Board. My perspective may be a little bit unique, as I've sat
19 on a lot of the Boards that I see around the table, the
20 Hospital Association, the Chamber of Commerce, Blue Cross
21 Board, et cetera. So I hope to bring that perspective to the
22 discussions and planning of this organizations. Pleased to be
23 reappointed. Thank you.

24 UNIDENTIFIED MALE: Ward, could we start with you?

25 (Pause - no microphone on 8:13:50 to 8:14:23)

1 MS. FISCHER: Hi, I'm Chelsea Fischer and I'm a current
2 medical school applicant, specifically doing (indiscernible -
3 away from mic).

4 MS. SMITH: Good morning, my name is Rebekah Smith and
5 I'm actually a fourth year medical student in the WWAMI
6 program.

7 MR. PETERSON: Good morning, my name is Loren Peterson
8 and I'm staff to Senator Donny Olson.

9 MR. LIND (sp): Good morning, I'm Woolsey Lind. I'm just
10 a citizen interested in Medicare delivery.

11 MR. HORN: Good morning, I'm Steve Horn. I'm from
12 Soldotna. I'm the Executive Director of the Alaska Behavioral
13 Health Association representing behavioral health proprietors
14 and grantees throughout the State.

15 MS. CULPEPPER: Good morning, I'm Delisa Culpepper. I'm
16 the Chief Operating Officer for the Alaska Mental Health
17 Trust.

18 MR. CHARD: Good morning, my name is Tom Chard. I work
19 for the Advisory Board on Alcoholism and Drug Abuse and also
20 the Alaska Mental Board.

21 CHAIR HURLBURT: Thank you. We welcome everybody here.
22 There will be a time that we'll have some opportunity for
23 public comment later on and that's in your agenda and we do
24 welcome you. I know there will be others who will be coming
25 in. Deb, could we ask you now to go over the agenda and

1 ground rules?

2 COMMISSIONER ERICKSON: I wanted to review our plans for
3 the next -- thank you, sir; you need to keep me honest -- day
4 and a half. So if you have your agendas -- they're printed on
5 blue paper behind tab one in your notebooks, and for folks in
6 the audience, there are copies of the agenda on the back table
7 as well as some of the handouts for today, copies of all of
8 the PowerPoint presentations we'll have today, too.

9 Actually before I review the agenda, I think I'd just now
10 ask that everybody who is here from the public, if you
11 wouldn't mind signing in and letting me know if you'd like to
12 join the Commission's ListServ, I'd appreciate it. And
13 everybody should feel free to have some breakfast, and we'll
14 have lunch delivered later today, too.

15 So as far as our plans for the day, this whole meeting,
16 we're really devoted to kind of a bit of review and catch up
17 for the former members of the Commission. We have five new
18 members on now our 14 member Commission and so it's also an
19 opportunity to provide an overview of what the Commission
20 studied and accomplished in their first year as well. So we
21 have a good kind of common starting point for jumping off for
22 planning for 2010.

23 And we're rushing a bit to get through some of the
24 planning work for this year because we only have three months
25 of the year before we have an annual report due on January

1 15th. So we'll talk a little bit more about that later. But
2 we're just coming up-to-speed at this meeting as much as
3 possible and jumping off from some of the issues that were
4 introduced at our very last meeting at the end of 2009.

5 So today, we're going to start with an overview by Dr.
6 Hurlburt of some main points about health and health care in
7 the State and then I'll give an overview of the Commission's
8 report and talk about a strategy for moving forward. And then
9 you all will have an opportunity to spend a good hour and a
10 half sharing with each other what your particular interests
11 and concerns about health and health care in Alaska are right
12 now.

13 We'll have just a real short break for lunch. We have
14 sandwiches being brought in. And then we'll go into a public
15 comment period, and we do have -- can we say we have a
16 tradition now if we've just met for a year? Every meeting,
17 we've held a public comment period and we'll continue to do
18 that.

19 Then we have the Assistant Attorney General from the
20 State Department of Law who is responsible for ethics in state
21 government is coming to make a presentation and have a
22 conversation with you, answer any questions you might have
23 after the public comment period. And then I'm going to try to
24 very quickly just go through some administrative business.

25 We'll review the budget I've drafted for the current

1 state fiscal year and also Dr. Hurlburt has a small proposed
2 Bylaws change for our existing Bylaws that we can talk about.
3 We'll spend just a half hour doing that and then we're going
4 to spend just a little over an hour talking about what is
5 happening with federal health care legislation, and I have
6 just an overview presentation that I will try to get through
7 very quickly, which is really hard to do with 1,000 page law,
8 but hit at least the highlights and the main points. And then
9 Mark Foster who is a local economist here who has really been
10 studying the economic impacts, taking some of the national
11 models and pulling Alaska data in will talk with us about his
12 analysis so far on the economic impacts to the State of Alaska
13 Federal Reform.

14 Then tomorrow morning for our half day, we're going to
15 start -- this was our jumping off point from the last meeting.
16 We were just introduced to the concept of evidence-based
17 medicine by a very brief conversation that Dr. Hurlburt gave
18 the group at our very last meeting. And then for those of you
19 who here might recall Dr. Cahana, Dr. Stinson had invited up
20 from the University of Washington talking about many of the
21 same concepts.

22 So we'll have a more in-depth presentation by Dr.
23 Hurlburt tomorrow morning and a conversation about that. And
24 then we'll spend the rest of the morning tomorrow talking
25 about our goals for this -- again our three-month year that we

1 have here. What do we want to try to accomplish and make sure
2 we get included in that report? Kind of set the agenda, begin
3 to set the agenda for the next year, the issue areas,
4 identifying issue areas where you all feel we need to learn
5 more about health and health care in the State in order to be
6 better informed for developing good recommendations and then
7 identifying some high priority strategies, what do you think
8 we should start studying for future recommendations. So we
9 will have that conversation together tomorrow morning and
10 wrap-up by noon. Does anybody have any questions about our
11 plans for the next day-and-a-half?

12 Just very quickly, I'm not going to go over this in any
13 detail, but I want to refer you to the pink sheet that's
14 behind your agenda, the meeting ground rules. Pretty basic.
15 There shouldn't be anything surprising here, but I include the
16 meeting ground rules in our notebook each time we meet but we
17 don't spend much time reviewing them. So I'll leave you to
18 read them yourself, but again just some of the basics,
19 practice active listening and don't interrupt each other. I'm
20 sure we don't even need to remind people of that. Keep your
21 cell phones on vibrate or silent if you can. Try as much as
22 possible to avoid jargon and talking in acronyms. I don't
23 think it's been too big of a problem with this group, but
24 usually if you get a bunch of government bureaucrats around
25 the table, it's hard to understand what they're talking about.

1 And then Dr. Hurlburt referenced our decision making
2 process. We try to be as informal as possible and don't have
3 us Robert's Rules religiously for every single discussion, but
4 whenever we do take a vote on kind of an official formal
5 decision, whether it's about a recommendation, a finding you
6 want to make sure is included in the report -- probably some
7 of our important business stuff, like approving the agenda --
8 we do have to record the individual votes, and our new law
9 requires that we provide a recording of all of the votes taken
10 during the year in our annual report. We'll include that as
11 an appendix. We weren't quite that formal last year, but now
12 we'll be a little more formal with that. For the most part,
13 we just try to make decisions by consensus though and don't
14 get too formal. Any questions about meeting rules and
15 process?

16 You all should have received -- somebody maybe picked up
17 their Table Tent without it -- the packet of additional
18 handouts. I just want to make sure you all saw and got those,
19 and you should be able to, hopefully, easily slip them in
20 where they belong. There is a Post-It note. If you could
21 just put them on top of whatever packet of which tab each
22 section goes behind?

23 And I think that's it. I think that's it for introducing
24 the day in our meeting rules and process. I'm trying to think
25 if there's anything logistical.

1 CHAIR HURLBURT: Anybody have any questions about that as
2 far as what Deb said introducing us? Thank you, Deb.

3 We'll move on. I maybe should apologize for the next 30
4 or 40 minutes. I'm going to provide some background and some
5 framework and do it in a fairly formal way. Normally I'll be
6 more informal when I talk, and tomorrow when we talk about
7 evidence-based medicine, I am. But I felt this was important
8 that I'll have a fairly formal presentation here for you.

9 In February of 2007, Governor Sarah Palin established the
10 Alaska Health Care Strategies Planning Council and that group
11 was tasked to develop strategies addressing access, cost,
12 quality of health care in Alaska, and the membership included
13 Jeff Davis who is the continuity between those two groups here
14 for us. That Commission met for a total of 24 hours,
15 generated dozens of possible solutions, largely with what was
16 described as brainstorming. The development of implementation
17 plans was considered beyond the scope of that short-lived
18 group, and the group also -- the time limitations precluded
19 them from being able to address the establishing of the
20 Administrative Order's directive to present fiscal information
21 to accompany each of the short and long term suggested
22 strategies. So next slide, please, Deb.

23 The legislation establishing this Commission which
24 followed on with, again, an Administrative Order from Governor
25 Palin initially establishing the current Commission in

1 December of 2008, the Legislature in 2010 session established
2 this Commission, with the Governor's Order, could last about a
3 year. The Legislature established it with a sunset of 2014 at
4 this point, and the Legislative Order, in part, addressed that
5 this Commission needed to deal with issues of quality,
6 accessibility, availability. Next slide, please.

7 And then in another portion of that legislation, we were
8 directed to reduce health care costs by using savings from,
9 and listed as you there, enhanced market forces, fraud
10 reduction, health information technology, management
11 efficiency, preventive medicine, successful innovations
12 identified by other states, and other cost-saving measures.
13 So the listing of perceived opportunities for cost reduction
14 highlights, to me, the important aspect of this part of our
15 charge.

16 And in addition in conversations that I have had with
17 members of the Legislature, including Senator Olson and
18 Representative Keller and others, Representative Hawker, the
19 Chair of House Finance Committee who also claims some
20 paternity for this group, there have been a number of members
21 of the Legislature who have been interested in this. Clearly,
22 their hope and their intent and their desire is that we help
23 lead the way in getting a handle on health care costs in
24 Alaska. My own bias is that, if we're able to deal with
25 issues -- that before we can really deal with issues of

1 quality, accessibility, availability, we have to forthrightly
2 address issues of cost and so that will be an important part
3 of what we do.

4 The list there talks about various things. And sometimes
5 when a candidate's running for office, the candidate will be
6 asked, well, are you going control costs, and the answer is
7 efficiency and fraud and abuse, and sometimes, those are easy
8 answers to give and we know there is more than that. Fraud is
9 a real thing. The members of the Legislature are interested
10 in it. Nationally, we're interested in it.

11 Some of you probably saw the news item yesterday that
12 there was an Armenian-American group that submitted bills of
13 about \$100 million over a four-year period to Medicare. They
14 received about \$35 million, and it was described that an
15 otolaryngologist ordered an ultrasound for a pregnant woman, a
16 forensic pathologist had his patients walking into their
17 office rather than being wheeled in, a dermatologist conducted
18 heart tests, a psychiatrist performed MRIs. Well the fact
19 was, none of these physicians knew what was happening. Their
20 identities had been stolen. There were identified patients
21 that were identified docs, but neither the patients nor the
22 docs knew what was happening.

23 So we know fraud is real, but we are not going to solve
24 the problem. And we also know that the issues of fraud are
25 sometimes abused and we talked about it of investigators

1 walking into physicians' offices with weapons and disrupting
2 the office and getting records and that goes on. So it's a
3 part of our charge, and it is real, and we need to be
4 sensitive to it there. Next slide, please.

5 We do, indeed, have the highest priced medical costs in
6 the country. Since we, as a nation, spend 50% to 100% more
7 than other industrialized countries around the world, we have
8 very high costs of health care here in Alaska. The country
9 that is closest to the United States in terms of spending a
10 percent of their Gross Domestic Product in dollar equivalents
11 compared to the United States is Switzerland, and Switzerland
12 -- we're about 50% more than Switzerland spends. In a recent
13 year, Switzerland spent \$3,800 a person per year for health
14 care, and we spent \$5,700. We've left that behind, and I'll
15 mention the current numbers lately. In that same year, Canada
16 spent just a little under \$3,000 a year. Next slide, please.

17 These next two slides don't show Switzerland, but this is
18 2007. This shows the comparison of the percent of the Gross
19 Domestic Product where the highest there in that comparison is
20 France. It's about 11%. As I mentioned, Switzerland was at
21 12 and the United States was at 16. We're now at 18%. The
22 next slide shows the dollar equivalents with the United States
23 and that comparison, a little over \$7,000 and the nearest
24 being Canada, with a little under \$4,000 there.

25 As I said at the ASHNA meeting in Fairbanks, I believe

1 the top three issues facing us related to health care are
2 cost, cost, and cost. I further said that, if those of us in
3 the health care industry don't address this issue at some
4 point, others will, and they will do it -- there will be folks
5 who don't appreciate and understand the unique ethical and
6 moral dimensions to this industry and so we do need to take it
7 on.

8 Bruce Lamoreaux from Providence was next on that
9 particular panel, and Bruce got up and said he respectfully
10 disagreed with me and that he thought the three primary issues
11 were quality, quality, quality. And as Bruce and I sat at the
12 same table the next morning, I said, Bruce, maybe we're in
13 pretty good place when the doc gets up and says it's cost,
14 cost, cost, and the Hospital Administrator gets up and says
15 it's quality, quality, quality. But obviously, we do need to
16 have both. Next slide, please.

17 So how about cost? Is it a big deal for us as a nation?
18 Is it a big deal for us as Alaskans? Are we addressing the
19 issue of cost of medical care nationally or as Alaskans? And
20 I'd answer that it is a big deal, both for us as a state and
21 as a country. And I think to date, we really are not
22 addressing the issues. We're addressing it around the edges
23 but not front on. Next slide, please.

24 A Commonwealth North presentation to the earlier
25 Commission that Jeff was on noted that, between 1982 and 2001,

1 medical care costs in this country increased about 275% and
2 the numbers for Alaska are actually a little greater than
3 that, or for Anchorage at least. That report noted that, in
4 2007, we were, indeed, in the good old days because Jeff
5 reported for Premera that the prices in Alaska were 40%
6 greater than they were in Washington State, primarily in the
7 Puget Sound area.

8 The increase in medical care costs during this period was
9 about double the increase in the overall cost of living
10 increase, and we note that can't go on forever. Soon there
11 will be no other room in the cost of living, other than for
12 health care. A corollary was that, between 1980 and 2001,
13 medically-driven bankruptcies in this country increased by a
14 factor of 2,300%. Seventy percent of the individuals filing
15 had had insurance when they started their illnesses. Of the
16 factors cited, the primary factor was hospital costs at 42%,
17 prescription drug costs 21%, physician bills as 20%.

18 Because of the problems that resulted in the earlier
19 Commission and in preceding Commissions going back to Governor
20 Steve Cooper's days, not only these issues didn't abate, but
21 they became more acute and so Governor Palin, as I mentioned,
22 in December of 2008 established this Commission, and the
23 Legislature established it more permanently and gave us our
24 charge this past spring. Next slide, please.

25 How about Health Care Reform? The Patient Protection and

1 Affordability Care Act, Affordability Care Act, Obama-care,
2 whatever you want to call it. I say that, in largest measure
3 at least so far, this is an attempt to change the payment
4 system for medical care but not really the reform of the
5 health care system.

6 Medicaid roles have and will significantly expand to
7 address the medical care needs of some of the 45 million
8 uninsured in this country. Some will have their health
9 insurance, private health insurance subsidized by the
10 government under PPACA. Employers will be mandated to provide
11 health insurance coverage for their employees where they may
12 not have in the past or else they will be assessed a financial
13 penalty. Individuals will be required to buy health insurance
14 or else pay a financial penalty. At present, it looks like
15 the financial penalty probably will be much less than the cost
16 of health insurance. Health insurers will be required to
17 cease and desist from practices that exclude coverage for pre-
18 existing conditions for imposing annual and lifetime caps on
19 the level of benefits that can be paid out. Coverage will be
20 extended to family members under 26 who do not have alternate
21 coverage. Yet insurers will be required to pay out at least
22 85% of their premium income for group coverage for medical
23 benefits and 80% for those with individual insurance.

24 These mandates, in some way, would push insurance, health
25 insurance back to more of what it was, say, back in the '30s,

1 1930s when the blues were just getting started and health
2 insurance was more community-based and there wasn't the
3 differential rates. There wasn't so much an exclusion of pre-
4 existing there. But at the same time, there was much more
5 participation on the part of the individual citizen. The
6 coverage certainly wasn't first dollar and wasn't as broad as
7 it is now. So the individual patient had more skin in the
8 game back in those days.

9 Well every one of these additional mandates, with the
10 exception of those dealing with what's called Medical Loss
11 Ratio or their percent of premium that goes for health care,
12 carries significant additional medical cost that will have to
13 be borne by the larger pool of those who are insured. Next
14 slide, please.

15 I do note, and I said that so far, as far as what PPACA
16 is going to do because, in the 1,000 pages as Deb mentioned or
17 in the three bills probably close to 2,000 pages, there are --
18 Ceci Connolly, who is with the McKenzie Company now, a former
19 *Washington Post* reporter, has noted that 1,000 places it says,
20 "the Secretary shall," Secretary Sebelius of Health and Human
21 Services. So there are a huge and vast amount of regulations
22 and policies that will be determined by the Secretary of
23 Health and Human Services and by her staff there. So there is
24 much to come, much that we will see. So to date, the health
25 insurance really has been health insurance reform.

1 Former Governor John Kitzhaber who is a physician who was
2 a two-term governor of Oregon in the past is now running again
3 after a period of time out of office, running on the
4 democratic side in the state of Oregon, who is very
5 knowledgeable about health and health financing issues, has
6 stated the same thing. He said PPACA, as we've seen it, is
7 not a Health Reform Bill. It is a bill that addressed health
8 financing and paying for health and that that's what it is.
9 And if he successful in being re-elected, he has already
10 stated he will ask for some exceptions from the PPACA law as a
11 democratic governor, if he is re-elected, to allow Oregon to
12 do some innovative things themselves, more in the line of real
13 health care reform. Next slide, please.

14 If PPACA is not going to bail us out of our health care
15 cost dilemma, do we just throw up our arms in futility? Well
16 my belief is that such an nihilism not only will get us into a
17 deeper hole and then result in such a reaction and upheaval
18 that unnecessary harm will be done to many of the good things
19 about health care in this country. But I believe that we do
20 have tools that we can use, many of which are being used
21 successfully elsewhere that can and have been shown to result
22 in both significant cost constraint and significant quality of
23 care improvements. Some of these tools are currently being
24 widely used, and Alaska, in many ways, is an outlier in not
25 using some of them. Next slide.

1 According to the Center for Medicare and Medicaid
2 Services, CMS, we are currently spending about 18% of our
3 Gross Domestic Product on health care. According to CMS by
4 the end of the current decade, we will be spending -- we were
5 projected to spend about 21% and with PPACA a little more than
6 that. As I mentioned a few minutes ago, the United States
7 spends 50% to 100% more than other industrialized countries
8 spend on medical care in terms of dollar equivalent cost or a
9 percent of our GDP. The current estimate for 2010 is that we
10 will spend about \$2.75 trillion for health care in this
11 country, or for our little over 300 million residents, about
12 \$9,000 for each resident of the country. Next slide.

13 Well what do we get for the higher expenditures? Our
14 life expectancy is lower than for other major industrialized
15 countries. Our infant mortality rates are higher. You see
16 Japan there. Where the United States is at 6.8, that's during
17 the first of year of life per 1,000 live births. Japan has
18 2.8. They do much better than we do.

19 In the past, we felt when you reach my age if you were
20 over 65, we did better. Recent data analyzed that. It was
21 published in *Health Affairs* and shows that, if you reach --
22 they took the 13 major industrialized countries and at age 65
23 for females, your chances of living 15 additional years, we
24 were 13 out of 13, and for males, 11. So we -- even when you
25 get older and with the high technology available here, we

1 don't do as well. Next slide, please.

2 Well how much of our Gross Domestic Product in our state
3 do we spend on health care? Our State's GDP is currently
4 estimated to be about \$30 billion. We were just a little over
5 that, and we slipped a little back under that with the current
6 economic situation around the country.

7 According to the Anchorage Daily News, the benefits and
8 salary cost benefits for employees in the total private sector
9 in Alaska, it's about \$12.5 billion. That means Exxon. That
10 means Providence Health System. It means the sandwich shop
11 and the beauty parlor on the second floor of this building.
12 That's the total private health care system.

13 The Health Care Commission has used an annual dollar cost
14 figure for health care in Alaska of \$6.0 billion. If that's
15 the figure, that would mean that health care costs about 20%
16 of our State's Gross Domestic Product, about 2% more than the
17 rest of the country. Or the other way of looking at that is a
18 little more than 10% greater than the segment of the Gross
19 Domestic Product going for health care in the rest of the
20 country. Next slide, please.

21 Recently, I've had personally some question about our
22 estimated annual health care costs and my reasoning follows.
23 We have a prevalence of about 110,000 Medicare enrollees in
24 any given month in this state. In our current population, I
25 actually saw numbers just yesterday that are out now saying

1 we're currently at 692,000. I had had 686,000. But about a
2 sixth of our population at any given time was on Medicaid.

3 For the next fiscal year, the projection is that we will
4 spend in excess of \$1.5 billion on Medicaid. Now Medicaid
5 enrollees for the most part, tend to be young women, women of
6 child-bearing age, women having kids, and children. In this
7 country now, just a little over 50% of all the deliveries in
8 this country are paid by Medicaid. And so most of the
9 enrollees are young women and young children. These are
10 healthy people. You pay something to deliver a baby, but for
11 the most part, young adults and children do not consume a lot
12 of medical care. That's what's called the TANF population,
13 Temporary Assistance to Needy Family.

14 A much smaller proportion of Medicaid enrollment is
15 what's called the ABD population, aged, blind, and disabled.
16 Now these folks do consume a lot of medical resources. They
17 may be disabled. They're elderly. They may be street people
18 or drug abusers, and these folks do consume a lot, but they
19 are a very small proportion of the Medicaid enrollment. So if
20 you have a sixth of our population that's mostly healthy young
21 people, younger adults and children that are using \$1.5
22 billion, that extrapolates to \$9.0 billion, which would be 30%
23 of our total State's Gross Domestic Product.

24 We spend a lot on health care here. We all feel very
25 blessed to live in a state that has no state sales tax and no

1 state income tax, but this appears whether it's 20% or 30%.
2 We are spending significantly more than the rest of the
3 country does and that is a tax and it does mean that those
4 dollars are not available for other things, like education,
5 like highway building, like other desirable things that we
6 would want do as a society or to leave in people's pockets to
7 choose how to spend there. Next slide.

8 Medicaid costs are causing financial strains for every
9 state as well as for our country. Though nationally, on a
10 national basis, we seem to assume we can generally print
11 money. The forecasts are that, by the end of the decade, the
12 fortunate states will be spending 30% of their total state
13 budgets on Medicaid and the unfortunate ones will be spending
14 50%. There is a reasonable chance that we'll be among the
15 fortunate states here in Alaska, and hopefully, that will
16 continue. But because of this challenge, Bill Hogan, the
17 Commissioner of Health and Social Services, talked with the
18 Governor's office and got approval from the Governor to
19 establish a Medicaid task force. And on this Medicaid task
20 force, there are four members of the Senate, four members of
21 the House, and four representatives from the Administration,
22 from the Department of Health and Social Services.

23 This group met a couple of weeks ago for the first
24 meeting. The plan is to have five additional meetings between
25 now and March looking at issues of Medicaid broadly, coverage,

1 costs, what the impact is on the State and what the
2 opportunities are there. Next slide, please.

3 At the first meeting, the group learned some startling
4 comparative things. For Alaska Medicaid, the most commonly
5 billed code is 99213. That, in terms of code language, is a
6 moderately complex visit for an established patient with a
7 physician lasting about 15 minutes. The fee schedule that is
8 paid in Alaska for Medicaid for a 99213 is \$108. For
9 Washington, it's \$68. For Oregon, \$47. For Idaho, \$57. If
10 you take the lowest fee there for Oregon, if Alaska paid
11 according to Oregon's Medicaid fee schedule -- and I'm not
12 saying this to advocate that but to make the point -- Medicaid
13 pays \$262,000 99213 encounters a year. If Alaska paid just
14 for that one kind of visit alone on Oregon's fee schedule,
15 Alaska would pay \$16 million a year less than we do. Medicaid
16 in Alaska pays 172% of what Washington pays, 229% of Oregon
17 pays. Next slide.

18 It's not just Medicaid. Prior to my becoming a member of
19 the Health Care Commission, this group, this Commission, heard
20 that for arthroscopic knee surgery for a workman's comp
21 patient the bill in Hawaii was \$600-some, \$800-some in
22 Washington, \$4,000-some here in Alaska.

23 At the recent Rasmussen/Providence health care reform
24 seminar at the University of Alaska, Jeff Davis stated that in
25 1998 provider pricing that Premera paid in Anchorage was 35%

1 greater than prices paid in the Puget Sound area and that's
2 why I referred to my earlier 2002 comparison as the good old
3 days because now Premera pays more than 100% more in Alaska
4 for the commercial population. And if anything, our
5 commercial population is probably slightly lower than it is in
6 Washington State. So the costs are quite a bit higher here.
7 Next slide.

8 Our medical costs are high in Alaska. They're higher
9 than elsewhere and the disparity seems to be increasing. In
10 January of 2009, just last year, the Palin Administration
11 projected the total Medicaid spending in Alaska in 2013 would
12 reach \$1.367 billion and that sometime during 2014 we would
13 achieve a run rate of \$1.5 billion. Well we know now that
14 we're going to spend over \$1.5 billion in fiscal 2012, and
15 this is just from last year's projection. This is not just in
16 past projection. The increase relates to a number of factors,
17 to price escalation, to increased Medicaid enrollment that
18 relates to the national economy, and the expansion of Medicaid
19 enrollment under PPACA, and to the increased utilization that
20 you always see with new enrollees in any health insurance plan
21 where you save up your problems, and now that somebody's going
22 to pay for it for you, you get the care that you need. Next
23 slide.

24 Well where can we find opportunity to reign in health
25 care costs, both nationally and within Alaska? Do we find

1 that in PPACA? Well other than seeming to target an assumed
2 abundant pot of gold that all health insurance companies must
3 have, it really doesn't address cost issues. I noted that the
4 ceilings being placed on administrative cost ratios for health
5 care for insurers, my own bias is that, depending on how
6 medical costs under this medical cost ratio are defined, it's
7 not necessarily a bad thing to do that.

8 The provision is purportedly intended to constrain the
9 greed of health insurers and their CEOs and to achieve the
10 admirable goal of having health insurance premium dollars go
11 toward health care as much as possible. Well the imposition
12 of a 15% administrative cost ceiling, including profit margin,
13 can really be self-defeating because, if it does nothing to
14 encourage payers to negotiate the lowest rates with providers
15 and to hold premiums down for their insureds, it doesn't
16 really help. There will be competitive market forces among
17 insurers for lower rates that will tend to constrain rates,
18 but consider that a 15% general administrative cost ratio,
19 that it includes a 2% positive margin. And I think the greedy
20 insurance CEO that is sitting to my left would be happy with a
21 2% positive margin. The insurance companies are not all
22 getting rich by a long measure.

23 Well if there is a 15% administrative cost ratio allowed,
24 which is claimed as one of the cost-saving things under PPACA,
25 and if you have a 2% positive margin, would you rather have 2%

1 on \$150 million or 2% on \$100 million? So there is no
2 incentive under that legislation for the payers, whether it's
3 state for Medicaid or whether it's private insurance or
4 Medicare, to hold prices down. Under that scenario, the
5 profits can go up.

6 There, I had personal experience when I was with a payer.
7 This was back in North Carolina, and we had a contract with
8 the largest firm nationally, well-respected, supposedly very
9 ethical firm that would contract. And we had individuals,
10 about a half million people that we insured across 22 states,
11 and we contracted with a firm whose name many of you would
12 recognize to access the contracts they had for things that
13 were very expensive that were seldom done, primarily major
14 solid organ transplants.

15 And Sloan-Kettering in New York informed us that this
16 contractor was going to them because the contractor made their
17 money as a percent of the difference between the fee schedule
18 that the provider had and the contracted rate. So the firm
19 that was supposedly getting us a savings went to Sloan-
20 Kettering and other providers and said your fees are too low;
21 you need to raise your fees. Well of course, they made more
22 money by having a bigger delta saving there, and we dropped
23 that and went with Alliance which was in the same kind of
24 business and didn't seem to engage in that practice.

25 So most people in all parts of the health care industry

1 are ethical, are dedicated, are compassionate, but there are
2 charlatans, like this unknown supposed forensic pathologists
3 whose patients were walking in for care there. Next slide,
4 please.

5 I wanted to talk mostly about cost issues, both
6 macroscopically in terms of our State's GDP and
7 microscopically in terms of the impact on the individual's
8 medical care needs. I really do believe that's the 800-pound
9 gorilla facing our state and our nation and all of us and that
10 we have to address that forthrightly in order to do other
11 things.

12 We do have other significant opportunities related to
13 health care and the well-being of Alaska. You will recall the
14 listing earlier, in the earlier slide about the fourth slide
15 in there, of what the Legislature has asked us to do. What we
16 die from has changed over the years.

17 Infectious diseases remain a major threat and we cannot
18 become complacent, but it doesn't make us sick and doesn't
19 kill us as much as it did in the past.

20 The majority of what we become ill, disabled, or
21 prematurely die from is what I call diseases of choice now.
22 The three most common examples are medical complications of
23 overweight and obesity, of tobacco use, and unintentional
24 injury. But we could a semester talking about these things,
25 so let me just kind of quickly go through that. Next slide,

1 please.

2 We know that, in our country now, more than a third of
3 American adults are overweight and another third are obese.
4 These findings continue to get worse. As many as 40% of
5 Alaska's young people are overweight or obese. The rates of
6 childhood obesity and overweight have tripled over the past
7 four decades. Next slide, please.

8 The complications of this are that the -- where the First
9 Lady, Michelle Obama, has taken on childhood overweight and
10 obesity as her thing, which I am so grateful to her for doing.
11 But there are a number of projections there. In 2004, CDC
12 projected -- and it was in a peer-reviewed article in JAMA --
13 that of American kids being born in the year 2000, one-third
14 are expected to develop diabetes during their lifetime.

15 Now 6% of Americans have diabetes now. This is very
16 costly. This is a cost source of losing vision, losing
17 kidneys, having amputation, having heart attacks, and so on.
18 If we go from 6% to 30%, the economic impact will be awful.
19 Next slide, please.

20 The projection in the White House paper on childhood
21 obesity is that the kids being born currently, in this past
22 decade, may be the first generation of Americans since the
23 beginning of our country that the kids don't live as long as
24 their parents lived, related to the growing epidemic of
25 overweight and obesity. It's a security issue. The military

1 finds that 25% of young men and women who are potential
2 enlistees in the military are not qualified because of being
3 overweight or obese. Obesity and inactivity causes 365,000
4 premature deaths in our country. Next slide, please.

5 Now that's still number two to tobacco, which causes
6 443,000 premature deaths, but the numbers are going up and
7 we'll surpass them. The direct medical costs, both for the
8 nation and for Alaska, related to overweight and obesity have
9 now surpassed those related to tobacco use. For Alaska, the
10 direct medical costs related to overweight and obesity are
11 almost half a billion dollars a year in this state, about \$150
12 billion nationally.

13 What's happened here? We have about 21% of Alaskan
14 adults who smoke. That places us number 41 out of the 51
15 states, I guess, including the District of Columbia. So we're
16 near the bottom of the pack, but that's less than half of
17 those who used to smoke. It's a particular problem for Alaska
18 Native people, where almost 40% of Alaska Native adults do
19 continue to smoke. Smokeless tobacco remains a problem,
20 particularly in rural areas. You'll see little kids going
21 around with a circle on their back jean's pocket from the
22 smokeless tobacco that's used. Next slide.

23 Smoking, as I mentioned, has declined by more than 50%.
24 9.7% of our young people smoke in the age 12 to 17. That puts
25 us number 14 among the states. So this is the future, and

1 hopefully, we are growing a new generation that will continue
2 to do better. When I mention this, I always need to give
3 credit to our Governor. When he was Chair of the Senate
4 Finance Committee, he was very instrumental in locking down a
5 significant portion of the tobacco settlement money, these
6 hundreds of billions of dollars from the tobacco companies,
7 for health education. Other states tried to do that.
8 Governor Gregoire, who was the Attorney General in Washington
9 at the time, was very passionate about this, but related to
10 their economic conditions, Washington has lost most of that
11 money, as have most states.

12 CDC, in terms of what CDC thinks we should be doing in
13 terms of smoking control efforts, ranks Alaska number four
14 among all the states related to our population and what we're
15 doing, and a lot of the credit for that needs to go to
16 Governor Parnell back ten, 12 years ago when he locked that
17 down and he remains supportive. Next slide, please.

18 Most of Alaskans now live in localities that have indoor
19 clean air rules that have been passed. That means Anchorage.
20 That means Juneau. It means Klawock, being one of the other
21 communities in Southeastern, and Petersburg just had a vote on
22 it and I haven't seen how that turned out, but slightly over
23 50%. The advocates will be pushing, I understand, starting
24 this fall and in the next legislative session, hoping over the
25 next couple of years to get the whole state to go and have

1 clean indoor air. They have folks like bar owners from Juneau
2 who will testify that it hasn't hurt their business, and those
3 that are often quite negative on this. But we have done some
4 good things. I mentioned the problem with little kids in the
5 Bethel area using smokeless tobacco. Representative Herron
6 from Bethel has sponsored and is sponsoring legislation to
7 increase the taxes because it's been shown, particularly with
8 young people, that higher taxes reduce tobacco use. Next
9 slide, please.

10 On what we used to call accidents, Unintentional Injury,
11 it is the leading cause of death in Alaska if you're age one
12 through age 44, and there are a number of reasons there. If
13 you make your living fishing, if you make your living hardrock
14 mining, if you make your living logging, you can't think of
15 more dangerous occupations than those. So it's related to how
16 we make our living, the resources that God has placed here for
17 us in Alaska. It's related to how we recreate and other
18 things, and I won't spend time on that. Next slide, please.

19 But this has improved way a lot since I've first come
20 here, and it's been done with highway engineering. The road
21 to Girdwood, as we all know, is much safer to drive than it
22 used to be. Still has some risks there. It's meant teaching
23 kids to swim. I remember when North Slope Borough put a
24 swimming pool in the high school up in Barrow and people
25 outside said, why in the world would you do that in Barrow?

1 Well part of it is to fight fires, their water source to fight
2 fires, but part of it was to teach kids to swim because our
3 lifestyle is water-related. The Kids Don't Float Program,
4 which is a very successful national program was started right
5 here in Alaska. There has been gun safety instruction,
6 medical care, pre-hospital, hospital care has all improved.
7 Next slide. So these things have helped reduce that there.

8 Well I've tried to make a good case that we, in the
9 United States, spend a uniquely high portion of our incomes on
10 health care. I tried to be fairly dramatic, tried to use some
11 shock and awe as I've done that, and that our results are
12 mixed at best in terms of outcomes for what we get. I've
13 tried to demonstrate that we, in Alaska, have a uniquely high
14 proportion of our economy devoted to health care compared to
15 the rest of the country. I've presented quite a bit of data
16 on prices. I have far more detail available, and maybe in our
17 next meeting, we can talk about that.

18 During its first year of existence, the Health Care
19 Commission discussed issues, such as the limited
20 implementation of the principles of evidence-based health care
21 and policy making in Alaska. We heard that as much as 30% of
22 medical practice does not stand up to the test of evidence-
23 based analysis, and tomorrow, we'll talk about that quite a
24 bit and I'll share some of my own experience where I, as an
25 expert, did some things that I know now were not supported by

1 the evidence, and we all continue to learn.

2 We've learned about the high pricing, both by individual
3 practitioners and hospitals. We've seen the comparisons.
4 Other medical care pricings are available. The projected are
5 for the increases, for example, for state employees of health
6 insurance premium costs going up 20% over the next couple of
7 years.

8 The reasons for the uniquely high pricing can be
9 multiple. One factor, I believe, is our legislative required
10 mandate that payers need to pay at no less than, essentially,
11 80% of billed charges, of billed fees. Well generally across
12 the country, payers will do anything they can to avoid tying
13 their contracted rates to billed charges because that's a
14 moving target. It's not a fixed target and that is a factor
15 that helps hold up health care costs here in Alaska.

16 The data that I've seen shows that Alaskans'
17 hospitalization is higher. For example for Premera, hospital
18 utilization is higher than it is in Washington State. Now we
19 can give some reasons for that, but they're also not the
20 mechanisms in place. That same data shows that the
21 utilization of primary care encounters with family medicine
22 docs, primary care internists, pediatricians is lower than it
23 is in Washington.

24 Any payer for health care services who knows anything
25 about what they're doing does not want to do anything to

1 reduce the number of visits with family medicine physicians,
2 other primary care physicians because there's a pretty
3 consistent payoff that, if you have that strong, established
4 relationship with a primary care provider, that your other
5 costs, your hospitalizations, your costs with non-primary care
6 providers where the costs are really the highest are reduced.
7 And so that's an opportunity for us here, and we talked some
8 about that on our allocation of physicians, and I'll talk a
9 little bit more about that tomorrow.

10 My own experience when I went with group health -- the
11 last time we left Alaska, I worked there and was responsible
12 for leading the non-primary care providers there and
13 administratively for the non-primary care facilities there,
14 and their self-image was they were very benchmark in terms of
15 hospitalization utilization, but they had been losing money
16 for about five years. And as I made rounds with some of the
17 docs at the hospital, I would hear, well, you're doing pretty
18 good; you want to go home today or would you like to stay
19 another day? Well at \$2,000 a day, that's not a very good
20 question to ask. The assumption was, well, the bed was there;
21 it was paid for. And that's what I mean where there are some
22 things that are in play elsewhere, and we tightened up on that
23 in a way that did not reduce the quality of care at all but
24 helped work with the physicians to understand there is a big
25 cost to doing that. That's where the best decisions are made

1 as far as utilization. But financially, the company turned
2 around and was stronger then.

3 Alaska has not experienced aggressive utilization of
4 evidence-based medicine in the past. One of colleagues here
5 has said to me, well, whose evidence, and that's the question.
6 Well as a physician, I sincerely felt that I was making the
7 best determinations in the best interests of my patient, but
8 tomorrow, we'll talk a little bit about whose evidence, of
9 grades of evidence, and strengths of evidence there.

10 The Commission and others have talked about health
11 manpower supply. Some groups looking at health manpower
12 supply have done, I think, a very sincere job with concluding
13 recommendations, essentially, for more, that that's what we
14 need. And I think there has not been the tie in those
15 recommendations to the resource requirements. Furthermore,
16 health economics are unusual in that, in most industries, more
17 translates to more competition, lower individual prices. Our
18 demand is so elastic in our industry that that's been the case
19 here. We're all familiar that, if you go to buy a new Ford or
20 a new Chevy, you pay more for the health insurance that the
21 United Auto Workers Union employee has than for the steel in
22 your vehicle, and we do know that other countries do better
23 than we do.

24 We know that less and less current medical school
25 graduates are choosing primary care. Relate that back to what

1 I just said there. If you go to Harvard, you can't even pick
2 that track now. Well but when we look at other countries that
3 spend less and seemingly get more than we do, a significant
4 difference is that the allocation of providers, of physicians
5 particularly, is different with not so many primary care
6 providers in this country and that's an opportunity that we
7 have. Next slide, please.

8 Well what are some of the opportunities we have as
9 Alaskans and that we as members of the Health Care Commission
10 have as we develop our recommendations?

11 This is a significant list, but it's far from exhaustive.
12 We do not sunset until 2014, but that will be here very soon.
13 We do need to be selective. In selecting terms to make my
14 list here, I believe our priority has to include cost issues
15 related to both price and supportable appropriateness of
16 services and believe that issues related to prevention and to
17 how health care is provided, read more primary care, will
18 positively impact both cost and outcomes. Turn the slides
19 off, please, Deb.

20 Now let me just close with a couple of observations and a
21 repetition of my comments related to PPACA. The Health Care
22 Commission worked impressively, collaboratively during its
23 first year of existence. Each Commissioner brought the
24 knowledge and experience of their own individual backgrounds,
25 but each Commissioner also clearly came to the table

1 representing all Alaskans and all of Alaska. As we welcome
2 new Commissioners, I believe it is important that we continue
3 that tradition. I also believe it is important that we keep
4 our focus on the charge to the Health Care Commission. We
5 will have the opportunity and the need to be knowledgeable
6 about the impact of the implementation of PPACA on Alaska. To
7 succeed in our meetings, our charge, I believe, it needs to be
8 important that we guard against being swallowed up by dealing
9 with the Obama-care bill, and the price of that would be that
10 we miss out on the opportunity to truly improve the value
11 equation for health care in our state. I think members of the
12 Legislature and the Governor's office have shared with me that
13 that's their hope, and I think that that's our charge here.
14 So thank you very much.

15 Before we go on to the next item, Jeff, we went around
16 and everybody introduced themselves briefly, so maybe if you
17 could that and there's an empty seat right here, Paul.

18 COMMISSIONER DAVIS: I apologize to everyone for being
19 late. I was actually advocating for more resources, trying to
20 get some additional health care resources from D.C.

21 CHAIR HURLBURT: Jeff, could you just introduce yourself?

22 COMMISSIONER DAVIS: Sure. Thanks, Ward. And I to the
23 Chair and the Commission also for being late this morning. My
24 name is Jeff Davis and I am the President of Premera Blue
25 Cross Blue Shield of Alaska. I live here in Anchorage, been

1 here for the last 12 years, been in healthcare for 30 years.
2 I have a varied background from clinical roles in the
3 beginning on through hospital administration and worked at
4 Group Health and building clinics, and back in the good old
5 days when managed care wasn't a bad word or two bad words, I
6 worked to build networks in multiple states. It got me
7 involved here. I worked for the employer side. I'm now on
8 the insurer side. So I've walked around this equation, this
9 whole conundrum, and hopefully, I bring a varied view that
10 appreciates the complexity of what we're dealing with. And it
11 is, indeed, a privilege to be on this Commission and to be the
12 continuity from the Strategies Planning Council to the first
13 Commission I'm now on, and I'm just honored to be here. Thank
14 you.

15 CHAIR HURLBURT: Thank you, Jeff. Paul?

16 MR. FRIEDRICH: Thank you, sir. Paul Friedrichs. I'm a
17 urologist by training. Very proud and grateful for the
18 opportunity to represent the federal side of the partnership
19 here in Alaska. I want to emphasize that my lawyers have
20 advised me I have to say I'm here as a liaison from the
21 federal side to make sure that I stay in my lane.

22 We see great opportunities to partner across the
23 continuum of care here, and I think many of the things that
24 you touched on we've discussed previously. So I look forward
25 to working with the Commission and figuring out how to expand

1 that partnership. Thank you.

2 CHAIR HURLBURT: Thank you, Paul. Deb, can we.....

3 COMMISSIONER ERICKSON: Do you want to see if folks have
4 questions or follow-up comments to your -- I think we have
5 time.

6 UNIDENTIFIED FEMALE: Deb, do you mind?

7 CHAIR HURLBURT: Deb suggested that we open up for.....

8 COMMISSIONER ERICKSON: Just for the Commission to ask
9 questions.

10 CHAIR HURLBURT:Commission Members. We'll have the
11 public comment period from 12:30 to 1:30.

12 UNIDENTIFIED MALE: I have a question; what's PPACA?

13 COMMISSIONER ERICKSON: PPACA?

14 CHAIR HURLBURT: I'm sorry. The Patient Protection and
15 Affordability Care Act. Now this is the Federal Health Care
16 Reform. That was the initial title. Now it's shortened to
17 Affordability Care Act. Probably those who don't think it's
18 the greatest thing since sliced bread will sometimes refer to
19 it as Obama-care. So it's called various things now. Any
20 comments? Yeah, Senator Olson?

21 SENATOR OLSON: Thank you, Dr. Hurlburt. I think that
22 was an excellent presentation, but the feeling that I get from
23 the numbers and the trends that are there is that we're going
24 down a slope and it's getting slipperier and slipperier, and
25 I'm pretty pessimistic by just the -- in just listening to the

1 perspective that you have. I was wondering, where do you see
2 the light at the end of the tunnel as being, especially since
3 there seems to be such a divergent, as you pointed out up in
4 Fairbanks, between the hospital essentially and the
5 practitioners? And we, as Legislators, I'm not sure that I
6 see a golden parachute or anything that's out there. So
7 because of that and being a person planning on living a long
8 time, I guess I'm looking forward to the Mayan calendar of
9 2012, if that's the case. Can you stop my pessimistic view
10 here?

11 CHAIR HURLBURT: I think there are some opportunities,
12 some very real opportunities. I think we do have to address
13 the issue of unit pricing in Alaska, where we're clearly an
14 outlier for the states. And there will be different on that,
15 but I think that's an issue that we do need to address. But I
16 think there are the other issues, the overweight and obesity,
17 where we hopefully will be having what's known as ATOCO, not
18 the Mobile Living Units, but Alaskans Taking On Childhood
19 Obesity. We have a group that's established.

20 There will be a request coming to the Legislature to work
21 through school districts to try to change the curve, and there
22 is some hopeful information. Anchorage has kind of flattened
23 that curve of the overweight and obese young people, and in
24 fact, it has not been publicized yet, but Matanuska may have
25 even bent that curve a little bit.

1 So I think if we can address kids particularly -- and
2 when Ward Hinger was with the Governor's office, he really
3 pushed us towards kids rather than the whole population, which
4 we need to address everybody, but that that's going to be the
5 future. So I think that there are clearly opportunities
6 there. If we can continue our efforts related to tobacco,
7 that that will help. I think that -- and we'll spend a couple
8 of hours tomorrow talking about evidence-based medicine. As I
9 -- and I'm a General Surgeon by my own clinical background, as
10 you know and many do here. I really thought that, if anybody
11 had gallstones whether they were symptomatic or not, I was a
12 knight in shining armor if I took your gallbladder out because
13 I saved you from cancer or jaundice or other things, and the
14 evidence doesn't really support that now, if somebody has
15 gallstones and they're not symptomatic. So I believed I was
16 doing the right thing. Well I think that we are much more
17 sophisticated in terms of evidence-based practice. We have to
18 assure that all of us who are physicians have it as a part of
19 our genetic markup that what we do is clearly supported by the
20 evidence. So I think that there are opportunities and reasons
21 for optimism. As you've heard me say, I'm a skeptic on
22 Commissions, but I think that there is so much need here.
23 There is so much commitment that I hope that we can really
24 impact on it for the State that we all love.

25 SENATOR OLSON: My last comment, Dr. Hurlburt, has to do

1 with your slide on slide 14, which has to deal with the
2 mortality and morbidity numbers as well as the life
3 expectancy. What are they doing right in Japan that we could
4 take lessons from? Obviously, we've gone through a World War
5 with them. They're on our shores. People around here seem to
6 be seeing more and more sushi bars going up, but I don't see
7 it impacting our health care system, or at least the health
8 care and morbidity and mortality here in Alaska.

9 CHAIR HURLBURT: One of the things that they do different
10 is that we, in this country, spend less than 3% of our total
11 health care budget on what we call public health kinds of
12 issues, and Japan, among other countries, spends more. So
13 they do have more efforts related to prenatal care, to good
14 care for women when they're pregnant. It is a higher priority
15 for them there. Some people would say that they have a less
16 diverse population than we do. But when you look at the data
17 -- for example, I saw something just the other day that the
18 average life expectancy for Hispanics in the United States is
19 greater than it is for Anglos, and that's an excuse that's
20 given, but they do spend more on prenatal care, on public
21 health kinds of things than we do in this country.

22 We may have come a ways. I found a document that came
23 out just before I first came up here, and I came up in '61,
24 put out by Health Education and Welfare basically celebrating
25 that the infant mortality rate for Native Americans had

1 dropped to 59 per 1,000 live births and saying this wasn't
2 good enough. But now we're down 6.8 as a country, and we're
3 about that for Native American people around the country. So
4 it's come down, but we have come a long way. We were in a
5 place where the health parameters for Alaska Native people
6 when I first came here was much like it was for U.S., all
7 races, shortly after 1900. So there have been groups that
8 have been very disadvantaged in our country and that's
9 impacted our data.

10 SENATOR OLSON: Sure. Thank you.

11 CHAIR HURLBURT: Anything else? Yes, Emily?

12 COMMISSIONER ENNIS: Dr. Hurlburt, I appreciated your
13 presentation very much. A good summary for a new member.
14 Your comment about health manpower supply and the need to be,
15 as I believe you said, tied to resource data, could you speak
16 to that just a little more? As we look toward perhaps as many
17 30,000 new Medicaid enrollees by 2014, we are concerned about
18 our manpower supply.

19 CHAIR HURLBURT: Yes. There's a concern about the
20 manpower supply, and as I say, the answer is often more and it
21 depends on your own particular viewpoint what you're
22 particularly looking at, but that cannot exist in a vacuum.
23 If we're spending at least 20% of our State's Gross Domestic
24 Product on health care, the answer can't be to increase that,
25 that 25%, that we need to look at how manpower is allocated

1 currently. As I said, I think for -- taking physicians, we
2 really ought to allocate more manpower toward primary care
3 that we have, but the cost issues do need to be a part of --
4 the decision can't be made in a vacuum, ignoring that. But
5 yes, there are increasing numbers of people, not more
6 Americans, but there will be more people on Medicaid. There
7 will be more people that will be insured and that needs to be
8 a part of it, but to say the answer is just buy more without
9 paying attention to the costs. For example, University of
10 Alaska WWAMI program, a very successful program, but in
11 addition to the students graduating with \$140,000/\$150,000
12 worth of debt, the State has invested \$50,000 a year. And if
13 they go through the excellent family medicine residency here,
14 the State invests another \$50,000 a year in that. So if an
15 answer is, we would like to expand that, they've been very
16 successful in retaining physicians in Alaska, but there is a
17 significant cost to do that.

18 COMMISSIONER ENNIS: Thank you.

19 CHAIR HURLBURT: Pat?

20 COMMISSIONER BRANCO: Well my comments are going to be
21 directed to Dr. Olson because I'm a wild optimist. I think
22 that we're poised at the perfect opportunity in time and space
23 to really ultimately affect the communities we serve in all
24 our different ways because, finally, there's a very, very
25 strong shift of attention to preventive medicine, and creating

1 a population where we've got the healthy ill, people who are
2 better able and prepared to deal with acute phases of illness
3 or trauma, will reduce our costs by keeping their stage
4 shorter, and I don't think it's going to take a great of work
5 to shift that focus and have -- apply the good leadership and
6 the energy in our communities to make it happen. And it's
7 much more about this community wellness concept, behavioral,
8 spiritual, clinical, and all the other elements and social
9 pieces, too. So I'm -- I refuse to be pessimistic. I think
10 these are daunting challenges, but we're up to it.

11 (Pause - mics turned off)

12 COMMISSIONER LAUFER: I have to agree. I'm an optimist
13 as well. I don't see the problem as really that difficult.
14 Basically, you're going to get what you pay for. This year
15 the match in family medicine nationally, 45% of the positions
16 were taken by U.S. grads. We have lots of orthopedists in
17 Anchorage. That's not a problem. The problem is primary
18 care. I am absolutely convinced it's the answer, but you are
19 only going to get that to happen if you pay for it.

20 Yesterday, my last patient I removed two skin lesions. I
21 made more off of those two lesions that took ten minutes than
22 I did seeing 20 people. I'm not paid to help someone quit
23 smoking. I do it and I would sacrifice the relationship to
24 help them do that, but we're not paid for it. It's very, very
25 simple. If there's a market for preventing heart attacks,

1 there won't be heart attacks. If there's a market for
2 \$100,000 admissions for stents, there are going to be
3 admissions for stents. We just have to change the fee
4 structure.

5 Another comment on the Medicare issue which is very
6 similar, we see about 11% Medicare patients; 30% of our
7 billing efforts -- this is a clinic we see 50,000 patients a
8 year with 12 doctors, two full time employees, 30% of our
9 billing efforts go to Medicare, less than 3% of our revenues.
10 This is philanthropic caring. We do it because we think it's
11 right for the community. If we were paid to do it, we would
12 do a lot more of it. It's very simple. If primary care docs
13 make a good living, more people will go into it.

14 One more. I just saw the finances for a friend who is an
15 orthopedist. He makes in one month what I make in a year.
16 Now it's fantastic. He does a great job of replacing your
17 hip, but that's a great disparity. If you're graduating
18 medical school, you have \$200,000 in debt, you put off having
19 a family, you're trying to decide what to do, that's a
20 disparity that will overcome idealism. Thanks.

21 CHAIR HURLBURT: And that's an elephant in the room we
22 can't ignore.

23 COMMISSIONER LAUFER: Well it's the real issue. It's the
24 obvious solution. You know, what do we do? I don't have a
25 \$30 million building. We have operated for 40 years out of a

1 \$3.0 million building.

2 CHAIR HURLBURT: Larry?

3 COMMISSIONER STINSON: I think Dr. Laufer brings up
4 excellent points, and I agree with those. One of your slides
5 talking about the clinic visit and what the potential cost
6 savings, that is a great way to start, a great way to think
7 about it. In our clinic -- and I may be incorrect but
8 seemingly -- we're in the special -- in the field that we're
9 in, we're the last ones, apparently, that still take new
10 Medicare and Medicaid, and they all come flooding towards us.
11 And if you cut the reimbursement further for Medicare and
12 Medicaid, then you're committing economic suicide to keep
13 doing that and that's where the Community Health Centers, all
14 of these other places are necessary. But you know, they also
15 get a little help from other sources. When you're in private
16 practice, you either stand or fall on your own. And we do the
17 same thing because we think it's the right thing to do, but
18 there gets to be a point where it's survival. And we're not
19 talking about doing the big hip replacements or something like
20 that, but a lot of what we do is in the clinic.

21 So while I agree there is money to be saved, there is
22 also that curve where, if you drop a little too low, it's
23 going to be even more difficult to get the patients picked up.

24 COMMISSIONER MORGAN: I'll be uncharacteristically brief,
25 if I can. Just three points. It's a pet peeve of mine as an

1 economist that -- and I do not minimize our cost problems with
2 Medicaid. I've been talking about that for three years, and
3 other people in the room have been talking about it probably
4 longer. But they always show in the slide the increased cost
5 in health care, but as Dr. Fraberg (sp) who taught me Advanced
6 Micro Economics, you must get a frame of reference. I would
7 suggest doing the same statistics for education,
8 transportation, government, and utilities comparing the United
9 States to other industrialized countries.

10 All I know is, when I went to college and it wasn't
11 during Lincoln but it was in the late '60s, my tuition at the
12 University of Kentucky was \$500 a semester. Now I have
13 friends of mine who have children graduating and some of them
14 from medical school owing \$200,000. My father who was a
15 dentist and one of my uncles who is a doctor went to the
16 University of Kentucky and University of Cincinnati, their
17 tuition a year was about \$7,000 in the '60s.

18 So let's -- I agree with side of the table. In some
19 ways, we might want to lighten up here a little bit. We do
20 have a problem. I think it's correctable, but sometimes you
21 beat yourself up a little too hard. I think it would be a
22 good suggestion to, whenever you throw up health care costs
23 have gone up 300% and we're the highest compared to other
24 industrialized countries, if you pick some of the other major
25 economic activities for the nation, such as education,

1 transportation, government, or utilities, and costs, I think
2 you would see sort of the same type of relationship, if not
3 developed, getting there. It doesn't change anything that
4 happens here. It's just I got my opportunity; I'm taking it.
5 I usually sit out there and say that and everybody goes, oh
6 okay, and go on.

7 I think where I have worked in an HMO Co-op, it was
8 owned. It was the traditional co-op from the 1800s, HMO, run
9 by the members, had 30,000 members, but got a Medicaid primary
10 contract that did everything that everybody here is talking
11 about, lots more money up front in preventive, health care,
12 nurses, the old style public nurses that went out and did
13 things. They made significant inroads in days, beds, dropping
14 it from 1,200 per 1,000 [sic] down into the 400s and reducing
15 primary or specialty visits. I think we've -- after -- and I
16 have explained why I didn't come in -- I was worried I'd be
17 last, but I guess I was third from last. I spent last night
18 until 11 o'clock at the Municipal Health Commission in your
19 seat dealing with the issue of costs and dealing with the
20 issue of budget restraints and the changes going on there, and
21 the main discussion was public health nursing, how we're going
22 to fund it and where we're going to get the money to do it.
23 But the good news is, we've got a lot of stuff here going.
24 We've got nurse family partnerships, accountability
25 organizations. We have Community Health Centers all over the

1 state doing a lot of this stuff and very transparent on cost
2 and delivering health care.

3 So in one way, yes, we've got a bunch of problems. We've
4 got a cost problem. On the other side of this, we can manage
5 our way out of that. We just all have to cooperate and work
6 together here, and I guess that's my only comment.

7 CHAIR HURLBURT: Thank you, Dave. Probably -- it's 9:30,
8 we ought to go on to you, Deb.

9 COMMISSIONER ERICKSON: Thank you. One thing that I
10 failed to mention first thing this morning, I want to make
11 sure that folks who are listening in on the phone know that
12 the presentations, the PowerPoints that we're going over today
13 and will go over tomorrow are all posted on the Health Care
14 Commission's website right now. So if you can manage to
15 follow along, you'd be able to find them there. And for folks
16 in the room if you came in a little bit later, they're
17 available in hard copy on the back table.

18 So for the next half hour or so, I'm going to take a
19 little bit of time just to provide some review for our
20 original members of the group on what the Health Care
21 Commission did this past year and an overview for all of our
22 new members and our former members can keep me honest and feel
23 free to chip in, if you think there's an important point that
24 I'm missing as we go through this. I'll try to be a little
25 informal. But we just want to make sure that everybody's kind

1 of at the same place as we -- we're not starting over from
2 scratch with our new reconstituted Commission. We're trying
3 to build on the work of the former Commission and keep moving
4 forward from there, so I thought I'd be important to spend a
5 little time reviewing together what we did this past year.

6 And before I get started talking about the Commission,
7 Dr. Hurlburt referred to previous groups. I thought it would
8 be helpful to talk a little bit about the history of attempts
9 at health care reform in our state.

10 Over the past 25 years, there have been a number of
11 groups formed. And going back about 25 years, 1987, Governor
12 Cooper had created under Administrative Order the Governor's
13 Interim Commission on the Status of Health Care and the Health
14 Care Industry in Alaska. That was a Body that met for a
15 couple of years.

16 By the way if anybody is interested at all in some of the
17 historical references, I do have copies of all of these
18 reports from all of these groups, if you're ever interested in
19 going back and looking at them.

20 That group produced a report after meeting for a period
21 of time. One of the things that -- they actually did a pretty
22 comprehensive job covering a number of different issue areas,
23 but that was, I think, the first time that the issue of long
24 term care and challenges related to long term care related to
25 health care industry and costs were being raised and analyzed.

1 That was just one notable thing about that report.

2 Then in 1991, the State Legislature created the Health
3 Resources & Access Task Force. That was a pretty large group
4 that met intensively and studied intensively the issues of
5 health care in our state. They met for two days a month for
6 14 months in a row, 17 people. And that group ended up
7 focusing on, as a solution, development of a single payer
8 system for Alaska. And so politically, the major
9 recommendation there didn't fly. There were some other
10 recommendations that were made; I think most notably from that
11 one, the need for the creation of a high risk pool for Alaska
12 and so ACHIA eventually came from the work of this Body.

13 And then this actually wasn't a group that was formed. I
14 just added this to this presentation I had made in the past
15 that Commonwealth North actually wrote a report. They did a
16 study and wrote a report between '93 and '94 that is really
17 interesting. I came across this just a month or so ago, but
18 it provides a little bit of an analysis and comparison between
19 the recommendations that were being developed by the Health
20 Resources and Access Task Force at the time. But of course,
21 this was during Clinton's health care reform efforts, and
22 there were concerns on the part of the medical community. The
23 State Hospitalization Association and Medical Association came
24 up with an alternate strategy compared to the HRAT group, the
25 task force.

1 So this report from Commonwealth North provides a little
2 bit of an analysis and comparison of these three different
3 approaches that were proposed between Clinton, the HRAT and
4 the medical communities' solutions.

5 Commonwealth North then, ten years later 2003, organized
6 and funded the Alaska Health Care Roundtable. Their study
7 ended up focusing on and providing some solutions related to
8 the importance of building primary care in the State.

9 And then most recently again, Governor Palin had created
10 under Administrative Order the Health Strategies Planning
11 Council.

12 And one of the things I wanted to note about all of these
13 groups is that they had all recommended that -- they were all
14 short term obviously, anywhere from the Health Strategies
15 Planning Council met for six months to two years. All of
16 these groups recommended that there needed to be a permanent
17 health policy body established in state statute because the
18 challenges of just understanding the problems with our health
19 care system or the challenges in our health care system and
20 coming up with some potential solutions was going to take more
21 than just one to two years and that there needed to be some
22 accountability over time for following through on those
23 recommendations.

24 And with apologies to the optimistic group on the other
25 side of the table, I'm only going to take a couple more

1 minutes but have an additional point related to the increasing
2 costs of health care. And this graph on the slide right now
3 is copied out of the Health Resources and Access Task Force
4 Report, and the reason I put this slide up is that this was --
5 when I started in this job a little over a year ago, this was
6 a graph that I remembered from the early '90s when that group
7 was studying and it was burned into my memory because I
8 remembered being really pretty horrified at the time and
9 thinking somebody has to do something.

10 And if you can't read the slide very well, it shows,
11 starting in 1991, total health care expenditures in our state
12 were \$1.6 billion. And at the time, our state General Fund
13 expenditures for Medicaid were about \$80 million, and I was in
14 public health and concerned that, you know, basic prevention
15 community efforts were getting some of the crumbs off the
16 table from what the Medicaid program was getting and so
17 concerned that, as we were approaching the mid-'90s, watching
18 this curve for state General Fund expenditures especially
19 approaching \$100 million and not being able to imagine what we
20 were going to be able to -- how the Department was going to be
21 able continue funding other programs with Medicaid growing
22 that much. Well this -- these consultants had projected that
23 overall spending in Alaska would be \$5.6 billion by 2003 if
24 nothing was done. We know now that the most recent estimates
25 from 2005 were approaching \$6.0 billion total spending. In

1 2005, Dr. Hurlburt was projecting that we could be spending as
2 much as \$9.0 billion this year, just extrapolating from
3 Medicaid. I think we know we're spending at least \$7.0 or
4 \$8.0 billion right now.

5 Being considered 15 years ago about just approaching that
6 \$100 million mark in state General Funds for Medicaid, the
7 Department will be asking -- seeing if -- Mr. Strewer (sp) can
8 keep me honest here. We're going to be requesting a \$180
9 million supplemental request, is that correct, for Medicaid?

10 MR. STREWER: That's potentially.

11 COMMISSIONER ERICKSON: Potentially. Looking at the
12 potential of requesting almost twice just in extra need, and
13 we're looking at, as Dr. Hurlburt reported, \$1.5 billion
14 spending total, all funding sources, for Medicaid. And a
15 little bit of context, Mr. Morgan -- I think we'll get more
16 from our economist later this afternoon too as well context --
17 the significance of the growth in health care to the cost to
18 the state of Alaska, I just put up numbers from the State's
19 operating budget for this current fiscal year. Dr. Hurlburt
20 noted that, over the next decade, we can see states' budgets
21 approaching 20% to 30% consumed by Medicaid costs.

22 Right now, we're at about 20% of our total state
23 operating budget, and you can see a comparison of just our
24 Medicaid expenditures, \$1.4 billion this year projected,
25 compared to the operating budget. These are the operating

1 budgets all funding sources total for the entire Department of
2 Education of \$1.4 billion and then going down from there the
3 operating budget. This doesn't include capital. It's
4 important to understand for the Department of Transportation
5 and Public Facilities, but half of what we'll spend just on
6 Medicaid alone in our Department this year is going to fund
7 the entire Department of Transportation, \$0.7 billion; the
8 entire University of Alaska system \$0.8 billion; and you look
9 at public safety, the money we spend to put troopers on the
10 streets, our court system, and Department of Corrections for
11 our correctional system, \$0.6 billion, combined for those
12 three departments, their operating budget compared to what
13 we're spending.

14 So I think the concern that led to -- after 25 years of
15 recommendations that there needs to be a permanent Health
16 Policy Board and that recommendation not taking, I think
17 there, at this point, is enough of a sense of urgency in
18 Governor's office, among legislators that somebody needs to
19 figure something out here and do something. We were
20 successful finally, with our two ex officio members from the
21 initial Commission, Senator Olson and Representative Keller,
22 championing in the Legislature this past session, the passage
23 of support and passage of SB172 that established the
24 Commission now in statute.

25 I've provided in your notebooks, and it's posted on the

1 website, of course for folks in the audience, a copy of the
2 bill that is our new law that is the underpinning for our
3 Commission. We're established now under Alaska Statute Title
4 18, Chapter 9, and new members here appointed just this past
5 month, and Dr. Hurlburt noted that we will sunset on June 30th
6 of 2014, if the Legislature does not choose to extend the
7 Commission at that point.

8 There are a lot more details behind these duties, but
9 just a quick highlight of the purpose of the group is noted as
10 being to foster development of a statewide plan to address
11 quality and accessibility of health care, and that in general,
12 our duties are to be the state health planning and
13 coordinating body and also to foster the development of a
14 comprehensive statewide health care policy and strategy for
15 improving the health of Alaskans.

16 I mentioned earlier this morning one of our other duties,
17 our third main duty, is to produce an annual report each year
18 by January 15th for the Governor and the Legislature. And so
19 we have that responsibility, even though we're just meeting
20 for the last quarter of this calendar year. We still have an
21 annual report due on January 15th. We'll talk more about that
22 later.

23 I did want to note too I've listed on this slide all of
24 the members, the seat designations for the group, and we do
25 have four new members added under SB172 compared to our

1 original group under the Commission created by Governor Palin
2 now for primary care physician, Mental Health Trust Authority,
3 community health centers. And then Colonel Friedrichs in the
4 seat designated for the Department of Veterans' Affairs health
5 care industry. That language is worded a -- it's interesting.
6 It says that somebody involved with the U.S. Department of
7 Veterans' Affairs and health care industry. So welcome
8 Colonel Friedrichs.

9 And then the same ex officio seats, non-voting members,
10 Linda Hall will be joining us shortly. She had another
11 conference she was speaking at in town here this morning and
12 again at noon, but Linda Hall is our State Insurance
13 Commissioner. She is representing the Governor's office. You
14 haven't had a chance to meet her yet. And we're fortunate to
15 have Representative Keller and Senator Olson continuing as our
16 representatives from the Legislature on this group, too.

17 I'm hoping you all had an opportunity to at least, if not
18 read, skim through and catch some of the highlights I pointed
19 out in the homework I sent the Commission members ten days ago
20 or so, some of the highlights. But I wanted to start off
21 before I talk about what we developed in terms of
22 recommendations, one of the things the Commission did was lay
23 out a framework for a five-year planning process and that
24 included the need to develop a vision -- and that's something
25 that the Commission did do in their first year, and we'll

1 review that in a minute -- the importance of being able to
2 understand and accurately describe the current health care
3 system and we got a good start on that, but probably have a
4 ways to go. And then another part of that is building the
5 foundation identifying the elements that we need as kind of
6 the infrastructure basic support for the health care industry,
7 understanding what those basic supports are and what we could
8 do to continue to strengthen and build that foundation, but
9 then identifying a series of strategies that could help
10 transform or move the health care delivery system in a way
11 that is more efficient and more effective and it increases
12 access, it improves access.

13 We identified the importance of needing to measure
14 progress along the way. As we continue building this plan, we
15 want to be able to measure the success of those strategies
16 that we might recommend and how well the system is doing in
17 moving in the direction of this vision. And finally noting
18 the importance that, throughout this process, being able to
19 engage public and stakeholders.

20 In addition to planning to plan, the Commission did
21 identify some specific recommendations for 2009. We'll go
22 over those in a minute. A lot of these recommendations, a
23 number of them anyway, are very general policy
24 recommendations. So in addition to those more general policy
25 recommendations, there is a table, if you haven't had a chance

1 to see it, towards the back of the 2009 report that laid out a
2 specific action plan, some specific steps that the Governor,
3 the Legislature, the Department of Health and Social Services,
4 or other state agencies could take to advance those more
5 general policy recommendations.

6 And then finally looking forward to -- you'll see in a
7 minute -- one of the recommendations of this Commission, the
8 same as all those former Bodies, was that there needed to be a
9 permanent Body. So in anticipation of the possibility and the
10 hope that there would be -- the Commission would be
11 established in statute, we laid out a suggested work plan for
12 this year in 2010. So we're going to review that together
13 here in a minute, too.

14 So as I mentioned, the Commission in 2009 defined a
15 vision. It focused on the importance of improving health
16 status, the importance of providing value for Alaskans' health
17 care dollars, both in terms of cost and quality. That
18 consumers and providers both would be happy with the system
19 was one of the things we found. There were more and more
20 consumers that were unhappy and providers very frustrated.
21 And that the system needed to be sustainable.

22 And the point about sustainability was so important to
23 the initial Commission that that comes out twice, both in the
24 vision for the future health care system for the State, and
25 you'll see at the bottom where we've listed the values that

1 were identified it's the very first value, is sustainability.
2 That the health care system needs to be sustainable, and any
3 recommendations, I think, to Dr. Hurlburt's suggestion that
4 recommendations related to workforce recommendations, related
5 to anything that we address, need to be tied to resources. We
6 need to not be choosing pie-in-the-sky and understanding that
7 those specific strategies need to be sustainable as well.

8 Goals the Commission identified were to increase access,
9 control costs, improve quality and safety in the health care
10 system, and to make sure that the overall system is
11 prevention-based to the greatest extent possible.

12 One of the things the Commission did not do during that
13 first year was to quantify those goals, so that's something to
14 keep in mind when we move forward with a plan for measuring
15 and evaluation, if you want to set some targets for those are
16 or not. It's something to think about, file in the back of
17 your mind.

18 In terms of values again, sustainability at the top of
19 that list but efficiency, effectiveness, the importance of
20 individual choice, not taking choice away from the individuals
21 engaged in the system, and personal engagement, that folks are
22 engaged in their health care and in protecting and improving
23 their own individual and family's and community's health as
24 well.

25 We talked about the elephant in the room and the 800-

1 pound gorilla both. The two kind of overarching themes that
2 emerged in discussions among the group in the first year were,
3 at the time at least one of the members would refer to as the
4 elephant in the room, healthcare prices in Alaska. But there
5 was also concern with the overview Dr. Hurlburt just gave
6 about the status of Alaskans' health. The group really keyed
7 on the fact that so many of the health status problems are
8 driven by individual personal health behaviors, and we have
9 one graphic that we did include in the report that really got
10 folks' attention showing that 40% of health status is driven
11 by individual choice and individual health behaviors.

12 So those were the two issues that really had driven,
13 initially, all the recommendations that were developed, but
14 then as the year went on, we started learning more and more
15 about the appropriateness of care. I think the statistic we
16 would hear is that as much as 30% of all health care delivered
17 is not necessary or wasted or due to fraud and abuse, but the
18 issue of appropriateness of care lead to a couple of brief
19 learning sessions at our very last meeting related to
20 evidence-based medicine, again by Dr. Cahana and Dr. Hurlburt,
21 and we'll be continuing that.

22 These aren't the only three issues though. There are a
23 number of other issues and strategies that the Commission
24 identified in the first year, and I've just popped them up
25 here on this next slide. They're probably kind of hard to

1 read, but just to highlight a few of them. The fact that
2 Alaska has a small market and lacks economies of scale might
3 be one of the reasons and an issue to study, if we want to
4 look more deeply into that. The issue of cost shifting
5 between different payers. The payment methodologies, whether
6 we're incentivizing the right type of thing in the way we pay
7 for care. The disconnect between payers and users, that users
8 indirectly are paying but not seeing directly the cost out of
9 their own pocket if they are fully insured, whether publicly
10 or privately, that sort of thing, whether they're feeling
11 enough pain as they make decisions about treatment and care.
12 Level of uncompensated care, system fragmentation and
13 duplication, the fact that consumers and policy makers and
14 payers have a hard time accessing information about pricing
15 and quality in order to be able to shop a little bit more and
16 comparison. Issues related to malpractice system and new
17 medical technologies driving care and heroic care, heroic
18 beginning and end of life care, how much money gets spent in
19 the first six months' and the last six months' of care and if
20 there is a different way to approach that.

21 So those are just a number of the other issues that
22 emerged and are touched on briefly in the report but really
23 have not been studied thoroughly yet and are on the table, on
24 the plate for the group.

25 The initial Commission spent their entire first meeting

1 in the very last days of February 2009. We specifically
2 avoided learning sessions in that very first meeting and
3 wanted the group to kind of bring up their own priorities.
4 And so I don't know if those of you remember, we had a couple
5 of brief presentations by the former two groups, the
6 Strategies Council and the Commonwealth North group, just to
7 kind of get the lay of the land and see how their process had
8 worked, if there was something we could learn from their
9 reports and their learning and their ideas. But those were
10 the only learning sessions we had at that first meeting. The
11 whole meeting was devoted for a day and a half to conversation
12 among the group, and it really was a rich discussion and some
13 themes emerged from that conversation that became the five
14 priorities that the group identified to focus on for the year.

15 Firstly is the consumer's role in health care, importance
16 of statewide leadership, the importance of understanding
17 workforce challenges and working more on workforce
18 development, health information technology, electronic health
19 records, health information exchange primarily but also
20 telemedicine, and access to care for Medicare beneficiaries
21 was kind of a burning immediate issue that the group wanted to
22 understand better and see if there was something that they
23 could do to help.

24 One point that I wanted to remind the initial members and
25 to inform the new members the group had made a decision at the

1 very first meeting that they did not feel it was their role to
2 take positions on either state or federal legislation or laws,
3 that this group was intended to focus on and develop their own
4 policy recommendations.

5 So even, just as an example, to the extent that some of
6 the workforce recommendations that were more specific than the
7 group identified, there actually was pending legislation at
8 the time related to some of them, as examples, a loan
9 repayment program. This group did not study that particular
10 piece of legislation, didn't come out with any sort of policy
11 statement to endorse that particular legislation but did
12 develop its own policy statement that kind of stands alone and
13 legislators and others could take or use, one way or the
14 other.

15 So four of those five priorities -- I don't know if this
16 graphic is going to continue to work for you or not, but in
17 the end of 2009, the four top priorities came together in what
18 we're reviewing as an overall strategy for moving forward with
19 a five-year strategic planning process. And again that was,
20 building the base, identifying having a strong workforce, and
21 systems to support health information technology as a
22 foundation for moving forward, and also statewide leadership,
23 continuing statewide leadership as the foundation for building
24 an improved health care delivery system. But that the
25 consumer's role in health was -- kind of our overall is to

1 improve the consumer's role, both in the relationships with
2 the health care industry and their health care providers, and
3 focused very much on primary care and the importance care and
4 innovative relationship-based primary care systems.

5 But on the other side, the consumers again have an
6 important role in improving and maintaining their own health
7 and what can we do. Can we identify recommendations that
8 would help incentivize folks to take more responsibility for
9 their own health and their family's health?

10 So a picture of our overall strategy, supporting improved
11 access, improved value. That's both again cost and quality
12 and making the system more prevention-based. And so that left
13 the little Medicare access problem hanging out there, not part
14 of an overall system strategy, but then the question, the
15 concern was, is the problem with access to Medicare,
16 especially and primarily in Anchorage, kind of the canary in
17 the coal mine that's indicating the system really is starting
18 to have more and more problems that need to be addressed.

19 Let's see how we're doing with time. Moving on, we've
20 got about 15 more minutes. So I'm just going to quickly go
21 through the recommendations, and if you have any questions, we
22 can delve into those deeper or you can read the background and
23 explanation for these in the report later.

24 Around strengthening consumer's role, two pretty general
25 policy recommendations that the state government -- again

1 these are -- for the most part, they're recommendations to the
2 Governor and the Legislature. They are a few recommendations
3 that the Commission targeted at a future Health Care
4 Commission, if there should be one. So these are policy
5 recommendations to the Governor and the Legislature that the
6 state government needed to support healthy lifestyles and
7 create cultures of wellness and also needed to support the
8 development of patient-centered primary care models.

9 And for our next meeting and in our 2010 report, I'm
10 going to pull in updates explaining where we're at and what's
11 happened over the past year since the 2009 report came out in
12 January related to these recommendations.

13 Just one thing I would note on this is that, in this past
14 year, the Department did apply for and receive a federal grant
15 which was a specific recommendation related to pilot projects
16 for medical homes.

17 Related to statewide leadership, again two policy
18 recommendations. I'll focus on the second one first, that the
19 Legislature should establish a permanent state health policy
20 planning board in statute, and we are here because that
21 recommendation was accepted and acted on this time. Thank
22 you, Dr. Senator Olson and Representative Keller.

23 The other specific recommendation related to fostering
24 statewide leadership. As the group was meeting during 2009,
25 we had one eye on what was going on at the national level, and

1 the group would even suggest, at times, whether we were
2 wasting our time to be studying at a state level when the rug
3 was potentially going to be pulled out from underneath us and
4 we were going to have our health care system restructured for
5 us by the federal government. But we decided to continue, but
6 the group identified the importance of state government
7 investing in understanding what changes in federal law will
8 mean for Alaska and so that's what this other recommendation
9 is related to here. And we'll talk later this afternoon about
10 where we're at in terms of state of Alaska's government in
11 response to the federal health care reform.

12 Around developing health care workforce, the importance
13 of keeping it a priority for health care reform and economic
14 development in the state; the importance of strengthening the
15 workforce pipeline; looking all the way back in the education
16 system to the very beginning in elementary school, making sure
17 that our educational system is supporting the developing of
18 health care workers for the future; that our workforce and our
19 recommendations need to focus on the success in Alaska,
20 especially our innovations and adaption to our unique
21 situation/circumstances, for example, our Community Health
22 Aide program in the tribal health system, the way mid-level
23 practitioners are used in the state compared to other states,
24 just a couple of examples.

25 That plan needed to be coordinated. There actually was a

1 group that -- there is a coalition that still exists and was
2 in the middle of planning a workforce strategic plan for the
3 State. I made sure to provide a copy. It's in the very back
4 of your notebooks in the envelope. That report came out just
5 a few months ago. It was done under the auspices of the AWIB,
6 Alaska Workforce Investment Board, but it's a broad
7 partnership representing hospitals, the private health care
8 industry, the University, Department of Health and Social
9 Services participating in that group has really shown the
10 leadership around workforce planning. But this Body
11 recommended that that sort of planning needed to continue and
12 be coordinated to the greatest extent possible.

13 And then as a specific workforce problem -- and in the
14 short time that the group had, we couldn't study all of the
15 workforce issues, plus didn't want to duplicate the work that
16 was being done by this other Body. We decided to focus on
17 specifically the problems of physicians. There had been a
18 study that came out a couple years before in 2007 that focused
19 on physician shortages in Alaska. So this group targeted that
20 and decided that specifically there was a lot of learning
21 around loan repayment being one of the most successful
22 strategies that could be used recruitment retention. So that
23 was a specific recommendation that came out of that. But the
24 importance of focusing -- to the extent the government
25 especially is investing workforce development, that dollars

1 should be focused on primary care because of the disparities
2 in primary care support and workforce and the importance of
3 primary care in our health care industry.

4 The WWAMI program should be expanded as resources allow
5 and there should be support for graduate medical education
6 development in the state, in the primary care areas where we
7 don't have right now only a family practice/family medicine
8 residency program. There is work underway for developing a
9 pediatric residency program, psychiatric, and identified a
10 need for primary care internal medicine.

11 Recommendations related to Health Information Technology.
12 There's a lot going driven with federal dollars and guidelines
13 right now. We'll learn more about that in the future, but
14 support generally for Health Information Technology adoption
15 that state government should support, to the greatest extent
16 possible, the private sector in adopting and utilizing
17 electronic health records and health information exchange.
18 Privacy and security needs to be ensured, and we need to be
19 continuing to develop and support broadband telecommunication
20 infrastructure development in rural Alaska and that
21 reimbursement systems for supporting delivery of care through
22 telemedicine need to continue to be developed and supported.

23 And finally around the Medicare Access issue, the group
24 spent some time learning about plans for developing two new
25 Medicare clinics in Anchorage, one Dr. Rhyneer's, the other

1 not a new Medicare clinic but an expansion of the Anchorage
2 Neighborhood Health Center that would increase their capacity
3 to be able to provide more care for more Medicare patients.
4 And in the end, the group decided they had concerns about the
5 model of care that was being proposed in the one private
6 clinic and noted that there was -- already the State had
7 invested several million dollars -- I think it was about \$5.0
8 million -- in supporting expansion of the Neighborhood Health
9 Center.

10 Because of concerns about the model of care and
11 recognition that there had already been support, you don't see
12 a specific recommendation related to a specific clinic, which
13 that was -- well that was kind of the focus of this group.
14 They decided that the focus needed to be on increasing the
15 supply of primary care providers especially and revisited
16 again those recommendations related to primary care
17 physicians. Federally Qualified Health Centers and Rural
18 Health Clinics, such as Community Health Centers in general,
19 could be supported as important safety net providers. Relief
20 from the inequities in federal reimbursement and also the
21 administrative burden that the federal Medicare program places
22 on providers needed to be requested.

23 Finally, this is a recommendation that a PACE program be
24 developed. And I probably don't have time to go into detail
25 about what a PACE program is now, but it's kind of a

1 wraparound program of care, Medicare and Medicaid waiver
2 program that's currently being investigated in Alaska. We can
3 talk about that more later, but it would guarantee anybody who
4 was enrolled in that program access to a primary care
5 provider.

6 I think what I'm going to do for now is just go real
7 quickly, skip through these next few slides. We did identify
8 there wasn't time to study the whole world of all potential
9 strategies for supporting improvement and movement towards the
10 vision of our health care system, but we identified and
11 provided a brief description of a number of different areas.

12 The group had really tabled, set aside the one area,
13 understanding that the federal legislation was focusing on the
14 federal discussions really was focusing on health insurance
15 coverage. We did decide not to address that issue in the
16 first year, although we did provide some background
17 information on insurance coverage in Alaska workforce
18 development. And then we never talked about real specific
19 services in discussion, not that I recall, but we wanted to
20 have a placeholder there if specific types of services, for
21 example certain behavioral health or long term cares services,
22 need to be studied at some point, but we kind of have a
23 placeholder for that.

24 A number of areas for potential study in moving forward
25 around improving value, improving cost and quality. We

1 couldn't divide those, by the way, even though we have two
2 separate goals related to cost and quality. Starting to look
3 at some of these strategies, the quality and cost issues are
4 so interwoven that, in trying to divide them out into two
5 different categories, it just didn't work. But the group did
6 identify that we got a good start in starting to understand
7 disparities in cost of care in Alaska and that we needed to do
8 a lot more work to study and understand that.

9 We needed to identify some more specific strategies for
10 fostering primary care development and innovation. We
11 considered the possibility of state government being able to
12 leverage their purchasing power of strategies between the
13 State's Medicaid programs, and the State's employees'
14 insurance programs, workman's comp could all be combined, that
15 that could be a way to start driving some changes in payment
16 methodologies if some ideas are identified there. The
17 importance of increasing transparency about cost and quality
18 might be a future strategy.

19 Moving towards value-driven purchasing, I guess this is
20 where leveraging state purchasing power may or may not come
21 in, but some of the ideas around evidence-based medicine,
22 payment for performance, bundling payment systems, and non-
23 payment -- requirement of reporting for medical errors and
24 health care required infections and non-payment for those
25 events, just some ideas, some certain strategies.

1 Controlling fraud and abuse, reforming the malpractice
2 system, and supporting process and quality improvement in the
3 health care industry are just some of the other ideas that are
4 discussed in the report.

5 And then again around prevention, the importance of
6 public health and community-based prevention. We do have,
7 specifically in our Administrative Order initially and now in
8 the law, a responsibility for looking at safe water and
9 sanitation systems. And then the group spent some time
10 learning about workforce wellness and also employee health
11 risk management as part of insurance plans and the success and
12 the value of those programs in improving health behaviors and
13 providing a supportive environment for folks to live healthier
14 lifestyles. So it was a more specific issue than those first
15 two that were a little more general.

16 So that's just a quick summary of what we accomplished in
17 the first year. Just a few thoughts about where we're headed
18 next. Again we have just a couple of months here to pull off
19 an annual report. This is a proposal for just a meeting
20 schedule to help us and how we might focus our time over the
21 rest of this calendar year and then into the next calendar
22 year.

23 What I'd like to do -- it's been a challenge to find
24 dates for -- it was a real challenge to find dates with ten
25 people. It's going to be nearly impossible for 14 people to

1 get everybody together at the same time, and trying to
2 schedule and identify those dates is a challenge. So I'm
3 hoping that sometime in the next month or two, we could
4 actually set a meeting schedule for the next calendar year,
5 for 2011, so we just have it set and don't have to struggle
6 with that in the future. But ideally we'll be meeting
7 quarterly next year.

8 And for the rest of this year, I had suggested some dates
9 that seemed to work for the vast majority of folks in this
10 group. We would meet again, as much as I hate to do this to
11 all of you, in another day and a half long meeting just a
12 month from now, again just for the purpose of coming up with
13 some ideas to include in our annual report here. Kind of an
14 expedited public comment period. We want to make sure we put
15 drafts out of our initial Findings and Recommendations for
16 public comment and then have some time to integrate those. So
17 I kind of laid out a schedule for how we might approach it and
18 identified a final date of January 7th for one day of meeting
19 to kind of wrap up our work and finalize a report and
20 incorporate public comments in.

21 And then our approach for next year would be to spend the
22 first two meetings -- the first quarterly meeting being in
23 February or March; the second one in May or June -- in
24 Learning & Planning Sessions on areas that you all will
25 identify over the course of this meeting and the next one and

1 where you focus your time. And then a meeting to draft
2 Findings and Recommendations for 2011 in either August or
3 September. We'd be able to have an earlier and longer public
4 comment period then, estimating mid-October to mid-November,
5 and then one final meeting for that calendar year to finalize
6 and approve the report probably in early to mid-December.

7 So that's just thinking about, again, where we're at, the
8 strategic planning process. We have developed the vision,
9 wanting to continue to describe the current system and
10 identify the strategies for continuing to build the foundation
11 and transform the system.

12 I just bulleted out -- these are -- I'm pulling these
13 bullets out of pages in the report and so there is one page
14 that just summarizes this 2010 work plan. We were envisioning
15 a full year, not three months, but something to think about.
16 The earlier Commission had identified the importance of
17 continuing to analyze the cost of health care, should
18 understand the impact at least of federal reform if it
19 happened. The Commission should track implementation of those
20 2009 recommendations. There were a few specific
21 recommendations for the Commission. We can go over those
22 later. The group will prioritize and look at that array of
23 other potential strategies and prioritize and pick the top
24 priorities for the next year for study and that we implement
25 the public communication plan we developed in the first year

1 and also an evaluation plan.

2 So that was what we thought the Commission should focus
3 on for their next 12 months coming out of that last process.
4 And finally, I just wanted to wrap up with the discussion
5 questions that will focus tomorrow's discussion. Again these
6 questions want to identify what gaps we have still about
7 information about our current system, identify what you all
8 think, at least as of tomorrow, in terms of highest priority
9 strategies for future study and recommendation development for
10 moving forward. Spending some time looking at the draft,
11 still kind of -- and complete list of indicators for measuring
12 progress and figure out how to move forward with finalizing
13 our evaluation system and figure out how we want to spend our
14 consulting dollars.

15 One of the things I didn't mention is that, when Governor
16 Palin created the initial statute and the initial Commission
17 under Administrative Order, the Department had included an
18 operating budget increment to fund it and it was not funded.
19 The increment was not funded. So we met for that first year
20 with no money, and I was warned that I might not have a job
21 after a few months, actually the first few months of the
22 Commission meeting, if we didn't get funded. Well there were
23 other things that happened and that's too long of a story, but
24 we ended up managing to scrape together some pennies and
25 crumbs that fell off the table from bigger programs and the

1 Department of Health and Social Services that kept us going,
2 but we really operated very much on a shoestring. And one of
3 the things we had no money for was consulting services. And
4 so we do have money now. We'll talk about that when we look
5 at the budget a little bit later today. So I need direction
6 from all of you in how you would like to target those
7 consulting dollars.

8 So we'll be setting the agenda for kind of our 2010
9 report and how we'll spend our time in 2011 and how we'll
10 spend those consulting dollars with this discussion we'll have
11 tomorrow. And with that, I will wrap up. We're right on
12 time, I think, but does anybody have any questions, either
13 about what the Commission did in 2009 and what our plans for
14 the next few months, few hours, and few days, and few months?

15 No questions. Very good. Well actually are right on
16 time with our agenda. It's 10:15. Our plan is to take a 15
17 minute break, and I'm hoping Linda will make it to join us and
18 that you all will be able to stay with us because we're going
19 to have one of our Information Officers come down from the
20 Commissioner's office to take a group photo in ten minutes.

21 UNIDENTIFIED MALE: I didn't do my hair.

22 COMMISSIONER ERICKSON: Well I'll lend you my comb. So
23 we'll have a group photo in about ten minutes, ten to 15
24 minutes before we get started again at 10:30.

25 CHAIR HURLBURT: Yeah. And when we get started, this

1 will be -- we'll have an hour-and-a-half about, so about five
2 or six minutes to talk about what your hopes and expectations
3 and aspirations are for the Commission and as members of the
4 Commission, so that's what it will be and kind of be thinking
5 about that during the break because I know everybody has a lot
6 of ideas here. Thanks.

7 10:16:52

8 (Off record)

9 (On record)

10 10:38:49

11 CHAIR HURLBURT: Let's get started now. We have from now
12 until noon. We'll break for lunch. So we have 80 minutes, so
13 about five minutes each, and this is to talk about what your
14 hopes and aspirations and expectations and any other editorial
15 comments that you want to make within five minutes. So we'll
16 start with Jeff and then just work around the table.

17 COMMISSIONER DAVIS: Thank you, Dr. Hurlburt. I'll start
18 with a story first. Well I won't with a story, but I'll get
19 to the story. Some of you have heard it already. And just
20 listening to some of the comments earlier, I was mentioning to
21 Pat I'm neither optimistic or pessimistic as to what we will
22 accomplish. I don't see the way out, but I believe that we
23 have an obligation to put our shoulders to the wheel and to
24 find the way out. And I think how that will happen is a lot
25 of dedicated, smart, informed people thinking creatively

1 around a table, and courageously, and trying to tackle issues
2 one at a time that can make a difference.

3 So I'll share a story because, I think, it illustrates
4 sort of where that attitude is coming from, and I know Karen
5 has heard this and others.

6 I was in the parking lot of Mountain View Sports with my
7 wife, and I was whining about federal health care reform and
8 how it was going to ruin the country and ruin the industry and
9 ruin our company and ruin our retirement and ruin my career
10 and on and on and on, and she finally said -- my wife's the
11 sweetest woman in the world, so she said this actually much
12 nicer than I tell it, but she said stop it. She said, you
13 know, how many people are given the position to influence
14 something that's so very important. You have been, so stop
15 whining. The glass is half full. Get to work and make the
16 most of it for the people you serve. And I think that she was
17 absolutely right. The one smart thing I did was marrying a
18 very wise woman. She was absolutely right, and I think that's
19 the attitude that I bring to this Commission. What we laid up
20 there is -- this is complicated. If we're spending an
21 additional -- what was the one estimate I saw, you know, \$180
22 billion a year more than we need to nationally, that's money
23 that's going into someone's pocket, and people don't give up
24 billions of dollars easily. And we all have a different view
25 of how this works, so it's going to be -- require some

1 difficult conversations and sacrifices on all of our parts and
2 kind of leaving our agendas at the door, as I said a moment
3 ago, for us to make progress.

4 So my expectation is, at least for me, that I'll bring my
5 best efforts to what we work on, the benefit, hopefully, of 30
6 years' of perspective in this industry, and that I will work
7 for all Alaskans to my best efforts and not just for the
8 people that I directly represent as the way this was laid out
9 in the charge to the Commission. And my hope and expectation
10 is that the rest of the Commissioners will bring that as well
11 and so I look forward to working with all of you. I did not
12 realize we were sunsetted. It's like, well, a permanent
13 Commission, for three years, you know, but a lot could happen
14 in the next three years. We'll see where that goes, but I'm
15 grateful to have this opportunity. Thank you.

16 (Pause - no mic)

17 COMMISSIONER MORGAN: Like I said, I've got -- working
18 with our Board and community health centers across at the
19 State at the Alaska Primary Care Association, I have some
20 concepts and ideas that we'll share with the Commission in
21 writing. But basically what I'd like to see come out of the
22 Commission is some concepts and ideas that we can put in
23 practice that can, at least, bend the cost curve, that can
24 start to slow down the acceleration of costs by how we deliver
25 health care, and more important, how we reimburse for it. My

1 specialty is reimbursement in Medicaid and Medicare.

2 There's a few other issues that's included in that three-
3 page -- things that the Board and the Association would like
4 to see come out of this. Most of it is working on the front
5 end of primary care to help reduce utilization from electronic
6 medical records to types of providers that are reimbursed in a
7 rural setting, but one area that we did include, which I went
8 into a little more detail, is I'm a bit concerned that
9 virtually every idea I've heard over the last two years needs
10 a staff at the other end to work with us to do -- to develop
11 those ideas.

12 I have never had a problem with our Health and Human
13 Services Division in Medicaid to entertain and try to come up
14 with innovative ways or changes to the reimbursement system or
15 types of providers or adjustments to the plan, but I've been
16 literally in a room working on something, like PACE or
17 patient-centered medical home type activities, and there was
18 more of us than there was from the State and it wasn't because
19 they weren't interested. It was because they are very limited
20 currently on staff, and I'm not talking about massive numbers
21 of people, but I'm talking about some actuaries, some
22 economists, some IT guys.

23 We talk a lot about everything else, but in order to
24 implement it especially on the Medicaid front, we're going to
25 have address a workforce issue. This sounds strange from a

1 guy only interested in costs, I know. It's sort of like a
2 doctor wanting to talk about costs, but we have to address the
3 fact that there has to be a partner at the other end to work
4 with us, if we're going to do it timely and move it along. It
5 takes six months/eight months to get a plan amendment through.
6 That's not anybody's fault. It's simply you don't have the
7 necessary individuals or boots-on-the-ground at the other end
8 to do it. They're not ineffective. They're not -- they don't
9 know what they're doing. They're simply only so many people
10 down there, so basically the other 12 or 13 issues that are
11 technical that we like to see processed and are actually in
12 resolution form that we're sending to the Legislature also,
13 which I've shared. But a couple areas that, I think, need to
14 be mentioned is Bill Strewer (sp) and Mr. Hogan might need a
15 few people that can sit across the table to work this stuff
16 through. Like I said, they've never said no. It's simply the
17 availability of staff time to work and to develop those to
18 process them through timely. So basically that's what I hope
19 to see out of this and thank you for the time.

20 COMMISSIONER FRIEDRICHS: Well thank you so much, sir,
21 and again I apologize for being late and for having to step
22 out for a teleconference. I very much appreciate the
23 opportunity to be here.

24 I'm here, as Ms. Erickson said, representing the
25 Veterans' writ large and all of those affiliated and that

1 really covers both the DOD and the Veterans' Affairs. So on
2 behalf of Mr. Spector (sp) and the DOD on the Army and Air
3 Force and Coast Guard side, thank you for the opportunity.

4 There's three things that we've talked a lot about on the
5 federal side here, and the first one really is partnerships.
6 And Dave, I think your point is spot on about that. What I
7 hope to see come out of this is a much stronger partnership
8 between the federal and the other entities here.

9 There is no question that very little that we are able to
10 do today to expand the capacity or the capability is going to
11 be done at an individual level and succeed. There is also no
12 question in my mind that there is a lot of great stuff that's
13 being done individually, and we're not sharing that
14 information very effectively across the organizations. For
15 example, we take care of, between the VA, the Army, and the
16 Air Force, 20% of the population of Anchorage. Both the VA,
17 the Army, and the Air Force are rolling out the medical home
18 model.

19 We've got one of the most experienced sites for the
20 medical home model or patient-centered care right here in
21 Anchorage, and trying to leverage those lessons learned from
22 practices, like yours or from Alaska Native, should not be a
23 challenge. That should be something that we're able to
24 foster. And so that would be one goal for us out of this is,
25 how do we partner more closely?

1 A second goal is, how do we share lessons learned more
2 effectively so we don't each waste resources reinventing the
3 same wheel?

4 A second issue that we're very interested in is quality,
5 and I agree with your comment, Deb, about cost and quality
6 being inextricably linked. Not a week goes by, including this
7 morning on the teleconference, where I'm challenged to explain
8 why I spend more for pretty much everything than anybody else
9 in the Department of Defense, and Mr. Spector has the same
10 discussions with the Veterans' Affairs Administration. How
11 can it possibly cost \$300,000 in Alaska when we can get it in
12 Washington D.C. for \$80,000? And we all know why that is.
13 After several years here, I understand it better. But at some
14 point, we have to ask whether this is the appropriate benefit
15 to those that we are serving. It is becoming increasingly
16 difficult in Washington D.C. to go back and ask for more
17 resources to deliver the same amount of care and not even
18 necessarily provide the standard of care.

19 So a second goal would really be to tease out that cost
20 benefit trade off, and some specific areas that we are very
21 interested in is trauma care. There is no question that what
22 we do on the military side is dangerous and it generates
23 trauma. There is also no question that this is the one state
24 in the Union that does not have a trauma system. So if a
25 soldier is injured jumping out of an airplane doing what he

1 has volunteered to do for his nation, we'll give him the best
2 care that we can here, but we don't provide the standard of
3 care that's available in the Lower 48. We don't meet the
4 minimums that have been laid out and well-described now for 20
5 years that we actually deliver in Iraq but are not able to
6 deliver to all of the citizens here in Alaska. And so that's
7 one area where that quality cost trade off would be one that
8 we're very interested in partnering more closely in.

9 We very much recognize that that quality cost trade off
10 requires increasing the capacity along the way, and we've
11 partnered with the local family practice residency. We are
12 helping to host the PA program, the nurse program, the dental
13 hygiene program, lab assistant program to build capacity in
14 the community. That's another area in which we look for
15 opportunities to partner and also to do it in a way that
16 builds quality, not just quantity, of health care providers
17 here.

18 We were talking at the break about going to Iraq and
19 seeing what it's like to practice health care in a tent. I
20 like to bring people to Selawik or Galena and show them what
21 it's like to deliver health care in Alaska to American
22 citizens. There's a quality cost disconnect there that's
23 related to everything that you described in your slides, and
24 there, I hope, will be an opportunity for us to bridge that
25 and acknowledge that we must move forward in that area. The

1 lack of running water for American citizens is something that
2 we, at the federal level, recognize as a striking challenge.

3 So those are the things that I would lay out. I think
4 that there's great opportunity with a Commission like this to
5 learn from each other. We've embraced an electronic medical
6 record now for almost 20 years. It is not the panacea to
7 anything. In fact, it's more often than not a pain in the
8 rear. It is a huge learning curve. It's a culture change.
9 It's a tremendous challenge to embrace and to incorporate it
10 well, but there are positive aspects to that that we can learn
11 from, and Alaska is poised, I think, to be on the cutting edge
12 for the entire United States because of how new we are in
13 building a system that interlinks much more effectively than
14 is occurring in other areas. And so we look forward to
15 partnering on that.

16 The last thing that I would leave with, from a federal
17 standpoint, is we are very much, from a service standpoint,
18 here to serve those for whom health care is an entitlement.
19 This is not a luxury. We don't approach this as someone is
20 getting care that they would like to get. These are things
21 that our country has said we will provide to those Alaskans
22 who serve in uniform or who have served and live here. That
23 is part of what I hope to get out of this is, how do we keep
24 that discussion on the commitments that we have already made
25 and deliver on those commitments in partnership with the

1 State, the Municipality, and the private health care industry?

2 Thank you, sir, for that opportunity.

3 CHAIR HURLBURT: Thank you.

4 COMMISSIONER LAUFER: I have all kinds of things to say,
5 and I think, it would take up too much time, but I'm on this
6 Commission actually despite a great reluctance on my part. I
7 did not send in a resume or CV but was called, and I said no.
8 And then I was told I was on a short list, and I said no. I
9 agreed to a year of it, and I did this because I think that
10 the answers for some of the problems are fairly
11 straightforward, and it's primary care.

12 I'm a family doctor. I'm not moving up in my career.
13 There isn't something after this. This is what I'm doing
14 professionally with my life.

15 I'm also a small business owner. We pay 34 cents on the
16 dollar for benefits. I feel like, to some degree, we're
17 dealing with the mafia, threatened by potentially bankrupting
18 costs. I'm a father. I have three children who are going to
19 pay off the debts, the credit taken out by the boomer
20 generation largely for this. And I think we could solve it if
21 we really were interested in doing that.

22 There are a couple things. These billions of dollars
23 have recipients, and they are large powerful organizations,
24 big employers with lobbyists, and I don't see them changing
25 until a true crisis occurs. Curves that go exponentially

1 steeper and steeper don't continue to do that. We've seen
2 that in the stock market.

3 I think what's required is a paradigm shift about what we
4 think about things, what we want for medical care. Do you
5 want to be uninsured your whole life, have a catastrophic
6 event which you, perhaps, are not even conscious for and die
7 of and have all of your assets liquidated and a large bill go
8 to the taxpayer? This is the current system, and we have to
9 think about that differently.

10 Medicare, for example, is not set up to care for people
11 as they get older. It is a legal way to externalize costs
12 that would otherwise be borne by communities or by the
13 insurance industry. You go on Medicare if you're actually
14 sick or likely to become sick, and this is a way to get the
15 taxpayer to pay my children. We could change, but we really
16 need to look at a new paradigm. And businesses, like
17 hospitals, that charge \$8,000 a night for a room are not
18 sustainable. It's not going to continue to occur this way.
19 We're increasingly less competitive in the world, and this is
20 part of the reason.

21 So I agreed to do this for one year, with great
22 reluctance. It has to change. I'm not going to change it.
23 It's going to collapse. That's my view. I'll stop. Thanks.

24 COMMISSIONER STEVENS: Thank you. I am not in the health
25 care industry, but I represent a large number of people who

1 pay for the health care industry. And as a business
2 organization, those costs generally fall to the feet of the
3 business community, whether you're a doctor in the business of
4 providing health care or a business doing any number of
5 things. Employees come and expect a benefit, expect health
6 care coverage of some manner, shape, or form.

7 While not being involved in the health care industry, my
8 mom was a nurse, my two sisters are nurses, and the woman who
9 lets me live with her is a nurse. So I have, at least, some
10 modicum of understanding about health care, and my mother's
11 theory was, if you couldn't see the bone sticking out and
12 there wasn't blood, you weren't hurt and you didn't go to the
13 doctor for a stitch for a little cut when a butterfly bandage
14 would do just as fine. And we've gone beyond that sort of
15 very simple premise to a system where, for every ache or pain,
16 there's either a pill or a procedure that will make me feel
17 well again, and common sense has left the equation.

18 You know, business is paying the cost of this, and
19 business finds it more difficult to bear the costs for --
20 whether it's insurance or benefits of any manner, shape, or
21 form, and just to be in business, the regulatory environment,
22 depending upon the kind of business you're in, is more and
23 more difficult. And I think there's a great disconnect in
24 this country about how things work and where things come from,
25 and as a result, you have a great number of people working

1 against the ability of business to do business, and it's
2 business being successful, business taking risks that creates
3 jobs. It's people who have jobs that pay taxes that help to
4 support all of this. It's businesses who are profitable who
5 pay taxes, and without profitable businesses creating jobs so
6 that people can pay taxes, we run out of money to pay for all
7 these things we think we need. And so we need to kind of
8 engage the public at large in a conversation about costs and
9 how things work.

10 Whether you like or dislike the oil industry, they're
11 paying for 85% or 90% of what we're talking about here at this
12 table. It's a very frustrating discussion. Whether it's
13 health care, whether it's transportation costs, whether it's
14 property taxes for community members, everything's
15 intertwined. And if we don't understand the systems, then
16 it's very difficult to say it's Jeff's fault that all of this
17 is broke or it's Noah's fault that -- it's easy to assign
18 blame, but it's very difficult when you're pointing to
19 remember that there's three or four fingers pointing back at
20 you as an individual. And somehow, we need to engage the
21 public at large in a conversation about who we are, where
22 we're going, and how we're going to pay for it. And if we
23 don't create jobs and create opportunities, we're just simply
24 going to run out. And I wouldn't disagree with the thing that
25 you said, Noah, that, you know, we're headed to a point that's

1 not going to be pretty, and if we don't hold a conversation,
2 we're not going to get there.

3 We need to engage our employees and let them know that it
4 doesn't cost \$100 a month to provide health care insurance.
5 It costs \$900 a month, depending upon the care -- or the level
6 of program that you're involved in. And so engaging employee
7 groups and helping them understand what it costs for each
8 individual organization, whether you're a doctor's office or
9 an oil company, you know, or a health care organization, there
10 are costs associated with providing those benefits, and we
11 need to engage employees so they understand what those
12 benefits are. And they need to understand and be aware that
13 how they act and behave drives some of those costs, and we've
14 had long conversations about responsibilities and how you
15 explain to people that, if you don't exercise, if you don't
16 lose some weight, if you don't do the things you need to do to
17 be healthy, then at some point, we're going to run out of
18 money to pay for the silver pill and the silver procedure to
19 keep you young and healthy.

20 I think there's an opportunity with this organization,
21 this Commission, to engage the larger body politic in that
22 conversation, and I agreed to serve a second round in this
23 process because I was impressed with the original discussion,
24 the original effort of this group, the ability of each of us
25 to leave our individual biases and individual representations

1 at the door and say what's in the greatest good of all of us.
2 And whether you're a hospital administrator or a business
3 owner or a doctor or a lawyer, we were able to set those
4 perspectives aside for a moment and say, how can we make
5 Alaska the great state that it can be and provide for those
6 who are less able to provide for themselves and be able to do
7 it in a way that's affordable for those who are paying for the
8 bills?

9 And I thought we had a great conversation and came out
10 with a report that I was proud to sign my name to, and I'm
11 hoping that we can continue that process and that great work
12 that we've put forth thus far. I think there is huge
13 opportunity. I don't disagree that there is opportunity to be
14 a pessimistic. There is opportunity to be an optimist. But
15 if we don't engage and we don't provide leadership -- and I
16 think there's an opportunity here for engaging and providing
17 leadership, and it's not that someone's right or someone's
18 wrong. It's engaging in that conversation to say, here's an
19 opportunity to change how we're doing things and here's what
20 you need to do to be a part of it. Here's what I'm going to
21 do to be a part of it, and here's how we, doing it together,
22 can be successful. And I think this state lacks for that kind
23 of leadership, and I think there's a huge opportunity here for
24 this august body to provide some of that on this conversation.
25 Thank you.

1 COMMISSIONER KELLER: We're going to get a string of
2 pessimism here. I appreciate, Noah, you making the decision
3 to join us. In particular just as you were talking, I thought
4 about the cost.

5 At the risk of sounding like Chicken Little again, I
6 remember, like Deb, ten years ago about, I went to a public
7 health training session that was about a week out in Chapel
8 Hills, and they predicted that health care costs over the next
9 ten years were going to rise at 10% per year or 8.9%, I think
10 it was what they said, per year over the next ten years. And
11 I remember being pretty pessimistic that that could be true,
12 and here we are and it's actually more than that and that's
13 about, I think saw somewhere, a 275% increase.

14 Right now, 42% of all federal program money is for health
15 care, and they're predicting that to go to 62% shortly by
16 2014. It's a crisis. It's a crisis in all states. I'm
17 involved in several legislative organizations that are
18 nationwide. We're very fortunate up here. We're one of the
19 three or four states that aren't looking at a big deficit in
20 the state, like California, of course, is the one that's in
21 the news. But at last count, there were 21 states looking for
22 ways to cut transportation, 37 trying to cut corrections, 37
23 post-secondary, 35 K-12 that they're looking to cut to be able
24 to pay for and keep up the Medicaid and health care cost
25 requirements and entitlements that are out there.

1 We're facing a crisis. That's why this Commission has
2 money, I would say, or people that see it. You know, there's
3 an investment being made here by some farsighted Governor and
4 some that really are concerned with what's going on.

5 Another thing this Medicaid/Medicare, the limited access;
6 we're very fortunate up here. You go Outside. I think it's
7 60% now of your doctors aren't taking new Medicaid patients.
8 That's what I just read here two days ago. You know, we don't
9 have that problem up here because we have decent Medicaid
10 rates, and of course, the Medicare one is all over, too.

11 So we have a crisis. And speaking about us in this
12 Commission, you know, part of that triangle that Deb had up
13 there, there's two things in there that are really important
14 to me.

15 One is the consumer involvement, engagement in the
16 process. If we cut a dollar anywhere in health care, somebody
17 gets hurt. You can do that top-down or you can let the
18 consumer do the cutting according to what makes sense for him
19 or her with what they have. And so I mean just to throw an
20 old idea out, I mean, it's an HSA thing, you know. It puts
21 the money in the control of the purchase and put a real value
22 then on some of the health care stuff that right now, frankly
23 you know, it's hard to know whether you're getting your
24 dollars' worth when you pay for some of the costs. You know,
25 it's very difficult because it's removed from the consumer.

1 Of course the prevention part of the consumer engagement,
2 the medical home model that looks at the -- it's consumer-
3 focused, you know. I think it's good things that we can look
4 at and work on, but the ideas that we come up with, you know
5 again, it comes back to here.

6 I'd like to talk a little bit more about the Commission.
7 The leaderships -- the leadership thing, in a sense, we're it.
8 You know speaking from a legislator perspective, we need
9 guidance from people that know what's going on. More
10 importantly, we need guidance and we need leadership ideas
11 that we can trust. And frankly, that's one of our struggles
12 here in a small population because we all have -- as I look
13 around the room and consider each one of us, including me, we
14 have -- it could be argued that we gain if there is more
15 spending in health care, each one of us individually. So we
16 have to lay that aside, get rid of that perception, and do
17 some things that are probably going to hurt. You know if we
18 make a recommendation here as a group, we're going to be
19 criticized if we get anything done. That's just the way this
20 whole thing works, you know. So I mean, it could be a painful
21 process that we're in for, and I would just encourage you to
22 take the perspective that Noah demonstrated, and you know, his
23 decision to do it because it could be a tough year, a couple
24 tough years.

25 So anyway it's a risky job we've got, and you know if I

1 was going to challenge you, my friends, people I've learned to
2 respect and appreciate, you know, let's take risks. Let's get
3 this thing figured, figure out some ways to go. So thanks.

4 COMMISSIONER STINSON: I appreciate everything that's
5 been said to this point. I agree largely with what's being
6 said.

7 As the national health care legislation unfolds, there is
8 going to be surprises. There is going to be changes. There's
9 going to be issues that we're going to have to deal with, and
10 we don't even know where all those turns are, but there is
11 also opportunities. There are some things that we can do.
12 There are some things that we can do in the long term. There
13 are some things that we can do in the short term. We just to
14 have the will and maybe, as Dave was referring to, the staff
15 to follow through with this.

16 I think your point earlier about controlling diabetes and
17 getting to people when they're young, that's huge because
18 diabetic health care in the elderly population is incredibly
19 expensive, incredibly time-consuming, and if you can head that
20 off, that's like having vaccines. I mean, you can't cure
21 measles, but you can prevent it. And that falls into the same
22 category. If you can prevent diabetes, you've just really
23 helped a lot of people and you've helped the whole system.

24 So on a lot of long term -- on a long term view, we need
25 to be doing those types of programs. We need to be

1 encouraging those types of programs. The seed money for those
2 types of programs will pay off. It's not going to have an
3 immediate benefit, but it will pay off.

4 On the short term -- and I know you're going to be
5 talking about this tomorrow and I've been -- obviously, I was
6 the one that asked Dr. Cahana to come and address this last
7 year. Since he addressed us, they did pass a bill in
8 Washington State that has already saved them a considerable
9 amount of money on evidence-based medicine.

10 The key part is, whose evidence is true? Is it real? Is
11 it realistic? Is it something that's acceptable? He has got
12 a database, and they've been using it on medications. And I
13 was hoping Mr. Strewer was still around because I wanted to
14 talk to him about Medicaid expenditures.

15 UNIDENTIFIED MALE: He's here. He came back.

16 COMMISSIONER STINSON: Oh, he came back. What they did
17 in Washington State specifically is -- I should get a copy.
18 I'd like to give you a copy of that bill. But they put
19 parameters, and they let the different practitioners, the
20 physicians, the allopathic and osteopathic physicians, PAs,
21 nurses set parameters on guidelines for different medications.
22 And first, there was much wailing and gnashing of teeth and
23 nobody wants to feel like they're inhibited. But eventually
24 they came up with guidelines on different medications,
25 including some very expensive medications. That got passed.

1 You can still waiver and go past what the guidelines are, but
2 it's like every three months and it forces you to kind of re-
3 look. Is this something that the person really needs to be
4 on? Are there less expensive alternatives?

5 This is something that's already saved them millions of
6 dollars in Washington State. I don't know what percentage of
7 the Medicaid budget goes to medication, but there's usually
8 good alternatives. And to be honest, sometimes I've seen
9 dosing that doesn't make any sense to me as a practitioner.
10 As a matter of fact, I see that in my particular field quite
11 often. And very often, you can get people on a small
12 percentage of what they were on before and they actually do
13 better.

14 So there are some opportunities, and I think you could
15 apply that to the surgical specialties. You could apply that
16 to the medicine specialties. But again with something that
17 would be agreed upon, good evidence excepted, and they've
18 started it in Washington State. Dr. Cahana has this huge data
19 bank that I've talked to him about and we could get access to,
20 and although each state is different, we could even start the
21 same ways of gathering information that they started in
22 Washington State up here, gather Alaskan-specific information.
23 Then you could make more informed decisions.

24 So there are opportunities, if you have the staff, the
25 time, the effort, the political will, because some of these

1 things -- he did tell me it was a little bit of a blood bath
2 to get it through Olympia, but in the end now, everyone's
3 taking credit for it. Politics.

4 So while there are some -- there are much bigger issues
5 that we probably are not going to have much of an impact on
6 and that's sad. It would be great if we did, but we're not.

7 There's some long term issues that, if we don't start
8 them now, like the diabetes prevention, that type of thing,
9 boy, that will bury you down the line. So those need to
10 start, but you're not going to see any sudden return. But
11 evidence-based medicine, there's a possibility that -- you
12 know, do people need to be in the hospital for four days after
13 a certain procedure when there's data that shows it's two
14 days, or in some places, it might be done outpatient by a home
15 visiting health nurse? It's less expensive. And if you've
16 got data that shows that the outcomes are the same, there are
17 some ways to influence this, and those are the kind of
18 innovative things that, I think, we should get involved.

19 COMMISSIONER CAMPBELL: I think you can -- I won't wax
20 philosophical. I'll try to be a little bit more practical in
21 my comments than some, but you can see the fiduciary
22 responsibilities right around this table, and I think, we all
23 appreciate those and those points of view. And as Wayne said,
24 being able to lay them on the table and do some good work for
25 the State is absolutely imperative.

1 The thing that I, I guess, almost could be in a panic
2 about is the manpower issue. I remember when Medicare came
3 in. I was a very young Hospital Administrator and had only
4 been in the chair about three years, but the bulge in
5 utilization absolutely buried a small rural hospital. Every
6 old farmer who'd been in putting up with a hernia for 25 years
7 and suddenly through his trust away and wanted that, and this
8 was across the diagnosis spectrum.

9 So I know we weren't going to concentrate on the federal
10 law, but it is the elephant in the room. And unless we, as a
11 state, try to get ahead of this curve on the primary care
12 people -- and hopefully we educate them in-state that those
13 dollars grow within our economy before they escape -- this --
14 I'm just -- I'm really, really pessimistic about what's going
15 to happen because I'd like to test Dr. Hurlburt's concept that
16 more practitioners may not drive the cost down. I guess I'm
17 willing to take that gamble and try to get enough manpower and
18 try to overcome, with some sort of incentives, the
19 maldistribution so that everybody doesn't huddle around their
20 favorite hospital. Get these people out into the areas where
21 this primary care can be given without \$100,000 transportation
22 bill.

23 Those are the things that really concern me, and I think
24 we, as an institution here now, should address this with
25 alacrity. Thank you.

1 COMMISSIONER BRANCO: Jeff, you commented on your wife.
2 And a longtime ago, 35 years ago, there was a Cat Stevens'
3 song called a hard-headed woman, and I thought it was the
4 silliest song ever written, and then I married a hard-headed
5 woman, and the other line in that song, she taught to be my
6 best. So over all these years, she's always challenged me
7 with me what you've done and achieved is no measure of who you
8 are as a person; it's all about what's next. And that's why
9 I've always stayed an optimist. I've seen every challenge and
10 I've failed on a number of circumstances, but it's the
11 collection of the will and leadership and the strength to
12 persevere that proved her right, and I'm awfully thankful I
13 married a hard-headed woman.

14 The next thing -- and I do -- my conversations are almost
15 always local. They're almost always personal, and they're
16 just real. So this summer, I had a blessing. I was diagnosed
17 with Diabetes Type II. Who'd have thought? But the blessing
18 part is, I said oh my, I have a choice to make now. I can no
19 longer prevent diabetes in my life, but what I can do is
20 prevent the complications associated with diabetes.

21 So I've lost 20 pounds in three months. I have got my
22 blood pressure under 120/70. I've got my triglycerides and my
23 cholesterol in great shape, and I'm watching my diet, and I'm
24 playing with my grandkids, and I'm doing the things right to
25 keep my costs, the costs associated with my care, out of the

1 health care system. It's my personal responsibility, and I'm
2 starting to tell that story to everybody I run into. So I can
3 no longer prevent diabetes in my own life, but I can start to
4 deal with preventing the complications.

5 So we have two factors going on. Hopefully that
6 education gets to the point where we're preventing diabetes as
7 a disease in our communities. That would be terrific. Also
8 managing the personal responsibility is a key part.

9 Now the third part. A local hospital in Ketchikan, tough
10 decisions, hard decisions over a course of time. Health care
11 is an odd business. It's an odd science. It's an incomplete
12 path, and we keep learning as we go. And so over the -- I've
13 been there -- a little over nine years ago when I walked in
14 the door, too many people in our building, employees, smoked.
15 There is no more smoking on our campus anywhere, patients or
16 staff. We've provided them tobacco cessation, took our rehab
17 therapy department and opened it up as an employee gym, said
18 this is free to you guys. Exercise. Do these things. But
19 that isn't the topic.

20 Prevention and wellness of your own staff is one piece
21 that I mentioned earlier about going -- our role and our
22 responsibility in our broader community, it's central to what
23 I'm doing, what we're doing there, and the reason I bring
24 these local issues here is because these are the laboratories
25 that we learn things that can be done. So I'm always

1 reminding myself of the value equation. And we've seen it a
2 couple of times today, but just as a reminder, value equals
3 quality divided by cost. And any time you can reduce the
4 denominator, you're going to increase the numerator. So as
5 you reduce costs, you should be having a powerful impact on
6 the quality provided, which has a direct benefit in the value
7 each of us experience.

8 So this year, I don't know how many in America have done
9 it, but our hospital didn't do a price increase. We looked at
10 everything we did, and we cut our costs. It's like a football
11 team or a baseball team. When you have challenging years, you
12 don't go and hire \$5.0 million players. You go back and talk
13 to people about let's learn how to tackle better and protect
14 the ball and do these things, the fundamentals. So we looked
15 at our fundamentals of producing high quality medicine and a
16 breadth of services.

17 My big fear is that we'll push the point where we cut
18 costs to the point of cutting the non-profitable services we
19 offer and that would be a crime to me. So there's a -- so
20 it's the Lexus model. The Lexus car company has this motto of
21 pursuing perfection, and perfection isn't the delivery of
22 perfect medicine every time. It's about getting the right
23 balance of all of it. There are high costs. There's quality
24 measures. There is a sweet balance out there, and I hope
25 that's what I can learn and what I can provide. I'm nothing

1 more than a collection of experiences, good and bad, and
2 that's what I bring to the Commission.

3 COMMISSIONER ENNIS: Thank you. I'm here representing
4 the Alaska Mental Health Trust, and we work for people whose
5 lives are impacted by developmental disabilities, children and
6 adults and their families, people whose lives are impacts by
7 chronic drug and alcohol abuse, chronic mental illness and
8 behavioral health needs, and our seniors who are a growing
9 number in our great state whose end of life care involves
10 treating and providing support for Alzheimer's disease and
11 related disorders, as well as frail and disabling conditions.

12 So we're happy that this Commission is now in a permanent
13 status, at least for the next few years, as the Trust has
14 worked long and hard in interest of establishing a formalized
15 Body.

16 We have three overriding hopes for our work this year and
17 forward. One that the concern for cost containment won't
18 overshadow our vision and the need for a systems plan. The
19 needs of our state are growing and changing. We're barely
20 keeping up with identifying them and so I know we need to
21 worry about cost containment, but we'd like to think that this
22 group can really focus on the vision and plan as well pay
23 attention to the cost.

24 We have an interest and concern for developing a state
25 plan that reflects an integration of our behavioral health and

1 long term care system with the primary care system. We're
2 kind of two separate entities now as we talk about our needs
3 and our plans. Even the report, the section on page 51 was
4 just a couple of paragraphs saying a lot of work is being done
5 on behavioral health and long term care and we need to review
6 it, and there's a lot to review. Believe me. There are a lot
7 of studies and a lot of plans that, I hope, we will have a
8 chance to take a look at. A lot of good thinking has gone
9 behind these studies, and we hope to see some implementation
10 of some of those recommendations.

11 And thirdly, we hope that we will begin to address our
12 long term care continuum, which does have gaps and we do need
13 to address those. So I'd like just to take a minute or two to
14 identify some of these key gaps that, we hope, will be
15 addressed by the Commission and our plan.

16 One is our increasing inability to serve behaviorally
17 complex, behaviorally challenged individuals and community
18 services. They're overrunning the primary care system.
19 They're overburdening our behavioral health centers. Assisted
20 living homes are not able to serve them, and services, such as
21 group homes for the developmentally disabled, we are finding
22 we cannot provide the support. We don't have the expertise.
23 We don't have the funding. We don't have the workforce. And
24 right now, we know, according to our recent contracted study
25 and report, there is a list of probably close to 100

1 individuals that are perhaps slated for out of state
2 placement.

3 We've spent a lot of time bringing kids home over the
4 last few years who are in institutions outside, bringing them
5 back to their families and communities, and now we have
6 another train leaving the State, if we don't develop the
7 expertise to support people with behavioral challenges in our
8 communities.

9 We need to talk about and we hope we can address the lack
10 of assisted living homes in our communities around the State.
11 Yesterday, I learned that Juneau doesn't even have one
12 assisted living home. So a family or a spouse who has really
13 reached the end of their ability to care may have to look
14 outside their home community for care for their loved one.
15 They don't have a small even mom and pop who can provide that
16 24-hour awake care for their loved one with Alzheimer's
17 disease. And all over our state, we're experiencing the lack.

18 In Fairbanks, we have about 12 assisted living homes.
19 They're always full. No vacancies. The Pioneer Home has a
20 five-year waiting time. This is a really critical need, if we
21 want to keep folks in their home communities at a much lesser
22 expensive cost. Quality of care is good. We do need to
23 develop this assisted living home system.

24 In our communities, we've got a lot of fragmented funding
25 sources and sort of little silos. I hate to use that word.

1 It's probably overused jargon, but we need to spend more time
2 coordinating and working together, understanding what each
3 other does. You've received a grant to do something or a
4 study. Everybody needs to know about it, and we need to
5 expand that statewide. We hope we'll have an increased
6 ability to identify and prevent senior abuse. Forums recently
7 conducted around our state indicated that that's a problem for
8 our older Alaskans. So again in the area of prevention, which
9 is so very important, we can't forget all those elements that
10 are so important of the last years' of life of our growing
11 number of seniors.

12 Our workforce shortages for community-based care are
13 dire. Many vacancies, 24-hour care. We want to keep folks in
14 the least restricted environment, the most inexpensive home
15 care as possible, but we'll have to have a workforce. And I'm
16 not necessarily talking about physicians here. I'm talking
17 about those direct service workers who come with high school
18 diplomas and some training and First Aid and CPR who really
19 make a difference in the lives of those that are receiving
20 care in communities and at home.

21 And again very importantly, I hope we can address what we
22 can do for the family caregiver. This is an element of our
23 workforce that we've overlooked. Not paid but dedicated, have
24 a heart for the work, and they are keeping the price tag down.

25 I will admit that community-based services have been part

1 of that growing Medicaid budget. We've developed more
2 services. State General Funds used to pay for these services.
3 We refinanced those General Funds and began being able to
4 apply Medicaid dollars to home and community-based care. A
5 great way to stretch our state's dollars, but we have grown
6 the Medicaid budget accordingly. And family caregivers can
7 help us contain those costs if we're looking for ways to do
8 that, but we have to support those family caregivers. We've
9 got to give them training. We've got to give them respite.
10 We've got to give them, perhaps, counseling to deal with the
11 stress of prolonged care. We have to help them sustain their
12 ability to care, and perhaps that will be with some financial
13 incentives. But believe me, it's going to be at a much lesser
14 dollar than care in a hospital or nursing home or even in an
15 assisted living home. So I'd like to hope that we can really
16 work to strengthen this workforce, this unpaid workforce.

17 And I think again, we really do need to work at
18 integrating our long term care, our community-based services.
19 There are many, many different fragmented, as I said,
20 resources, and part of the problem is we all speak a different
21 language. We speak about our models of services differently.
22 We have a little philosophy, but I believe that we can find a
23 common ground so we can merge and collaborate better and
24 perhaps save costs there as well as we look at long term care
25 in communities.

1 And lastly, there is a lot of information out there.
2 There are continual grants being made available, new services
3 being developed. We need a clearinghouse. I'd like to hope
4 we have some centralized source for acknowledging all that's
5 happening in our state for behavioral health and long term
6 care and a way to disseminate and make sure we're all kept up-
7 to-date with what's happening so that we can connect better.
8 There is a lot to be done.

9 Just as I was reviewing the list of studies and
10 recommendations, and I stopped at about number 18, that have
11 been Commission-provided paid for the last decade, there is
12 just a lot of information. We need to synthesize that, and
13 I'd like to think that the Commission can spend -- or take
14 that opportunity to look at what has been recommended over the
15 past year. There's a lot of good information, but we do --
16 when we talk about staff and you mentioned meeting with the
17 Administration of the Department and not very many state
18 staff, and I think that has been part of the problem. There
19 is no one that has any time left to be appointed to really do
20 the synthesis of all this information, so that they can even
21 bring it to the Commission here.

22 And anyway, I think that's enough. We appreciate the
23 opportunity to share our hopes with you, and again, there's a
24 lot of work to be done and I'm glad to be part of it. Thank
25 you.

1 COMMISSIONER DAVIDSON: So I think -- great discussion
2 this morning. I think that we should be really clear about
3 what it is that we're really being asked to do, and the
4 legislation very clear.

5 We are asked to do two things. The first is to develop a
6 comprehensive statewide health care policy. The second is to
7 provide a strategy for improving the health of all residents
8 of the State. And pretty much what we've spent about 95% or
9 99% of this morning talking about is the cost, and the cost is
10 one part of that. And it seems like it's really easy to get
11 lulled by costs. It's really easy to get lulled by data, but
12 what we really should be doing -- and it seems like we're sort
13 of coming at this from the wrong direction. We're asked to
14 make costs to sustain a system that we already have, and what
15 we really should be doing is taking a look at what is it that
16 we want health care to be in Alaska. What's our ideal? What
17 are the resources we have available to be able to do that, and
18 where are our priorities in being able to make that informed
19 decision? And again I think it's really easy to get lulled by
20 the data and the cost, et cetera. And as I look around this
21 table, we are all people who are very well insured. We have
22 fabulous health insurance and -- well maybe not so fabulous,
23 maybe not as fabulous as it used to be. We pay for it, but
24 the truth is that everybody pays for health insurance, whether
25 it's Medicaid, Medicare, Denali Kid Care, private insurance,

1 we all pay for it, but we seem to make this distinction that
2 the only people who really pay for insurance are the private
3 sector and for private insurance and that's not true. We all
4 pay for the full spectrum of health care.

5 Again I think it's really easy to get lulled by data, but
6 I think it's really important by the numbers. And I think
7 it's important to remember that, as we have these
8 conversations, we're actually talking about people. We're
9 talking about real people. We're talking about families. And
10 I think that every time we talk about cost, we should also
11 talk about not only the financial cost but also cost in terms
12 of whether somebody is well enough to be able to go to work,
13 whether somebody is well enough to be able to get on the bus
14 and pay the \$1.50 or \$2.00 or \$3.00, or who knows with this
15 budget situation, maybe \$5.00 and maybe the bus isn't coming
16 anymore so they take a \$27.00 cab ride because the bus doesn't
17 serve their neighborhood anymore to be able to get care for
18 them or their child at the closest available health resource.

19 So I guess I would ask us, really, to focus on what is
20 really our health plan for the state of Alaska? What is it
21 that we want it to look like? What are the resources that
22 Alaska has available to add to that mix? What are the other
23 resources that we might be able to find to add to that mix?
24 What is it that we can do and what is it that we can't do, and
25 make an informed decision. We are kidding ourselves if we say

1 that we should make these cuts here, recognizing that in our
2 little scheme or our little small world, we're going to be --
3 it's going to be okay because the community health centers are
4 going to take care of people who otherwise don't have
5 insurance, or it's okay because the tribal health system is
6 going to take care of people who live in rural Alaska, whether
7 they are Alaska Natives or not Alaska Natives, but teachers,
8 people who happen to live in those communities. I think we
9 should be really, really clear about the decisions that we
10 make and be clear about who wins and who loses in all of those
11 situations.

12 So again what really is our health plan and how are we
13 going to finance it with the resources that we have available
14 and how are we going to plan for the future?

15 The other piece is, you know, it may be something like
16 we're going to do away with this particular service. If we're
17 talking about cutting costs, there is only several ways to do
18 it. You either cut optional services, you cut reimbursement,
19 or you decrease eligibility. Well if we do that, then what's
20 that going to do to the cost of Medivacs for people who aren't
21 going to get the services, but guess what, they're going to
22 get sicker, and who pays for that cost? So I would encourage
23 us to have a robust conversation about when something happens
24 here it's a little teeter-totter whether we like it or not.
25 When something goes down, something else rises.

1 The other thing is our people are all sort of spun up
2 around health reform and people call it all kinds of things.
3 Some people call it Obama-care, and some people call it health
4 reform, and some people call it by a variety of acronyms. And
5 the truth is, health reform has been happening for about over
6 500 years in our country. It's just been happening slowly
7 over time. Health reform, whether we realize it or not,
8 happens every single day.

9 The one thing that I can say is that the Affordable Care
10 Act has really focused the discussion, and it happened for a
11 reason, whether you agree with it or don't agree with it. But
12 I remember learning something from my older daughter when she
13 was in kindergarten, and she said you get what you get and
14 don't throw a fit. You learn how to use what you can, how to
15 mitigate things that you don't necessarily like or don't
16 appreciate, but you deal with what you have and you move on.

17 So I think the Affordable Care Act has focused the
18 discussion. I think there's a lot of politics on one way or
19 the other, depending on how you feel. Some people think it's
20 the greatest thing since sliced bread. Other people think
21 that we're just all going to go to hell in a hand basket --
22 excuse my language -- because this is the worst thing that
23 ever faced our country. And the truth, honestly, is somewhere
24 in the middle, and it may be at various points along that
25 spectrum. And I guess the thing that I would just caution us

1 against is the whole us versus them mantra that we seem to be
2 falling into right now in our country, that, well, we're doing
3 the very best we can, but you fools over there have a lot of
4 change that you need to make in order for this all to work.
5 And I just think that we have to be really careful because we
6 are them; they are us. I'm not going to -- you can correct my
7 grammar later, but we're all in this together. Alaska's a
8 very small state.

9 And the other thing that I always remember besides the
10 data is that, at the end of the day -- I've said this before -
11 - it's a real life test. It's a real person test that
12 matters. If we know people, individual people that we know by
13 name, by face that, one, don't know that they may be eligible
14 for services, they don't know how to access care, and if the
15 providers who provide that care can't be sustainable to be --
16 can't be reimbursed at a rate that's sustainable over time,
17 and whether that means they need to make efficiencies using
18 the formerly called Toyota lien process, now the Lexus model
19 since they had challenges with safety, or whether it is
20 dealing with other kinds of issues that if people -- if you
21 can't maintain those programs over time, then it doesn't
22 matter how hard we work. Real people are going to lose.
23 Health care is going to be impacted, and collectively, we have
24 all failed because it is not us and it's not them. It's all
25 of us together.

1 The other thing is, I think, that as long as we're
2 talking about costs and there's a lot of talk lately about the
3 spiraling costs of Medicaid, is that we should also be aware
4 of opportunities that we have to be able to help with that.
5 Maybe it's by taking advantage of the 100% FMAP through a
6 variety of ways that we have in our state that may be able to
7 alleviate that trend, but we're not necessarily talking about
8 that openly.

9 The other piece is, what about long-term care? We don't
10 have a state long-term care plan. Whether it's home and
11 community-based services or the full spectrum to residential
12 services, we don't have one. The same is true for behavioral
13 health. There's a full spectrum of care.

14 The number one cause of death in Alaska is due to
15 unintentional injuries, and you are a person -- if you're a
16 person who needs alcohol treatment or substance abuse
17 treatment in this state, you can expect to wait six to nine
18 months or longer, and somehow, we're okay with that. And I
19 guess I would just caution us that, you know, the way the --
20 the system that we have now isn't necessarily the system we
21 have to live with, and it may be things like alternative
22 provider types. So for example, the tribal health system
23 realized a few years ago that we don't have enough dentists.
24 The dentists aren't coming, so we developed a dental health
25 aide therapy model in our communities to be able to provide

1 dental services to people in communities. Was it
2 controversial? Absolutely. It is working now? Absolutely.
3 But sometimes, we have to do something that's different than
4 what we know today, and I think that before -- I guess I'll
5 stop there, but just say my concluding statement is that it's
6 not about us and them. It's about all of us and that, before
7 we start talking about cutting costs for what currently is, we
8 should take a step back and say what would we like it to be,
9 what's our health care delivery model, what is it that we'd
10 like to see, how are going to finance that, what is the
11 appropriate level of financing, and with those finances, what
12 should take priority? That's it. Thanks.

13 CHAIR HURLBURT: Senator Olson, everybody else has gone
14 if you'd like to share your thoughts, hopes, and aspirations.

15 SENATOR OLSON: Thank you very much for this opportunity.
16 As we look at, as was pointed out by the previous speaker,
17 there has been a reform that's been going healthcare-wise over
18 the last number of centuries, but what I see, from a
19 legislative standpoint, is that it has speeded up and the
20 number of dollars has increased dramatically, and because of
21 that, we've had this -- you know, the Tea Party movement, if
22 it does indeed take hold and it has some type of credibility
23 with some numbers back there in Washington D.C., there is
24 going to be some hard tightening and some pretty tough
25 decisions that need to be made to provide and to continue on

1 with the same type of lifestyle and the level of health care
2 that we do have. And so because of that I think, we need to
3 be well aware as legislators about what we're doing to make
4 sure that we don't get into throwing from one to the other
5 side and back and cause confusion, especially amongst those
6 people that are elderly within the constituency because all it
7 reeks is havoc. And because of that, I'm hoping that we have
8 a common sensical and political statement to be kind of a
9 bipartisan coalition type of answer to the health care issue
10 because, you know before long -- you know, my mom is in her
11 80s and I see the difficulties that she has. You know, it
12 won't be long now before I get to start tapping on that age
13 numbers as well as having those type of physical problems and
14 in need of that medical care, and I want to make sure that 20
15 and 30 years from now when I'm out there hopefully rocking in
16 the rocking chair that I say, you know, I wish I had done this
17 back then. And so that's what I'm looking at this Commission
18 to try and get together, to come together with a bunch of
19 different ideas, different perspectives, and say let's press
20 ahead on what we have here because to do otherwise is, I
21 think, going to be detrimental to not just the people of the
22 state of Alaska. It's going to be detrimental to me and us,
23 in particular, as individuals.

24 CHAIR HURLBURT: Thank you.

25 (Pause - no mic on)

1 COMMISSIONER ERICKSON: We have a lot of food, so I'm
2 hoping everybody in the audience will plan to join us, and we
3 will reconvene in 45 minutes. We have got to start on time
4 for our public comment period, so that's what we'll start at
5 12:30, from 12:30 to 1:30. And maybe if I would just ask the
6 public in attendance to let the Commission members go first,
7 we have a little bit of cushion in our time here, but still,
8 it'd be nice if they could get a chance to eat before we start
9 the public comment period. I think that's it.

10 11:44:31

11 (Off record)

12 (On record)

13 12:31:47

14 COMMISSIONER ERICKSON: The first thing -- Dustin, we're
15 tied in on the teleconference line now, is that right?

16 DUSTIN (LAST NAME UNKNOWN): Yes.

17 COMMISSIONER ERICKSON: And it's open, open for people on
18 the other side to speak?

19 DUSTIN (LAST NAME UNKNOWN): It is now.

20 COMMISSIONER ERICKSON: I think the first thing we should
21 do -- we have, so far, two people signed up in the room, but
22 what we should do is check and see if there's anybody on the
23 phone who would like to -- and just get a list of names and we
24 can call people individually.

25 CHAIR HURLBURT: Is there anybody the phone who would

1 like to participate during the public comment period? We
2 should have plenty of time. We have an hour allocated. We
3 just have a couple of people signed up so far. If we don't
4 have folks, we'll move on to something else on the agenda.
5 But if there are folks who would like speak up, we do have
6 time. Anybody on the phone?

7 (Pause - silence)

8 COMMISSIONER ERICKSON: We can check back again after.

9 CHAIR HURLBURT: Yeah. Do you have the.....

10 COMMISSIONER ERICKSON: I didn't bring them up for you,
11 but the two people in the room who've signed up are Pat Luby
12 with AARP and Debbie Thompson with Alaska Nurses Association.

13 CHAIR HURLBURT: Yes?

14 COMMISSIONER DAVIS: I think there's a third also.

15 MS. SMITH: My name isn't on the list, sorry.

16 COMMISSIONER ERICKSON: That's okay, and I mean, we can
17 do that. I mean, even at the end after everybody's done, we
18 can see if there's anybody else in the room who has changed
19 their mind and also check back on the phone one more time.

20 CHAIR HURLBURT: We had thought about five minutes would
21 be the timeframe on that, but as I say, we're not real tight
22 on it. So would you like to go first?

23 MS. SMITH: Okay.

24 CHAIR HURLBURT: Why don't you come up?

25 COMMISSIONER ERICKSON: Have them introduce themselves.

1 CHAIR HURLBURT: Press the button and then introduce
2 yourself.

3 MS. SMITH: So again my name is Rebekah Smith. I'm a
4 fourth year medical student in the Alaska WWAMI program, and
5 one of the things I found really interesting today were your
6 comments about increasing the workforce up here. And
7 specifically, I'd like to know more about what you intend to
8 do to develop medical education in the next ten, 20 years?

9 CHAIR HURLBURT: I think I'll look to you as our
10 gatekeeper. Do we want to respond or do we want to just take
11 the comments?

12 COMMISSIONER ERICKSON: This is just a time to take
13 comments from the public.

14 CHAIR HURLBURT: Yeah.

15 MS. SMITH: Well I'm totally out of line. I'm sorry.

16 COMMISSIONER ERICKSON: No.

17 CHAIR HURLBURT: (Indiscernible - no mic) should do.
18 Yeah, yeah, we would be interested in hearing your perspective
19 on it, Deb.

20 MS. SMITH: So I think that one of our big problems is
21 not just recruiting competent health care workers but
22 retaining people from Alaska to come back and practice after
23 they receive their education, and I think a big element of
24 that is that, you know especially with medical school, you
25 have to leave for at least part of the time if you're in the

1 University of Washington program and then for residency,
2 unless you do family practice, you have to leave for, you
3 know, three, four, five, six, however many years, and by the
4 time you've been gone that long and put down roots other
5 places, you're far less invested in the community up here. I
6 think it's really crucial that, if we're to get good
7 continuity of care up here and get providers who are really in
8 touch with the community, we do an adequate job of providing
9 resources, educational resources.

10 CHAIR HURLBURT: Since you were so nice to come and make
11 your comments, I'll break the rule, I guess as Chairman. But
12 if you do have a chance to look at the past Minutes, you'll
13 see that the Commission did address that. We felt that the
14 priority needs were in primary care, which we defined as
15 family medicine where we have the existing residency and there
16 are efforts to expand that, primary care/internal medicine in
17 which there has not been not much more than a little talk so
18 far; pediatrics in which there has been more action and
19 discussion involving Providence and some of the pediatric
20 groups and psychiatry, and with those four specialties being
21 the ones identified that should be the priority as we look to
22 expand potential GME opportunities here in Alaska.

23 MS. SMITH: Great. Thank you.

24 CHAIR HURLBURT: Larry?

25 COMMISSIONER STINSON: I should probably recuse myself,

1 but I'm currently her preceptor in the WWAMI program, and she
2 is exactly the type of person you want to keep. She wants to
3 go into psychiatry. She's from Eagle River. She would do
4 wonderfully up here, and I think she does want to come back
5 here. And when people do do their residencies out of state,
6 that's the danger time for us as Alaskans because, if you
7 think that she's not going to get a lot of job offers wherever
8 she is, she will. And when people go outside for their
9 residencies, then Alaska is competing nationally to bring
10 these people back. And when we're lucky enough that we have
11 people who grew up here and have roots here, they'll come
12 back. But as we've already talked about, at some point, we
13 really -- I really do hope the State invests in more of the
14 residency, not just family medicine which has been a great
15 success, but in the other primary care specialties up here so
16 we can retain these people.

17 CHAIR HURLBURT: Great. Thank you.

18 MS. SMITH: Thank you.

19 CHAIR HURLBURT: You bet. Now who was going to speak for
20 the Nursing Association? Debbie, okay.

21 MS. THOMPSON: Good afternoon, I'm Debbie Thompson. I'm
22 the Executive Director of the Alaska Nurses Association, and I
23 was kind of enjoying sitting there taking a deep breath. I'm
24 getting ready for our three-day conference and our annual
25 meeting. Today's the pre-conference, and it was just really

1 kind of nice to sit back there.

2 What I'm here to tell you is that I would like to
3 express, on behalf on the nurses in the state of Alaska, how
4 important we think that this Commission is, the importance
5 that it does for all entry levels into any kind of health
6 care. Nursing is a big part of health care, and we like to be
7 invited to the table and sit at the table. We also like to
8 participate, and I'm learning to take a deep breath and be
9 able to speak a little bit more eloquently publicly.

10 I was looking at your agenda, and I really appreciate the
11 types of things that you're going to be addressing over the
12 next afternoon and tomorrow and wish that I could be here to
13 listen in the audience, but I'm a little bit busy. And I
14 would like to tell you that myself or a representative of the
15 Association will be attending your meetings from now on.

16 CHAIR HURLBURT: Thank you very much. Thank you for
17 coming, and we wish you a very successful meeting. Thank you.
18 Pat, do you want to bring the AARP perspective for us?

19 MR. LUBY: Thank you, Mr. Chairman, Members of the
20 Commission. My name is Pat Luby. I'm the Advocacy Director
21 for AARP in Alaska.

22 Under the national health care reform, employees are now
23 allowed to keep their dependents up to age 26 on their group
24 coverage. Most companies and most government entities have
25 gone ahead and decided to do this, not just for their active

1 employees but also for their retirees.

2 We've gotten calls in the last couple months from Alaska
3 Public Retirees. Governor Parnell has made a decision not to
4 allow anyone who is retired who has dependents up to age 26 to
5 sign up under the program, even though they would be paying
6 all the expenses of that insurance.

7 You know certainly, you have a bully pulpit, and one of
8 the things that we think the Health Care Commission could do
9 is maybe talk to the Governor, encourage him to go ahead and
10 change this regulation. And if he won't, we'll be talking to
11 Representative Keller to see whether we could get the
12 Legislature to take a look at this. If you have a retiree-
13 only health plan under HIPAA, you don't come under the
14 requirements of the new national care reform.

15 The *Wall Street Journal* just did an article about that
16 this week. Michigan has made the same decision as Alaska has
17 made. TRICARE, apparently, is trying to figure out -- they
18 actually have some legislation that's been introduced in
19 Congress because they're also being affected by this. Some of
20 the national companies that are covered under ERISA because
21 they work throughout the state, if they have a retiree-only
22 coverage that differs from their employee coverage, they're
23 also under this. Horizon, for example, has decided they're
24 not going to offer this to any of their retirees. But we've
25 heard from many of our younger retirees who are members of

1 AARP who do have children under 26. They're willing to pay
2 the full freight to get them in the group. The group is going
3 to be less expensive, but they certainly would like the
4 opportunity to do that. And if you can work your magic with
5 the Governor maybe after November 2nd, we would certainly
6 appreciate it. It's an issue -- we called Retirement and
7 Benefits. They said they think this will affect thousands of
8 Alaskans. It's much bigger than we certainly anticipated, and
9 I think it would be a good thing to do to make sure that all
10 Alaskans are allowed to secure that coverage. Thank you.

11 CHAIR HURLBURT: Thank you, Pat, very much. Another
12 invitation for anybody on the phone? Anybody on the phone
13 that would like to make a comment?

14 MS. CHARVET: Hi there, my name is Jennifer Charvet. I'm
15 with Alaska Brain Injury Network.

16 CHAIR HURLBURT: Thank you, Jennifer. Can you go ahead,
17 please?

18 MS. CHARVET: I can. All right. I would just like to
19 share a few of the observations we have found working with
20 people with traumatic brain injuries here in the state. We
21 are the main point of contact for anyone in the state seeking
22 information and referrals and advocacy for brain injury, and
23 my role as Resource Navigator has been to listen to people,
24 survivors, family members, providers, anybody working with
25 someone with a brain injury to help them locate resources and

1 information, answer questions, and help them find the support
2 they're looking for.

3 In the last three and a half years, I've talked to about
4 800 to 900 survivors, and many of those I've talked to
5 multiple times. So the need is quite great, and the variety
6 of needs that I hear really run the gambit kind of totally
7 across the health spectrum, anything from serious medical
8 issues to behavioral health type issues, to you name it
9 because it can affect every area of life.

10 So I just wanted to let you guys know what we're here and
11 we've been paying attention to the needs of Alaskans with
12 brain injuries for quite a few years. We have put together a
13 ten-year state plan that you guys might be interested in
14 taking a look at. We would love to share, and I'm excited
15 about the work you guys are doing.

16 CHAIR HURLBURT: Thank you, Jennifer. Jennifer, maybe
17 could you spell your last name, just in case we didn't capture
18 it adequately?

19 MS. CHARVET: Yes, no problem. It's C-h-a-r-v as in
20 Victor, e-t. Charvet.

21 CHAIR HURLBURT: Thank you, Jennifer, and thanks for your
22 comments. Anybody else on the phone? Anybody here? Going,
23 going, gone. There will be other opportunities for it at
24 future meetings, and we do invite public participation.

25 I think what we will do, since we're well ahead, is move

1 on to the -- where are we -- 3:15 session on the
2 Administrative Business with the Budget and Bylaws and other
3 administrative issues, since Judy is not here yet for the
4 ethics part. Deb, would you like to start on this?

5 COMMISSIONER ERICKSON: Yes.

6 MR. FRIEDRICHS: May I ask, Mr. Chair, before we begin,
7 would it be appropriate -- and I apologize if we have not met
8 before, if you are comfortable sharing some information on the
9 Nursing Association's recommendations for improving the role
10 of nurses and the capacity of nurses, if we have to hear that?
11 That is, I agree, such a crucial part of health care delivery,
12 and if we've got time, that'd be very interesting to hear what
13 the Nursing Association perceives to be the way ahead, if
14 you're willing, sir?

15 CHAIR HURLBURT: I'm sure you have no thoughts on that,
16 Debbie. So we would invite to come. Yeah. Thank you, Paul,
17 for suggesting that.

18 MS. THOMPSON: Well let me think. Where do I want to
19 start? I believe that nursing is a profession that used to be
20 a calling, at times still is a calling, but has become a
21 profession, and we struggle to compete with professions that
22 pay a six-figure income and you can sit at home and make video
23 games and make lots of money. I speak from having one of
24 those children in that millennium age group who said, mom, I
25 watched the hours you worked; I watched the time you were on

1 call; you missed every birthday; you missed every Christmas,
2 and you don't make enough; I can do video games really well.

3 I believe that our retention and lack of focus on
4 retention is a part of our problem. We are losing our brain
5 trust in nursing, and when I mean that, I mean nurses of my
6 age, that 50 and older nurse who has worked in different
7 areas, has expertise in different areas, is able to draw on
8 alternative ways to do things, has seen an old piece of
9 equipment that has been archived 20 years ago, still knows
10 about it, can direct someone to go find it. We are bringing
11 our new people in fast. We're trying to get them up and ready
12 to function fast, and we are not allowing them the time to be
13 mentored well, to learn alternatives. We are just wanting
14 them to get up and running.

15 By the same token, we're not allowing the nurses who are
16 experienced to move forward into a mentoring position because
17 we are health care and health care is costly. And we are
18 looking ways that we can be more efficient with less support,
19 less manpower, less money. We are at that part in business
20 where we have to change the way we think. We have to decide
21 what our resources are. Are our resources the dollars that we
22 bring in and that's it, or are our resources the people who
23 deliver the care that keeps those patients coming back to the
24 hospital or a doctor's practice or wherever they're receiving
25 treatment?

1 I believe that our resources are those people that
2 sustain the care that's given at the bedside, whether that is
3 the direct patient caregiver or that is the indirect patient
4 caregiver. And by indirect, I mean, is that the person who is
5 supporting that nurse who is giving the direct care? Is that
6 the professor at the college who is teaching the nurses to
7 give that direct care? There is a lot of hands that go on
8 that allow the nurse at the bedside to give the care.

9 Nursing, when you go into an acute care facility, is the
10 big budget item. That is where you look at cutting money
11 because it screams out on your budget sheet. I am married to
12 a CPA and so I've coined his phrase; sometimes we, as
13 institutions, are penny-wise and absolutely dollar stupid, and
14 we will get rid of things. We will make things complicated
15 for someone giving care that increases the cost so much, just
16 by the process they to have work around to accomplish their
17 goal, than if we would supply the supplies, the backup, and
18 the resources to do their job.

19 Nurses are terrific work-arounds. I don't know where we
20 learn it. I don't know where it comes from, but if there are
21 four ways to do something and they take too much time, they're
22 inefficient or something just doesn't work, a nurse will come
23 up with another four or five ways to do it and get the same
24 accomplished goal. They don't do one thing at a time. They
25 can't be that task-oriented. When you are taking care of

1 patients, you are listening to a report that's being given to
2 you by someone bringing a new patient to you, you are trying
3 to get things together to give your educational direction to a
4 patient who is being discharged, you are listening to someone
5 who has taken vital signs and you're having to categorize
6 everything in there. You multi-task. And when you're tired
7 and you're overworked and there's not enough support, errors
8 happen. When errors happen, it comes back to nursing, but we
9 don't do the research to show us all of the reasons why those
10 errors are happening and it's because we're taking away the
11 support.

12 I feel the same with physicians. You know, they take
13 call, like nurses take call, sometimes a lot more, sometimes
14 not. I always laughed. I thought -- when I started my career
15 in OR nursing, I thought maybe I should work for a
16 dermatologist. You know, they really don't take a lot of
17 call, and it was kind of the joke in nursing school. And I
18 thought no, it's really the life.

19 That's just a little bit of what I see as problems, what
20 I see we need to look at and change. If you have questions,
21 I'll try and answer them.

22 COMMISSIONER CAMPBELL: Debbie, as you aware, I'm
23 interested in the manpower spectrum. Do you have any
24 recommendations on where we find these professors to teach our
25 next generation, and a hopefully expanding generation from our

1 end?

2 MS. THOMPSON: Well you know, that's probably a really
3 loaded question, and I think part of it is returning to
4 school, a nurse my age returning to school and you look at the
5 cost of returning to school. And I'll tell you I'm 57, so I
6 look at the cost of returning to gain my Master's to be able
7 to teach and the number of years I look at still having in a
8 career and I think cost benefit and energy output, I'm
9 wondering if it's worth it because the pay is abysmal for who
10 we expect to prepare our next generation of health care
11 providers, specifically nurses.

12 COMMISSIONER LAUFER: I just want to thank you for that.
13 I've been practicing medicine for 15 years, and I've always
14 had fantastic nurses to whom I'm beholden. This issue, like
15 you said, of a calling eroding into a profession is
16 threatening all of us. I think the last study I read for the
17 typical primary care visit, 45 other people make a living off
18 of this, when the only people who see it as a calling and a
19 profession being something higher or something about human
20 beings are the patient, the nurse, and the doctor. The threat
21 is the erosion of the entire culture of medicine into big
22 business.

23 I don't actually fear socialized medicine. I fear
24 corporate medicine and that's what's happening. Nurses
25 actually are abused worse than the doctors, and I'd have to

1 say that every nurse I've ever worked with has -- not every --
2 always my nurse, which I say in a possessive, has always
3 worked at a level of professionalism well above and beyond
4 anything I could pay them, but you can kill that.

5 MS. THOMPSON: I think overwork, stress, and burn out
6 chases people away from the profession. And if you don't have
7 a desire to do nursing or to be a physician for the
8 responsibility that you take on, for the emotional toll that
9 it takes on not only what you're giving to the patient in the
10 bed but every family member or friend who comes in, you work
11 long hours. You are not always appreciated by the other 43
12 people that make a living off of what you do, and you're not
13 always appreciated by the patients anymore either. So it is
14 very easy to look somewhere else to get a job. A job is much
15 different than a career or a calling, and a job just gives you
16 money to live. And that, I believe, is what we are seeing
17 happening a lot in medicine and in nursing now is that people
18 are going out and looking for jobs rather than to have a
19 profession or a career, and it's easier to just leave it if it
20 doesn't work or it doesn't meet your expectations.

21 COMMISSIONER FRIEDRICHS: Ma'am, in a number of states in
22 the Lower 48, there has been a push towards Ph.D. nurses who
23 have a broader scope of practice to help fill the shortage of
24 primary care physicians in particular. What is the State
25 Nursing Association's position on that and do you see that as

1 an avenue that Alaska should pursue?

2 MS. THOMPSON: I see it as an adjunct to what Alaska
3 already has, and we have a fabulous nurse practitioner program
4 at UAA. We have a fabulous Nurse Practitioner Practice Act
5 that allows them to practice as independent practitioners
6 without the Ph.D. I know Outside there are a significant
7 number of states who do not allow their nurse practitioners to
8 practice that way, and I think that that started the push to
9 the DNP, the Doctor of Nursing Practice. I think it's a
10 really good idea. I think it gives validity to what nurses
11 are doing now. I think it could be, in some ways, confusing
12 and physicians have a concern for that, that if you are going
13 to a nurse practitioner but she's a Doctor of Nursing of
14 Practice, what does that mean? And I think that that also is
15 valid, but there are a lot of doctorate-prepared nurses who
16 are more in research, not in the practice. And so I don't --
17 I'm not sure how we address that. I do believe that there is
18 a role for that, and I believe that a lot of our practitioners
19 are fulfilling it now, and in fact, have more -- what's the
20 word I want to use -- credit hours in their family nurse
21 practice schooling than a lot of the DNPs are going to have at
22 the end.

23 COMMISSIONER DAVIDSON: I just wanted to make sure I
24 understand your answer. So the Nursing Association doesn't
25 yet have an official position or you do?

1 MS. THOMPSON: We don't. You know, we do support it.

2 COMMISSIONER DAVIDSON: You're considering it?

3 MS. THOMPSON: We do support it because we support
4 education for all nurses in any way, but the validity of it at
5 the end, the impact to the state of Alaska, I'm not sure the
6 impact will be that different because our nurse practitioners
7 already practice at that level.

8 CHAIR HURLBURT: Yeah, Keith?

9 COMMISSIONER CAMPBELL: I'll just make one comment. As
10 one of the chief lobbyists for the Nurse Practitioner Act when
11 I was busy in the hospital field was to help disseminate this
12 level of practice throughout the state, and I guess I'm still
13 a strong advocate of it because it's a wonderful thing. But
14 one of my greatest disappointments was that these nurse
15 practitioners didn't disburse throughout the state as widely
16 as I had hoped when we lobbied this bill through because that
17 was the -- that was the big cry. If you give us this level of
18 care or level of practice, we'll go to the quasi-small towns
19 out around. But lo and behold, they stay where they're
20 trained, just like MDs do, right around a medical center. And
21 I guess that's just an aside of unintended consequence, quite
22 frankly.

23 MS. THOMPSON: I think that that's -- right and I think
24 that that's true. I also think that, because we are so rural
25 and because we have so many challenges on getting people to

1 stay in rural areas -- and I come from Montana and we have the
2 same rural problems and the same trouble getting practitioners
3 of any kind into our smaller, more rural towns. I think that
4 that is probably a side effect of being human. And I worked
5 in a small rural hospital, and I know that you're never off
6 duty. I know that you may not be at the hospital, but
7 somebody saw you out in your garden and they're going to call
8 and say that there is an emergency coming in and I saw Debbie
9 gardening. Just send the cop by; he'll get her and bring her
10 in.

11 When I first moved to Alaska and moved here in Anchorage,
12 I happened to live across a lake from an orthopedic surgeon
13 and he did the same thing. I can do my case now. Debbie's
14 out in her back yard; just call her.

15 COMMISSIONER FRIEDRICHS: It's a calling.

16 MS. THOMPSON: It's a calling, and it's a reality. You
17 know, I don't know how we make people go and stay. I mean,
18 people go out there and work horrendous hours and are never
19 off and then they think they have no life. And then they come
20 in and practice here and make money. I don't know how we fix
21 that. You all are smarter than I am.

22 COMMISSIONER MORGAN: Doubt that. This may be a question
23 more for someone from the Alaska Public Health Association,
24 but are you guys discussing at your conference or have been
25 discussing a new initiative on the federal level called the

1 Nurse Family Partnership programs? Has that come up?

2 MS. THOMPSON: You know, I've heard the concept and the
3 idea, and I know that the public health conference is coming
4 up, and I would bet you that it will be discussed at great
5 length there.

6 COMMISSIONER MORGAN: The reason I ask is it's totally
7 based on RNs or nurse practitioners.

8 MS. THOMPSON: Yes, it is.

9 COMMISSIONER MORGAN: And to help you out, I know with
10 Eastern Aleutian Tribes, when I was there at our community
11 health center, we basically had advanced nurse practitioners.
12 We had four of them, four at our six clinics. So some of them
13 were pushed out. I think a lot of them went to community
14 health centers that utilize them, but not a great many, I will
15 agree.

16 MS. THOMPSON: And I believe that some went out and
17 rotated out through the Bush and came back in.

18 COMMISSIONER FRIEDRICHS: One more question, if I may?

19 MS. THOMPSON: Sure.

20 COMMISSIONER FRIEDRICHS: Within the nursing community,
21 we've struggled on the Air Force side with the standard of
22 care that recommends that nurses not transition to outpatient,
23 primary outpatient work until they've had at least three
24 years' of experience, which clearly is a challenge when you're
25 short across the board and guarantees that your youngest

1 nurses stay in the most acute environments. Is that being re-
2 looked at within the nursing profession in general, and here
3 in Alaska, are there alternative strategies that you're
4 looking that might help us with some of the workforce
5 challenges?

6 MS. THOMPSON: You know, there are facilities in Alaska
7 who have been fantastic in offering internships and
8 fellowships to new nurses, and again, I will use myself as an
9 example. And I did get out of college more than 30 years ago
10 so I can't say it's current, but I believe it's still valid
11 today.

12 When I graduated from college, I had a very strong lab
13 practice. I had a very strong theory practice, and I saw as
14 many procedures as they could humanly get me to. I got to,
15 for lack of a better word, try a lot of procedures with the
16 guidance of an instructor, but I had to learn the art of
17 practicing nursing and that is an art. And there is a lot to
18 be said for learning the critical thinking skills that a nurse
19 has to rely on, and I think that we are still putting them out
20 and we have done very good at increasing the amount of nurses
21 that we graduate at UAA. Do I think they need some practice
22 in an internship program and do I think they need some
23 practice in an acute care facility? I do.

24 I have been an educator in the surgical services area and
25 a mentor myself, and I have mentored nurses without any

1 practice in a medical surgery type setting, and I have
2 mentored nurses who have gone out and had at least a year of
3 practice as a med surg nurse, and it's worlds apart on they
4 can adjust to a crisis type situation and be able to
5 critically think through the process as it's happening. And
6 in an outpatient facility where you don't have the mentoring
7 or the support, I think it's really important to have that
8 before.

9 CHAIR HURLBURT: Any other questions? Thank you for
10 sharing with us.

11 MS. THOMPSON: Thank you.

12 CHAIR HURLBURT: Anything else, any other comments?
13 Anybody on the phone with any comments?

14 COMMISSIONER ERICKSON: So we're going to maybe make a
15 little more time for a couple of other topics later in the
16 afternoon if we need it and move to the 3:15 agenda item. If
17 you can turn behind tab four in your notebook, there are just
18 a couple of quick business items.

19 One is a draft budget for this current state fiscal year,
20 and the other is a proposed change to the Bylaws. So budget
21 first, the top page there. Hopefully, you had a chance to
22 look at it quickly, but it's very brief if you hadn't.

23 One other thing that I thought I would mention too when
24 we pointed this out is, behind tab two, right behind the
25 SB172, the bill that established us in statute, is a copy of

1 the Department's fiscal note explaining to the Legislature how
2 this money would be spent, and there's actually a little more
3 detail in that document if you're interested in referencing
4 that or looking back to that.

5 What I've laid out here is a pretty general budget. I
6 erred on the side of not putting too much detail in itemizing
7 everything, but I am certainly willing and able to do that, if
8 you would like me to. My intention is to provide to you all
9 on a quarterly basis at each of our future meetings a
10 financial report itemizing what we've spent to date,
11 projections and obligations for the rest of the year so we can
12 stay on top of this together. But starting off with our very
13 first budget, I kept it a little more general. But again if
14 you're not comfortable with this, I would be happy to put more
15 detail around it.

16 So I'll just go over real quickly the main points and
17 then see if anybody has any questions, comments, any changes,
18 if you want to send me back to the drawing board to do it over
19 and we'll take it up again at the next meeting, whatever you
20 all would like to do.

21 So starting off, we have \$173,300 allocated for salary
22 and benefits for my position, the Director position, and also
23 we have an Administrative Assistant position that was
24 authorized and funded by the Legislature in this fiscal note.
25 And it takes a few months to get positions through the

1 bureaucracy, but we do -- actually I have managed to get the
2 position established now and I'm hoping to start the
3 recruitment process very soon in the next week or so. So
4 hopefully within a month or so, we'll have somebody onboard to
5 provide some more staff assistance to the Commission.

6 And then for travel, I've actually started out -- I've
7 budgeted five meetings for this current fiscal year, even
8 though we're starting late, and just thinking back to the
9 slide I showed you of what I was anticipating we would have
10 for a meeting schedule this year, trying to squish up a year's
11 worth of meetings into three months and then getting on our
12 regular schedule after the first -- and maybe -- I shouldn't
13 assume that folks know what the state fiscal year is. State
14 fiscal year is July 1st to June 30th. And so we're already,
15 what, three or four months into -- three-and-a-half months
16 into our current state fiscal year.

17 So anyway the schedule I laid out for you all having two
18 more meetings to get our 2010 report done, November and the
19 very beginning of January, and then having two quarterly
20 meetings for the first half of the next calendar year. That
21 will be five meetings total.

22 One of the things I would mention related to this just to
23 put some budget figures around it, I thought that you all
24 might want to consider holding the meeting that would be
25 during the winter in Juneau since it will be during the

1 Legislative Session, but that's just a suggestion, and for
2 budgeting purposes, I threw that in.

3 One of the things we talked about at our very first
4 meeting with the initial Commission was they were interested
5 in actually meeting in a number of different communities
6 throughout the year and that could be for another time, unless
7 you want to take it seriously and budget for it now. There
8 are logistical problems and costs associated with that, but I
9 thought, well at least, one meeting could be in a different
10 location, and for the Legislative Session, maybe in Juneau.

11 So that's why five meetings and all but one in Anchorage
12 and then one in Juneau. Some additional funds for staff
13 travel. Consultant contracts, \$200,000. Commission meeting
14 expenses \$5,000 per meeting, and we're able to use -- as much
15 as possible, I try to find free conference rooms, but I think
16 occasionally and probably for this next meeting, we're going
17 to have to meet at a hotel because I haven't been able to find
18 one free conference in the city yet, unless somebody has some
19 ideas. I've just been looking at government ones. Printing
20 and other associated expenses for -- that would fall under the
21 contractual line, like HR and network support, IT support,
22 there are a number of -- more and more the way some of the
23 state support systems services that used to be free to the
24 state agencies, as their budgets have been cut back, they've
25 started charging state agencies, and there's kind of a per

1 capita charge for every employee that we get from the
2 Department of Administration and that can run about \$10,000
3 per person. So that's that other category down there. Yes,
4 yes, questions?

5 COMMISSIONER MORGAN: I have one simple question.

6 COMMISSIONER DAVIDSON: I'll jump -- I'm sorry.

7 COMMISSIONER MORGAN: (Indiscernible - away from mic)
8 Sorry. I'm not used to all this fancy high-tech stuff. You
9 and the Chair basically have developed this budget, correct?

10 COMMISSIONER ERICKSON: Yes.

11 COMMISSIONER MORGAN: This is what you need to do this,
12 would you say?

13 COMMISSIONER ERICKSON: This is what I think we need;
14 yes.

15 COMMISSIONER MORGAN: Well I've looked at the budget, and
16 if you think this is what we need and this is what we can do,
17 I think we should just go ahead and approve the budget, unless
18 someone has an objection, because I've done a lot budgets, and
19 to me, it's a little cheap, but hey, I'll take it. Of course,
20 you know where I work.

21 COMMISSIONER ERICKSON: Yeah.

22 COMMISSIONER MORGAN: I mean, it seems reasonable, to me,
23 if this is what you need to do it and if that's what the Chair
24 and you -- I'm assuming you didn't just, you know, go into a
25 room and write it down. You've been discussing it with the

1 Chair. Just lie to me.

2 COMMISSIONER ERICKSON: Yeah, you're right.

3 COMMISSIONER MORGAN: Okay. Yeah.

4 COMMISSIONER DAVIDSON: I was going to, in about three
5 words, move and ask for unanimous consent for this budget as
6 proposed and detailed and recommended.

7 COMMISSIONER MORGAN: And I second.

8 COMMISSIONER DAVIDSON: A unanimous consent motion
9 doesn't require a second.

10 COMMISSIONER MORGAN: Okay.

11 COMMISSIONER ERICKSON: Our parliamentarian and other
12 duties as assigned.

13 CHAIR HURLBURT: Any discussion? It has been moved that
14 the Commission provide unanimous consent for the budget as
15 presented. Everybody in favor say aye.

16 MEMBERS IN UNISON: Aye.

17 CHAIR HURLBURT: Opposed? No. It carries unanimously.
18 I'm sorry?

19 COMMISSIONER DAVIDSON: You should ask if there is any
20 objection.

21 CHAIR HURLBURT: Is there any objection? Thank you. I
22 have said it before, Val is such a delight. Thank you.

23 COMMISSIONER ERICKSON: Our token attorney.

24 CHAIR HURLBURT: The Bylaws.

25 COMMISSIONER ERICKSON: Yes. So moving on to the next

1 page. I was not planning on -- I was hoping that folks -- and
2 our Bylaws, we spent some time working on together as a group
3 with the former Commission and you all can take a look at them
4 at your leisure, if you haven't had a chance to do so already.
5 They're pretty basic, straightforward Bylaws. Something that
6 we had left out -- it really probably could go unstated; I
7 think we just assumed, made some assumptions, but decided
8 after some questions as the new Commission was getting started
9 that it was better to be clear and avoid questions and debate
10 in the future than to make assumptions.

11 So there are two proposed changes, two concepts really
12 that we add a new -- under our kind of process and
13 parliamentary authority section, Article VII, that we make
14 clear that no person may substitute for a voting member and
15 proxy voting is prohibited. And usually that's clear, that's
16 assumed unless it's stated otherwise in the Bylaw, but again
17 because of some questions and suggestions we had heard, we
18 thought it would be better to just state it up front. And
19 then the other thing was having to change the number of voting
20 members we have now have on the Commission and what
21 constitutes a quorum based on that was another kind of more
22 technical change.

23 COMMISSIONER CAMPBELL: So moved.

24 COMMISSIONER STINSON: Second.

25 CHAIR HURLBURT: Any discussion? It's been moved and

1 seconded and there's no discussion. All those in favor of
2 adopting.....

3 COMMISSIONER ERICKSON: Excuse me. I'm sorry. The other
4 thing I should have mentioned up front is that, under our own
5 Bylaws, we're not allowed to approve these. You have to hear
6 them in a meeting and then we can approve them.....

7 CHAIR HURLBURT: Oh at the next meeting, okay.

8 COMMISSIONER ERICKSON: We can't approve until the next
9 meeting. So I'm sorry. I should have said that right up
10 front.

11 CHAIR HURLBURT: That's good. Thank you.

12 UNIDENTIFIED MALE COMMISSIONER: So there's a first
13 reading and second reading?

14 COMMISSIONER ERICKSON: Uh-huh (affirmative).

15 COMMISSIONER CAMPBELL: You can hold my motion until next
16 time.

17 CHAIR HURLBURT: We'll come back to that next month then.
18 Thank you. Any other housekeeping kind of business, Deb?

19 COMMISSIONER ERICKSON: No, I don't think so. I think
20 actually it would be a good time to take a break, even though
21 we didn't have one scheduled. And I can go ahead and set up
22 Judy's presentation, and we can go ahead and reconvene and be
23 right on time again at 1:30.

24 CHAIR HURLBURT: Then we'll break until 1:30. Thank you.

25 1:16:43

1 (Off record)

2 (On record)

3 1:33:36

4 CHAIR HURLBURT: Can we gather back together again,
5 please? The next session that we have is the -- these are the
6 ethics and the ethics training for members of the State Boards
7 and Commissions. I'm accountable, as the Chair of the group,
8 for this, and I guess Judy will give the right term of
9 whatever I'm called.

10 UNIDENTIFIED MALE: In trouble.

11 CHAIR HURLBURT: In trouble, right. Right, yeah. But we
12 all have certain responsibilities and accountabilities, as we
13 were appointed by the Governor through the Board. They are
14 not onerous. They're not unreasonable, but we just need to be
15 aware of it so that we don't compromise ourselves as
16 individuals or us as a group or the Governor who appointed us.
17 And so we need to know about that, and it is a part of any
18 group and since we're really reconstituted now as a larger
19 group, a new group by the Legislature and this is our first
20 meeting. Judy Bockmon was able to come and will be sharing
21 with us on that. So Judy, welcome and we look forward to what
22 you have to say.

23 MS. BOCKMON: Thank you. I'll just introduce myself
24 briefly, Judy Bockmon. I'm a Senior Assistant Attorney
25 General of the Department of Law and I serve the function of

1 State Ethics Attorney. I've been doing that job for a little
2 over four years now, and I fairly regularly give this
3 presentation to boards and commissions and a similar
4 presentation to state employees.

5 Ethics, that word means a lot of different things to a
6 lot of different people. As I'm sure everybody appreciates,
7 it's a word that's been in the news a lot lately, even in this
8 morning's paper, and it does have different meanings and it's
9 something on everybody's mind. But we're here today to talk
10 about the Executive Branch Ethics Act, and just to add to what
11 Dr. Hurlburt said, the reason I'm here today and maybe wasn't
12 invited in earlier to this Commission is that the Ethics Act
13 applies to boards and commissions that are established by
14 statute within an agency. So previously this Commission, as I
15 understand it, was established by Executive Order. So by the
16 terms of the Executive Act, the Ethics Act didn't apply, even
17 if you may have been asked to be familiar with it and try to
18 comply. But now you fall within the code and it's important
19 that you have an understanding of what the Ethics Act is.

20 The Act was first adopted in 1986. It's been amended a
21 number of times, most recently in 2007, but I think, it has
22 stood the test of time to some extent. It sets broad rules,
23 most ethics issues are fact-specific, circumstance-specific,
24 and it doesn't have too many just bright lines, do this, don't
25 do that. It is more the rules are applied in the

1 circumstance.

2 So this presentation has three parts. I talk about
3 ethics generally. I'll talk about the rules, the Code of
4 Conduct, and I'll talk about the procedures. And feel free to
5 ask questions as we go along. I usually tell people, if you
6 have a good example pertinent to your Board, feel free to
7 bring it up because that helps everybody in understanding the
8 rules. Usually I say if you have personal issue, you might
9 want to save that and speak to your Ethics Supervisor, the
10 Chair, confidentially, at least initially. And so I think,
11 you were given a handout today. That's simply to take away.
12 We're not going to refer to it. We have our slide
13 presentation.

14 The Department of Law has a website page. You can find
15 it by going to the main law page and then linking on Executive
16 Branch ethics. On that page, there is a copy of the statute,
17 the regulations, various guides we have on certain topics,
18 disclosure forms, and there is even another training
19 presentation. If you haven't had enough after this hour or
20 so, there's a separate interactive PowerPoint that is
21 different from this one, and I encourage anyone who is
22 interested to make use of it.

23 Deb and I have got to work out our hand signals on the
24 slides. So ethics. The question is always, will you make the
25 right decision? And hopefully after today, you'll have a

1 little bit better idea of what to do in order to make the
2 right decision under the Ethics Act.

3 It's important to understand that there are, essentially,
4 four actors or groups of actors that are involved in the
5 Ethics Act.

6 The first is all public officers. The Act applies to all
7 public employees and members of boards and commissions to you,
8 everybody that's either employed by the State or serves in a
9 capacity, even a volunteer capacity.

10 The next most important function is that of the Ethics
11 Supervisor, and for any board and commission, is the Chair.
12 The Chair, as Ethics Supervisor, is the Governor, although by
13 delegation, it is to Linda Perez who is Administrative
14 Director of the Office of Governor and who has served in that
15 capacity through quite a few administrations way before my
16 time and is very knowledgeable.

17 The other actors include the Attorney General, and our
18 role, principally, is that of providing advice to Ethics
19 Supervisors -- training is sort of an adjunct to that -- and
20 also investigating complaints that might be filed under the
21 Ethics Act with the Attorney General.

22 The final actors/actor is the Personnel Board. It has an
23 oversight function, in part. I report to the Board on
24 activities that we have at Law, complaint activities. All of
25 the Ethics Supervisors report to me and then I report on all

1 ethics activities to the Board.

2 The Board also has a role in the complaint process. It
3 comes after the initial investigatory phase and following a
4 public hearing if we ever get to that point, and the Board
5 becomes the final decision maker. That has rarely, rarely and
6 maybe only in a couple of instances ever happened in the
7 history of the Board, and we'll talk more about complaints
8 later.

9 The other thing I could say is that the Chair also serves
10 as the Ethics Supervisor for the Executive Director under the
11 Act.

12 We discuss ethics because state service involves the
13 public trust, the State's assets belong to the citizens, and
14 the public demands accountability. Unethical decisions damage
15 the reputation of the State, its officers and people, and
16 ethical lapses are costly. It impacts the integrity of
17 individual actions, but it also, if it's a serious matter, can
18 result in having to undo actions that have been taken, if they
19 were taken improperly in violation of the Ethics Act. So our
20 goal is always to avoid getting to the point of acting and
21 resolving -- without resolving ethics issues, but to resolve
22 them ahead of time.

23 The Ethics Act takes a very balanced approach to
24 evaluating what most people consider to be conflicts or to
25 evaluate potential violations and actual violations of the

1 Act. The Legislature recognizes this is a small state, and
2 everybody, but especially Commission members, bring to their
3 service their outside interests and activities and family
4 members. And so when we look at ethics matters, we're looking
5 to avoid substantial material conflicts and we will recognize,
6 in some cases, that there are minor conflicts or unavoidable
7 circumstances that shouldn't prevent a person's participation
8 in some state action. And again we'll talk a little bit more
9 later about that idea.

10 So it's a balancing that we do, which is why, when I say
11 things are circumstance-specific, there can be circumstances
12 where interests and conflicts and problems are so obvious and
13 so substantial that there is -- it's easy, it's an easy
14 answer, but there are others where it involves a little more
15 thought and analysis. And so our goal is always to balance
16 your interests with integrity of your Commission's actions
17 when we're dealing with these issues.

18 So attitudes about ethics. Somebody did a study that got
19 built into this presentation before my time that says that we
20 each individually think we're highly ethical and we certainly
21 have our own ethical standards and we think others think we
22 are ethical, but we don't think that others are as ethical as
23 we are or that they should be. And I like, you know, that
24 slide because it tells us something important. It tells us,
25 as I said earlier, that everybody has a different idea about

1 what ethics is, what is ethical, what is not ethical. And
2 people, citizens look at State action and they think it's
3 unethical, and they're not thinking about the Executive Branch
4 Ethics Act. They're thinking about their own perception of
5 ethics. And while we're going to talk about the specific
6 Ethic Act rules, it's always important to keep in the back of
7 your mind what the appearance of the situation, what the
8 citizenry will think about when they see you involved in the
9 matter or the particular action.

10 The Ethics Act matters aren't judged on appearances
11 alone. We look at the actual facts and try to determine
12 whether there is an actual problem, but I tell everybody
13 appearances are important. So just keep that in mind. And
14 you may want to err on the side of the appearance, as opposed
15 to the technical Ethics Act requirement. And I don't have any
16 problem with that, as long as it doesn't impede your
17 Commission's business.

18 So let's see. Where are we? It's just part of nature to
19 see things differently, and you just need to keep that in mind
20 when you're talking about ethics. There is a difference
21 between ethics in the broad sense and the Executive Branch
22 Ethics Act.

23 So ethics is about attitudes, and there are times where
24 it's easy to justify crossing the line. It's easy to say to
25 yourself it doesn't matter, and hopefully the most important

1 thing you might take away from this presentation is, please
2 don't do that. If a doubt is raised in your mind, the better
3 choice is to raise it perhaps first with your Chair or with
4 the group and have it resolved. Don't, as I say, justify
5 crossing the line in your mind, and Deb can hit the bubbles
6 and you can see the different kinds of things that come up.
7 You know, it's no big deal, everybody does it, and others that
8 I'm not going to spend time reading to you.

9 But again it's your attitude that you bring to the
10 position about ethics and your need to disclose and your
11 concerns about how your interests may relate to the
12 Commission's business.

13 So to summarize what I've been saying, in order to be
14 ethical under the Ethics Act, it takes an understanding of the
15 rules which we're going to move onto in a moment, remembering
16 the public nature of your position, having strength of
17 character, and in that, thinking about ethics, the rules,
18 conflicts and appearances, but also taking action. And by
19 that, I mean making disclosures and having the issues
20 addressed. And sometimes it means raising issues that other
21 people have or that you think they have. You know, we can't
22 solve or address all ethics problems if nobody ever reports
23 them. And so your first obligation under the Act is to
24 disclose and have your conflicts addressed.

25 That's part one. And so we're going to go on to the

1 basic rules. The Ethics Act has a Code of Conduct, and the
2 regulations that are in place right now supplement that Code
3 of Conduct. They have a title that says Code of Conduct, and
4 some people think they are the Code of Conduct. But the rules
5 are really in the Act and the regs are supplementary to the
6 rules in the Act.

7 The Act, principally, is focused on conflicts that arise
8 from your own personal interests and has a variety of terms,
9 and actions that you might take to benefit yourself personally
10 or to provide an unwarranted benefit to somebody, but most of
11 the time, we're talking about the connection between the
12 action and your own interests.

13 I know this Board, from reading the summary on the
14 website, is basically a planning and policy making Commission,
15 I think, and you probably won't have some of the types of
16 conflicts that others do that award grants or that are
17 regulatory bodies, but there is still going to be issues,
18 possibly, that come up in the course of your work that you
19 need to think about. And again we'll see how that fits into
20 the rules as we go forth here.

21 The first thing we want to do is learn some of the
22 definitions or at least be exposed to some of the definitions
23 in the Act.

24 Immediate family members. The Act talks about your
25 interests and those of your immediate family members.

1 Interests of immediate family become your interests for the
2 purposes of analysis on the Act or application of the Act and
3 that includes all those people on that list, which I'm not
4 going to read to you but it's usually the people closest to
5 you and a few others. And it doesn't mean you have to keep
6 track of all your relatives and what they're doing all the
7 time, but it does mean that if one of them appeared in front
8 of you or had some business with the Commission it should, you
9 know, raise a red flag and say, well you know, that person
10 represents my interests and so how does that fit into this.
11 Again you won't have some of the problems that other boards
12 and commissions do because we're not dealing with grants or
13 contracts maybe. Do you let any contracts?

14 COMMISSIONER ERICKSON: I don't know if the Commission is
15 going to be involved in the actual award or not, but I will.

16 MS. BOCKMON: Yeah, the decision maker might be somebody
17 else. At any rate in some senses as I said, you don't have
18 the problems that others may.

19 Personal interest and financial interest, a number of the
20 rules use these terms. Generally a personal interest is an
21 interest in an organization from which someone gets a benefit.
22 I think about it as a non-financial interest from the public
23 officer's perspective. It can be as simple as membership or
24 some other role you might have in an organization.

25 Financial interest is a little bit easier to grasp,

1 perhaps. It's an interest that's a source of income, be it an
2 outside business. You all come from some form of employment,
3 perhaps, or have business associates, own property, private or
4 professional relationships, sources of income. It also
5 includes the situation where you are an officer, employer,
6 director, a manager of a business. So that's a financial
7 interest.

8 Two more important definitions are benefit, which
9 essentially has a very broad definition. There's a laundry
10 list of things, such as dividends, salaries, deposits, loans,
11 leases, money, patronage, advantage, anything of value,
12 regardless of financial gain.

13 Official action, this is a term that we find in a number
14 of different places, and it was amended in 2007 to include the
15 three words highlighted in, I think, it's green there, advice,
16 participation, or assistance. I understand the Legislature's
17 intent in making that amendment was to broaden the definition
18 of official action, and I think at this point, it really means
19 any substantial involvement or any involvement in a matter.
20 We always looked at it as something more than the final vote,
21 more than the final act of signing on a contract. It did
22 involve participation, but now the Legislature has made it
23 very clear that almost any kind of participation to any
24 substantial degree falls within the concept of official
25 action.

1 And from the standpoint -- I was going to add a comment.
2 I know you have a couple of non-voting members. Well this is
3 where you need to understand that the fact that you don't vote
4 doesn't mean you are not taking official action. If you're
5 involved in the discussions and judgments of the Commission
6 generally, then you're still involved in official action.

7 Now we're going to run through some of the rules. The
8 first section of the Act having rules is titled Misuse of
9 Official Position, and it is sort of a laundry list of
10 different rules. The principal concept is you can't take
11 action. You can't use your State position for personal gain,
12 and you can't take action or participate in action that would
13 grant an unwarranted benefit or treatment to another person.
14 These are, as I said, broad concepts, and you have to look at
15 the specific situation to understand whether there is an
16 Ethics Act issue.

17 It's also improper to use your position to secure
18 employment or contracts, and by that, I mean take action in
19 your job to benefit a prospective employer or someone with a
20 contract that you want. It is not putting your status on your
21 resume or CV or talking about your experience on the
22 Commission. That's not misusing your position to secure
23 employment or contracts. When we look at that under the
24 Ethics Act, we're talking about somebody who is going to take
25 action to benefit someone to secure some outside employment or

1 contracts.

2 Next, you can't accept compensation from others for
3 performing your duties. Well you get, I know, maybe travel
4 and per diem and sandwiches in your role in volunteering on
5 this Commission. State employees, of course, have salaries,
6 but none of us are allowed to accept compensation for
7 performing our roles. This has been construed to prohibit the
8 State ferry employees from taking tips, and in some cases,
9 receiving cash awards for participation on, you know, outside
10 panels and work projects where you're in your State capacity.
11 So you can't accept compensation from others for performing
12 your duties.

13 COMMISSIONER BRANCO: Judy?

14 MS. BOCKMON: Yes?

15 COMMISSIONER BRANCO: May I ask a question?

16 MS. BOCKMON: Sure.

17 COMMISSIONER BRANCO: Can you define others? Is my
18 employer an "other"? Thank you.

19 MS. BOCKMON: In coming to the Commission, we assume you
20 have permission and you are working -- maybe not everybody but
21 working in some capacity and that's not what we're talking
22 about. We're talking about someone who is looking -- the idea
23 is always someone who is trying to influence or influence you
24 in your actions, so someone outside of your realm who is
25 looking at the Commission's work and wanting you to take some

1 action.

2 You may not use State time, equipment, property, or
3 facilities for your own benefit or gain. That is just, don't
4 use State -- the example I used to give for this and personal
5 gain is don't use the State phone systems for long distance
6 calls; don't use the copiers for copying your business or non-
7 profit's newsletter. You can't use State equipment for these
8 kinds of things when serving in a State official capacity.

9 A little bit of a catch-all. It's improper to take
10 action on a matter to benefit your personal or financial
11 interest and that's the one that is really important to most
12 boards and commissions because it draws upon the ideas or the
13 foundation of the Ethics Act. What is your personal interest?
14 What is your financial interest? You shouldn't let those
15 interests influence your actions, and therefore, you're not
16 permitted to take action on matters that might benefit your
17 interests. And as I'll talk a little bit again later, we do a
18 balancing in that regard. And in the context of this Board
19 where you all come to your service by designation to fill some
20 role, there is also a balancing in that context that does when
21 we're talking about what your interests are, and I'll get back
22 to that. Finally on this slide, it's improper to coerce other
23 subordinates to benefit your personal or financial interests.

24 So that's part of the laundry list. There is another one
25 involving adjudicatory hearings, administrative hearings, and

1 the short version of all of that that is on the slide is the
2 State officers are not permitted to make *ex parte* or contacts
3 with hearing officers or final decision matters in
4 adjudicative proceedings, absent the presence of all parties
5 or prompt disclosure of the content to all or if you're
6 responding to a request from the hearing officer.

7 COMMISSIONER MORGAN: Ma'am, I'm sorry to interrupt. I'm
8 from South Louisiana. When you say an adjudicatory *ex parte*
9 something, what is that in English?

10 MS. BOCKMON: Sorry. Well administrative hearings, there
11 are any number of agencies and some boards that have to hold
12 hearings to adjudicate or to decide matters relating to an
13 outside party's interest, contract matters, perhaps grant
14 matters, and I don't know that I could the range. And in the
15 process, there is a designated hearing officer who holds a
16 hearing and there may be a final decision maker that takes the
17 recommendations of the hearing officer to make a decision.
18 And the concern -- this was an amendment in 2004 or '05.
19 There was an apparent concern that sometimes probably mostly
20 State employees as opposed to Board members but it applies to
21 both, might think they have the ability to have an inside
22 track to a hearing officer. And so this is a design to make a
23 violation of the Ethics Act, if you make -- and by *ex parte* I
24 realize it's a legal term and I try not to use, but make a
25 contact with a hearing officer that's not part of the official

1 record, that's not in the presence of the other parties, the
2 idea being trying to take the hearing officer aside to
3 influence the decision making when you shouldn't be doing
4 that. They are, obviously, staff to these folks that do get
5 to talk to them, but the idea is you shouldn't go outside the
6 hearing process to make contacts to influence the final
7 decision. Does that help? Sorry.

8 All right. Political activity. The Act basically
9 prohibits state officers from using state resources to engage
10 in campaign or partisan political activity. You are not in a
11 position of having leave, but all state employees have to take
12 a leave to engage in campaigning activities during the work
13 day, and there is a separate prohibition against the use of
14 state resources for partisan political purposes. That phrase
15 has a specific definition. It means with the intent to
16 benefit a candidate or a potential candidate or political
17 party or group, and it doesn't mean having the intent to carry
18 out your day-to-day functions to the benefit of the general
19 public and the state at large. But these are fairly strict
20 prohibitions, and there are only a couple of exceptions built
21 into the Act.

22 One would be the use of the Governor's residence, which
23 is a state building, for meetings to discuss political
24 strategies, recognizing that the Governor lives there and is
25 entitled to do other things besides be Governor in his

1 residence and use communications equipment, so long as there
2 no charge to the State. And there was an issue about use of
3 the state aircraft a number of years ago, and in 2007, the
4 Legislature added a prohibition on -- that results in
5 permitting limited incidental use of the aircraft for combined
6 purpose trips. That's where -- usually it would be a governor
7 or senior official might travel to another location for state
8 business and want to have a lunch with party officials in that
9 city. The way it's structured is restricted to 10% of the
10 actual time involved, and I'm not, at this point, aware of any
11 situation where we've actually applied the new rules. It is
12 somewhat difficult to envision or to deal with the travel and
13 divide it out in the sense that the statute intends, but there
14 needs to be -- it can happen for very, very limited purposes.
15 There has to be disclosure and proportionate reimbursement of
16 the costs and that too is a discouraging factor because of the
17 flying and aircraft. Even 10% of the cost probably in many
18 instances is greater than if the candidate took the -- or the
19 person took the -- made a separate trip. So at any rate.

20 Gifts. Gifts is an important topic about which there are
21 a number of rules, and the basic rule is that you may not
22 solicit or accept a gift if it could be reasonably inferred
23 that the gift is intended to influence your action or
24 judgment. And that's any gift of any value. If you think
25 somebody is giving you something to influence your work on

1 this Commission, it should raise a red flag, and hopefully,
2 you'll decline. There is a -- we look at this rule more
3 objectively and do look at, in effect, the appearances,
4 contrary to what I said earlier because it's whether someone
5 looking at you could reasonably infer that the gift was
6 intended to influence your action or judgment.

7 Our regulations say that an occasional gift worth \$50 or
8 less is presumed not to be intended to influence and so it
9 gives you some latitude to do things like have a meal or have
10 a drink, but you should always, in the back of your mind, be
11 asking yourself whether the offer to pay or the offer to take
12 you along or the offer to give you something, even if it's
13 less \$50, is intended to influence your action because you
14 don't want to accept those kinds of gifts.

15 A gift can be anything that benefits you personally and
16 relates, in some fashion, to your work.

17 In 2007, the Legislature added a provision saying that
18 all gifts from lobbyists are presumed to be improper, unless
19 the lobbyist, the giver, is an immediate family member. And
20 this presumption trumps the one I just talked about. So any
21 gift of any value from a lobbyist is presumed to be improper,
22 and my suggestion is simply don't accept them.

23 Presumptions are designed to start the analysis, and
24 there are any number of circumstances with respect to both of
25 the two presumptions that would overcome the presumption.

1 That is, a \$50 gift could be intended to influence under the
2 facts and circumstances, and a gift from a lobbyist might not
3 be. When this provision was added, we had any number of
4 inquiries from people who said, well you know, my longtime
5 best friend of 20 years who I exchange Christmas gifts with or
6 go out to dinner with or take a bottle of wine to their house
7 for dinner are lobbyists, and we're talking about registered
8 lobbyists, lobbyists who do lobbying as a business. And my
9 suggestions to those folks were, initially, well make a
10 disclosure up front before anything happens and then we can
11 address the parameters of that and recognize that gifts like
12 birthday gifts from longtime friends are not what this Act is
13 intended to address, but also remember that, if that person is
14 someone who has business in front of your agency, you need to
15 think twice about what's being given and what's happening and
16 what possible action is pending and think carefully before you
17 engage in gift giving. So don't take gifts from lobbyists,
18 regardless of value.

19 So I think that's it. We've talked about what gifts are.
20 Gifts are anything.

21 There is a reporting requirement for gifts. The basic
22 requirement is that we report gifts worth more than \$150 if
23 given to you or a family member within 30 days if -- you may
24 take or withhold action affecting the giver or the gift is
25 connected to your governmental status. The \$150 is simply a

1 bright line -- one of the very few bright lines in the Ethics
2 Act -- for reporting. It doesn't mean the gift is proper or
3 improper. It simply means that it's at a level the
4 Legislature felt we should be looking at them. If it's
5 connected to your government status and you disclose them to
6 your Ethics Supervisor, there are forms to do so and the
7 Ethics Supervisor will then approve acceptance, or if there's
8 a problem found, will deal with what the remedy should be,
9 which could be giving it back or paying for it or something
10 like that. But gifts \$150 need to be disclosed.

11 There is a second disclosure for gifts received from
12 another government, foreign governments, local governments,
13 federal government, and these are reported to the Office of
14 the Governor who determines disposition. It's generally felt
15 that most of these gifts are in the nature of what we would
16 call a protocol gift, and it would be, in most instances, rude
17 to not accept the gift, and it's really a gift given on behalf
18 of -- to the State, to you on behalf of the State and it
19 becomes a gift to the State. How are we doing?

20 UNIDENTIFIED COMMISSIONER: (Indiscernible - away from
21 mic)

22 MS. BOCKMON: No gifts from the federal government. Well
23 you know, and I just throw that out there. You never know
24 because sometimes you folks fly people around to look at
25 things, or you know, things just do come up. You would be

1 surprised. Although that provision I see mostly in the
2 context of there are any number of protocol type visits,
3 courtesy visits that the representatives of foreign
4 governments stop by the Governor's office and they bring the
5 most amazing collection of little gifts that you can possibly
6 imagine. So at any rate, next topic.

7 Improper use or disclosure of information. There are two
8 rules. The first is you may not use or disclose information
9 acquired during your official duties if doing so would benefit
10 you or an immediate family member, unless the information has
11 already been publicly disseminated.

12 Public dissemination has been given a specific definition
13 in the rule, in the regulations. It, essentially, means
14 broadcasting. If the information has been broadcast at a
15 meeting like this or posted in a publication or filed in court
16 in a public record, that's been broadcast. Anybody can use
17 the information and all of the State people can use it. The
18 definition, at the moment, doesn't include posting online,
19 although we have a pending rule change to add and bring that
20 definition into the real world, but I would consider anything
21 posted on any State website publically as publically
22 disseminated information that anybody could take advantage of.

23 The other rule is that you may not disclose confidential
24 information unless authorized, and I don't know that that will
25 come up. Maybe it could come up in the context of this

1 Commission's work, but no disclosure of confidential
2 information. This provision is one of two that applies to
3 both current officers and former officers and so it sort of
4 tracks with you once you leave. If you had been privy to some
5 confidential or non-disclosed information, you shouldn't be
6 using it to your benefit after you leave your position.

7 COMMISSIONER BRANCO: Judy?

8 MS. BOCKMON: Uh-huh (affirmative)?

9 COMMISSIONER BRANCO: Does the public nature of this
10 meeting constitute public disclosure?

11 MS. BOCKMON: Uh-huh (affirmative), yeah. I mean, this
12 is an open public forum.....

13 COMMISSIONER BRANCO: If it's discussed here.....

14 MS. BOCKMON:and it's discussed here and anybody
15 here who learns something can take it away, and it's also
16 going to be in your publicly available Minutes and recording,
17 however that is done. So yeah. I mean if somebody brought
18 you a report, statistical report and said -- I don't know
19 where it would come from but you know -- this is the
20 information regarding this issue that we've collected and it
21 becomes part of your work and your record, that's a public
22 record. It's available publically, and I would consider it
23 having been discussed and distributed in a public meeting to
24 be publically disseminated.

25 The next provision deals with improper influences in

1 grants, contracts, leases, or loans, and I won't spend much
2 time on it because I understand you don't award such things.
3 But the idea here is that you should not have an interest --
4 state officers should not have any interest in any grant,
5 contract, lease, or loan that they have authority to act upon.
6 And this provision is more strictly interpreted than others to
7 really preclude the officer from having any authority. That
8 is, if the situation arises, either the authority has to be
9 removed or the applicant can't apply and have the situation.
10 It's pretty strict. There are a couple of exceptions for
11 competitively solicited contracts and certain kinds of loans,
12 but -- and there is a disclosure requirement -- and you can
13 click through, Deb, a bit; there you go -- for interests you
14 might have in these things awarded or administered by your
15 agency, which you don't have that situation so I will move on
16 from that.

17 I didn't say earlier, but in the context of that slide
18 versus the misuse of position -- inability or you shouldn't
19 take action that might affect your interests, the remedy in
20 that situation and with respect to your work here is to
21 refrain from participation, disclose and refrain, unless your
22 Chair says you can participate. In the contracts/grants
23 situation as I suggested, that's not adequate under the
24 interpretation of that provision. There can't be any
25 authority for that person to have an interest in the matter.

1 Improper representation. Generally as a state officer,
2 you can't represent, advise, or assist someone for
3 compensation in a matter pending before the administrative
4 unit. I don't expect that that would be the case in this
5 situation, but the remedy for all boards and commissions is
6 that the person, if he or she is going to or in a position to
7 having to represent another party before the Commission, then
8 that member must refrain from participating in whatever the
9 matter is. This would, more ordinarily, come up in a
10 licensing situation, for example, somebody's partner's license
11 is under review by the Licensing Board and the member wants to
12 participate on that partner's behalf and therefore can't
13 participate in the Board's actions.

14 There are restrictions on employment after leaving state
15 office, and of course, all of you folks are already employed
16 or maybe most of you. And the idea is really that after
17 leaving your state position -- and it doesn't apply to board
18 and commission members, although we most often see it in the
19 context of state employees -- you can't work for somebody else
20 for compensation on a matter you worked on while in state
21 service. I'm not sure what an example would be in the context
22 of your work.

23 The one I see most often is DOT engineers that are
24 retiring and they've worked on a contract or they've been
25 involved in an RFP. When they leave state service, if they

1 went to work for a DOT contractor, they wouldn't be permitted
2 to work on a project or under a contract that they had a role
3 in while they were in state service, or if they did, they
4 would violate the Ethics Act. It's a two year bar. There is
5 a waiver provision that's rarely, rarely used which requires a
6 finding of the commission or of the agency.

7 Matter is narrowly construed. In understanding the
8 intent of the Legislature, we want to protect state action
9 which is the goal. We don't want people while they are in
10 state service looking to their future and taking action on
11 matters, thinking ahead to benefit a perspective employer, but
12 we also want to apply this in a way that doesn't unduly
13 restrict people from taking their experience from state
14 service and going off and continuing to work and be employed.
15 It's important to be able to bring people into state service,
16 and we hope they gain useful experience while here and should
17 be able to take it with them.

18 So we look at matter narrowly. Particular contracts,
19 particular proceedings, and it's been applied to legislation
20 and regulation matter, but it is narrowly applied. It doesn't
21 apply to the formulation of policy, and it doesn't apply to
22 ministerial activities, such as supervision of employees that
23 don't involve the merits of the award of a benefit to someone.
24 Advice is available from the A.G.'s office, from me basically,
25 to former employees on how this would be applied in particular

1 circumstances, and given that most of what you do is planning
2 and policy, I wouldn't expect this provision to apply in most
3 instances after anyone -- if anyone is contemplating leaving
4 the service of this brand new Commission any time soon.

5 There are restrictions on lobbying after state service.
6 It doesn't apply to you folks here because you're not a board
7 or commission having regulation adopting authority, but it
8 does apply to all of those -- that list of state officials and
9 is a one year prohibition.

10 And finally it's a violation of the Act to assist
11 somebody else to violate the Act. That's hopefully relatively
12 straightforward.

13 So those are the rules. That's the Code of Conduct as it
14 exists in the statute at this point. There are probably some
15 nuances and details that I didn't touch on, but those are the
16 basic rules, and essentially, you just need to understand that
17 you shouldn't be taking action and you shouldn't be involved
18 in matters where you might potentially affect your own
19 interests or provide an unwarranted benefit to somebody else
20 and again most -- I wouldn't think that would occur, given the
21 work of this Board. So that's part two.

22 Conflicts. Generally the Ethics Act, I think, only uses
23 the word conflict once, but particularly when we're talking
24 about board and commission work, what everybody thinks about
25 is, do I have a conflict? And what the public may think is,

1 this person appears to have a conflict. So conflict, in the
2 words of the Ethics Act is, are you going to potentially
3 violate the Ethics Act? That is, you know the rules and if
4 you take action, are you going to potentially affect your
5 interests? That's a conflict.

6 Conflict is defined in different ways. It's a situation
7 -- if the situation is one where your regard for one duty
8 would lead you to disregard another, or the matter requires
9 you to serve two masters where you might do wrong to one of
10 them, or if by your action, you promote your private interests
11 to the detriment of the public interest. That third one is
12 really what the Ethics Act is all about. And as I said
13 earlier, not every situation that involves your interests
14 would necessarily mean you can't participate.

15 The Act requires a balancing, as I said earlier, and
16 there are some factors built in that we are to consider if
17 there is a situation where there is a potential violation. So
18 the first thing we always want to think about is, will the
19 action result in a violation? And then if there is that
20 situation, examine whether the interest involved is
21 significant or insignificant, whether the interest is one
22 possessed generally by the public at large. And the example,
23 I think of the people that serve in the Permanent Fund Board.
24 Everybody gets a Permanent Fund check. That's something that
25 everybody has an interest in and so the Permanent Fund folks

1 don't violate the Ethics Act by taking actions that might, in
2 one way or another, affect the amount of the Permanent Fund
3 check. If your interest is one large class of persons, that's
4 the same thing, or if the action would only have insignificant
5 or a conjectural affect on your interests. And perhaps one
6 way to think about that is, if you have a really minor, minor
7 interest in a company and somehow that company is in line for
8 a contract or a grant, well, is your minor interest
9 disqualifying? It may depend on the situation, and you may
10 still not want to participate, the state officer might not.
11 But there could be a situation where the ability in the
12 context of whatever the action is to affect that interest is
13 too conjectural to require the person to refrain from
14 participation.

15 So there are those standards, but the first question is
16 always, are you in a position to potentially affect your own
17 interests? If so, then we can look at the secondary analysis
18 if it seems appropriate.

19 As I suggested earlier for this Board and some others,
20 the Legislature contemplated that each one of you, I think,
21 would represent a particular group of people in the State, be
22 it -- and I should have the list in my head, but you know, the
23 tribal health community, I see, the statewide Chamber of
24 Commerce, the Hospital and Nursing Association, and these
25 interests -- these are all interests -- the Legislature asked

1 that someone be put in your position representing those
2 interests so you could contribute and reflect that interest.
3 So the conflict provision, the issues in the Ethics Act don't
4 mean, if that interest is under discussion, you can't
5 participate. What we generally say -- and again everything
6 comes back to what the matter is that's being addressed, but
7 generally speaking if the discussion or the action relates to
8 the group's interest as a whole, then you would be okay in
9 participating. But if, for some reason, the discussion or the
10 action relates to your particular organization or employer or
11 would have a substantial effect on your employer or
12 organization, then there is a bigger problem that needs to be
13 looked at because you can more closely effect your interests
14 in that situation.

15 Most of the times, this comes up with the Marine pilots
16 and that board has two Marine pilots. There are three Marine
17 Pilot Associations in the State. It has Marine agents, a
18 public member, and there are frequently questions regarding
19 the income or the benefits that Marine pilots get, and we have
20 to look at whether the particular is one that is across the
21 board or is it something that relates to the pilot members'
22 own organization. Same thing happens with fisheries. There
23 are fisheries, and this is a constant problem. The Fisheries
24 Board deals -- you know, they're broken up into regions, the
25 way they deal with the fish, and they actually have a cycle

1 where they deal with different regions, like Cook Inlet and
2 Bristol Bay, and those kinds of things at different times, and
3 they always have a long list of matters. And the members that
4 come from those regions then have some level of conflict that
5 has to be addressed. So you look at, is it something that
6 affects the entire group or does it affect you more narrowly
7 and your interests more narrowly? And it's hard to give, you
8 know, a one answer fits all, but you have that distinction of
9 being people who are sitting here because the Legislature
10 wanted your input from your perspective given. And also
11 because you're a planning and policy group, you're not going
12 to have quite the problem that, say, the Marine pilots or the
13 Fisheries folks have in terms of affecting your own financial
14 interests. So just keep that general idea in mind, and if
15 something comes up that is a particular concern, you can raise
16 it with your Chair, and if he needs to, he can call me. Any
17 questions about that? Good.

18 I'm going to talk about procedures a little bit, and
19 we'll talk about the complaint procedure some. But the most
20 important thing for you all is the disclosure procedures. We
21 have something which is called the Notice of Potential
22 Violation and/or -- because people think that's bad, but if
23 you're giving notice of a potential violation, that's actually
24 good because you're thinking ahead and you're recognizing
25 there is a problem that needs to be addressed, but people

1 don't like that. So I let people request Ethics
2 Determinations. And our goal is always to protect the
3 integrity of the Board's action or the Commission's action by
4 addressing it in advance.

5 Under the Ethics Act, boards and commission members are
6 required to declare their conflicts orally on the record.
7 Different commissions do it in different fashions. Everybody
8 has an agenda coming in, so you should have idea whether you
9 have a conflict. I don't know if you make time at the
10 beginning for declaration of conflicts or you would do it in
11 the context of when particular matters are taken up. And
12 again because your policy and planning functions are a little
13 different than other boards, it may not be something that you
14 can always see in advance. But nevertheless, everyone should
15 understand that, if something comes up as you go along, you
16 should disclose before any action is taken.

17 The requirement says disclose on the public record, as I
18 said, and in writing. By regulation if your meeting is
19 recorded and Minutes are kept such that we can get back to an
20 oral disclosure, that constitutes the writing. You don't have
21 to sit there and fill out a form at the same time. You can,
22 if you have a complicated situation, put something in writing
23 to your Chair ahead of time to have it looked at and maybe
24 examined in an advance, but you would still have to make the
25 declaration on the public record.

1 Then the procedure is that the Chair makes the decision
2 on your participation. If anyone else objects to the
3 decision, you would take a vote of the Board or the Commission
4 and that determines whether you can participate or not. And
5 if you comply with the decision, which we would hope you do,
6 that protects you if someone were later to charge you with
7 violating the Ethics Act for having participated in a conflict
8 situation. So the procedure is important.

9 I noted in your new statute a couple of things that I
10 just wanted to flag because it talks about adopting Bylaws,
11 addressing conflicts, and your statute says a member has to
12 declare a substantial financial interest in an official action
13 and request to be excused. Well under the Ethics Act, you
14 really have to declare any financial interest, any conflict,
15 regardless of whether you think it's substantial or not and
16 then your Chair would make the judgment as to whether it is
17 substantial, such that you need to be excused. So that's
18 something that you -- if you're complying with the Ethics Act,
19 you comply with this provision in your statute, I think. And
20 the statutes seem to have the same sort of outline, ruling by
21 the Chair, opportunity to override the ruling by majority
22 vote. That's sort of consistent with the Ethics Act, but I
23 did want to point out that, while your statute says declare
24 substantial financial interests, the Ethics Act might suggest
25 you to declare something more than just your substantial

1 financial interest.

2 Your Act also talks about the filing of a written
3 disclosure listing all potential conflicts valued at more than
4 \$5,000. The Ethics Act doesn't have that kind of disclosure
5 requirement, so that would be something in addition because
6 Ethics Act disclosures are all in the context of the matter
7 before the Commission. And most likely, this kind of
8 conflict, if there were a matter that affected that interest,
9 you shouldn't be participating. But I just wanted to note
10 that this disclosure is a little different than what the
11 Ethics Act requires.

12 Let me see. Where else are we? Complaints. Hopefully
13 you will never have to be involved in this process, and there
14 are a number of slides and I'll try to go through it
15 relatively quickly, but I think it's important that everybody
16 understand that there is process. It's been in the news a
17 lot, and there are some misunderstandings about the process
18 and so bear with me. We're almost done.

19 There is a procedure for filing ethics complaint, and the
20 Act -- it's not complicated. The Act simply requires that it
21 be in writing, that it be signed under oath, and contain a
22 clear statement of the details of the alleged violation. In
23 most cases, the Attorney General is responsible for
24 investigating an ethics complaint. They're filed with the
25 Attorney General, and we investigate all complaints, except

1 those filed against the Governor, Lieutenant Governor, or
2 Attorney General because of the inherent conflict that that
3 would present. That is obviously, the Attorney General
4 shouldn't be investigating, or his staff, his complaints
5 against himself or herself, and the Governor appoints the
6 Attorney General and the Attorney General serves as legal
7 advisor to the Governor and the Lieutenant Governor and so
8 there is an inherent conflict.

9 The way the Legislature addressed that in setting up this
10 scheme was to have the Attorney General immediately refer any
11 of those kinds of complaints to the Personnel Board, who hires
12 independent counsel to act in place of the Attorney General
13 and with the authority of the Attorney General to investigate
14 and address the complaint. There has been a misunderstanding
15 perpetuated in the media, I feel, and by some complainants
16 that the Personnel Board is the entity that's making the
17 decisions, but in the last couple of years, all of the
18 decisions that you may have read about or heard about have all
19 been rendered by independent counsel acting with the authority
20 of the Attorney General. Just as we would do, the Attorney
21 General and I would do, in a matter not involving the senior
22 officials at a level in the process that it is our or the
23 independent counsel's authority that is exercised, the
24 Personnel Board, again, has oversight. The independent
25 counsel because he -- I guess they've all been or are employed

1 by the Board -- reports to the Board, but it is the
2 independent counsel's decision.

3 So there are levels of review. The first thing is just
4 what I'll just loosely call the intake or the preliminary
5 review. Is it properly completed? Does it state a claim?
6 Sometimes at this stage depending on the nature of the
7 situation, I might go back to the complainant and explain to
8 the person about the Ethics Act or ask them what they really
9 mean or do they have additional information. And sometimes I
10 do some preliminary investigation to determine whether what is
11 being talked about really warrants investigation. It is
12 possible at this point, if it's not properly completed or
13 doesn't state a claim or doesn't warrant investigation in our
14 judgment or independent counsel's judgment, to dismiss the
15 complaint with notice to the complainant and the subject.

16 If we determine to accept a complaint for investigation,
17 it is served on the subject. Response is requested.
18 Investigation ensues. All information, the complaint and
19 everything, during this phase, the first phase and this phase,
20 is confidential, unless the person agrees -- the subject
21 agrees to waive confidentiality or we proceed to formal
22 proceedings. So we take the position that we don't
23 acknowledge, discuss, or reveal the nature of complaints or
24 the status of complaints. They have a way of making
25 themselves into the news, and there are First Amendment

1 considerations regarding citizens' ability to comment on their
2 government that come into play. There is no penalty in the
3 Ethics Act for a complainant who is not a state officer
4 disclosing a complaint, but we don't respond to inquiries
5 about them.

6 There are three possible outcomes at this point. We
7 could find no probable cause to believe a violation occurred,
8 in which case the complaint would be dismissed by the
9 Department of Law or independent counsel. We could find
10 probable cause but no hearing warranted and recommend or
11 direct action to correct or prevent the violation. Or we can
12 find probable cause that there is a knowing violation and
13 issue an accusation which leads to formal proceedings.

14 At any of these points along the way, a matter could be
15 resolved by settlement and discussion. We have a policy to
16 make any settlement document a public record, and I think that
17 generally has been followed, as far as I know, by independent
18 counsel as well because it is important that, even though the
19 proceeding may be confidential, the public understands that
20 there has been a resolution and what it is.

21 So formal proceedings. Also if there is something that
22 can't be corrected or someone fails to comply with corrective
23 action, the formal proceedings, without going through
24 everything, become -- it's a public matter. There will be a
25 public hearing with a hearing officer appointed by the Office

1 of Hearings and Appeals after the person answers. Law or
2 independent counsel would serve as sort of the prosecutor.
3 The subject would defend and present evidence. A hearing
4 officer hears the matter, reports to the Personnel Board, and
5 makes recommendations regarding whether there is a violation
6 and potentially what remedy there should be.

7 You can keep going Deb. I've gotten beyond this. I
8 haven't figured out how to shorten the slides to fit the
9 conversation.

10 Anyway so that's the process. Ultimately, the Board then
11 becomes the decision maker that makes the determination of
12 whether there is a violation and what the penalty should be.
13 And as I said, certainly not in my tenure and I don't believe
14 more than a couple times throughout the history of the Act,
15 have we ever gotten to this phase. There is a high incentive,
16 I think, for folks who are found to have violated the Act to
17 resolve it before we get to the public proceedings, and in
18 most cases I think, that has been what has happened, insofar
19 as I have been able to figure out the history.

20 Finally I want to mention that there are significant
21 penalties. There are remedies under the Act for violations.
22 Simple remedies are ordering the action that violates the Act
23 to stop. The Board has authority to order divestiture,
24 restitution, forfeiture. In the cases of boards and
25 commissions, the Personnel Board can recommend removal of a

1 Commissioner. We can void contracts or require repayments of
2 loans, access civil penalties of up to \$5,000 per violation,
3 require payment of up to twice the financial benefit realized
4 from a violation. And action under the Ethics Act and the
5 imposition of civil fines doesn't preclude criminal sanctions.
6 If we were to find evidence of criminal activity, it would be
7 referred and addressed in the ordinary criminal process. So
8 significant penalties are possible.

9 To wrap up, if you're unsure, please ask. Please
10 disclose. Please seek counsel. Err on the side of reporting
11 and not just justify moving on, and understand that we do
12 apply the language of the Act to the specific circumstances
13 and don't judge on appearances. It's always better to
14 disclose.

15 Finally all public officers are required to understand
16 the Act, report potential violations, refrain from retaliation
17 against anyone who does report a violation, take advantage of
18 the disclosure opportunities, and cooperate with
19 investigations.

20 So I can answer any more questions. Otherwise, I
21 appreciate your time and attention and asking me to come.

22 COMMISSIONER DAVIS: Thank you, Judy. That was great.
23 As you pointed out, there aren't a lot of bright lines though
24 and so there is a couple parts of this I'm struggling with,
25 one kind of big, and I think maybe some of my colleagues on

1 the Commission also are struggling with.

2 As you pointed out, we're all appointed representing an
3 interest, and some of those are, you know, fairly broad. It's
4 easy to see how we could find ourselves discussing potential
5 policy recommendations that would have a broad impact. For
6 example, I'm appointed to represent the health insurance
7 industry. So if we're looking at talking about something that
8 affects, let's say, the state rules around physician -- how
9 you determine reasonable and customary reimbursement for
10 physicians, that would have and could have an impact on the
11 health insurance industry as well as on the physicians around
12 this table. So we could have a whole bunch of people who
13 really were invited to the table to bring their perspective as
14 to what that might mean who have to say, you know what, I have
15 to recuse myself from this, leaving only the people who really
16 aren't familiar with the subject matter to try to determine
17 the policy recommendations.

18 So I'm really struggling with how, you know, we would do
19 that or if it's a matter that might affect the tribal health
20 somehow or business somehow. I mean, those are the things
21 that I'm just not sure how we cut that, without declaring, you
22 know, nine out of ten agenda items off limits for us.

23 MS. BOCKMON: Right. I think a couple of things. It's
24 hard sometimes to state a general rule, or it's always hard
25 almost under the Ethics Act to state a general rule, but a

1 couple of things. You're here to represent your interest and
2 so you can do that, no question in my mind generally. But you
3 wouldn't -- in the instances that it has been applied in the
4 past, if it gets down to something that might substantially
5 affect your business, your employer, then you might want to
6 pause and have it looked at and seek input from your Chair and
7 the rest of the Commissioners. But everybody knows that you
8 sit in that position, and with this disclosure of significant
9 financial interest, everybody visibly knows or has access to
10 that information. So everybody knows that's where you're
11 coming from, and we're going to presume that you act in the
12 best interests of the State and this Commission in taking that
13 action.

14 And absent it really coming down to something that has a
15 direct -- and again I'm using words that I'm not sure I fully
16 understand the context, and it always helps to have a
17 particular matter for me to actually say yes or no. It really
18 has come down to an action that is not, in general, affecting
19 the entire class. And in your example, you're affecting more
20 than one class but more targeted, such that you could be
21 perceived as potentially acting to benefit your own personal
22 interests. And it's hard in this kind of group, I think, most
23 things should proceed in the ordinary course, and I don't know
24 of an example. Like I've seen the Marine pilots, it's easier
25 to flag it, and similarly, the Fisheries. And I don't know in

1 the context of this group how it would come up.

2 COMMISSIONER DAVIS: If I may, let's see if I'm hearing
3 you correctly. So if the policy matter we're determining
4 affects, you know, all physicians or all health care insurers,
5 then physicians at the table, the health care insurance
6 representative at the table presumably is okay to speak out.
7 But if -- this is just a hypothetical to try to illustrate it.
8 If we were saying this policy should affect everyone but
9 Premera Blue Cross Blue Shield of Alaska, that would be a
10 problem?

11 MS. BOCKMON: Yeah, that would be a problem. Yes.

12 COMMISSIONER DAVIS: Yeah. So it's that kind of
13 distinction?

14 MS. BOCKMON: Yeah, that kind of dichotomy. And the
15 other thing, I guess, I would say about this is that because
16 you're dueling with policy and planning, there is possibly
17 somewhat of a disconnect between the action and any benefit or
18 adverse benefit -- adverse effect on your organization because
19 you're making a policy report to the Governor or the
20 Legislature, and whether those entities are going to act upon
21 what you've recommended, maybe/maybe not. Maybe some; maybe
22 not all of it. And so there is a disconnect when you're
23 dealing with those general matters, but I think you know, your
24 example, which most likely may not have occurred, is a good
25 one. So I don't really think, in the grand sense, that you'll

1 have a lot of potential problems. It would be more if
2 somebody were coming to you to try to influence your -- that
3 you might want to be concerned about.

4 COMMISSIONER DAVIS: Thank you. That was very helpful.

5 MS. BOCKMON: And I appreciated the question because it's
6 a hard area to really deal with, and it's particularly hard if
7 you don't have a concrete example.

8 COMMISSIONER DAVIS: May I ask one more question?

9 CHAIR HURLBURT: Sure. Please.

10 COMMISSIONER DAVIS: So this is very specific and maybe a
11 personal example. So in my organization, I have an
12 organizational superior who is a registered lobbyist in
13 Alaska. He is in many states and federally. And we have a
14 rule in our organization that, if you're out at, you know, a
15 dinner meeting for example, the highest ranking officer picks
16 up the bill. So if I'm out with him, and you know, maybe with
17 others, am I in a precarious position that a lobbyist has now
18 just purchased my dinner?

19 MS. BOCKMON: Well I think that sort of illustrates the
20 situation that I had. A lot of people, just like this, after
21 this was added -- and really when you look at that situation -
22 - if I understand and add to the example, in that situation,
23 that's your superior. That's your company rule, and you're
24 not being given that benefit because of your role here on the
25 Commission and so it really doesn't come within the Ethics

1 Act. If you want to be more comfortable, you can fill out a
2 disclosure, a general, you know, Request for Ethics Advice
3 Disclosure, give it to the Chair, and he, with my input, can
4 give you the generic guidance back. But the reality of what
5 you just described is you're not getting a gift that's
6 connected to your position on the Commission, you know,
7 because state officers can still get expensive gifts from
8 their spouses and their employer gives them benefits and
9 things like that. So under the gift provisions, we're talking
10 about gifts that you would understand are connected to your
11 state service. Certainly if it's -- obviously given your
12 industry, you're somewhat taking action that could affect the
13 giver, but the context of what you described is not a gift
14 with respect to those.

15 CHAIR HURLBURT: Any other questions? Judy, thank you
16 very much.

17 MS. BOCKMON: You're welcome. And if anything comes up
18 after the fact, tell your Chair and he can send me an email or
19 call me. Sometimes it's easier just to talk.

20 CHAIR HURLBURT: Thank you. Are you here or are you in
21 Juneau?

22 MS. BOCKMON: I'm downtown.

23 CHAIR HURLBURT: Downtown, so you're close if we have any
24 questions?

25 MS. BOCKMON: I'm close. I'm close; yes.

1 CHAIR HURLBURT: Thanks.

2 COMMISSIONER DAVIS: Thank you very much.

3 MS. BOCKMON: You're very welcome.

4 CHAIR HURLBURT: Let's take about ten or 15 minutes and
5 come back.

6 2:50:52

7 (Off record)

8 (On record)

9 3:16:34

10 CHAIR HURLBURT: If we could gather around and get
11 started again, we have plenty of time until five, but if we
12 finish a half hour early, we'll finish a half hour early.

13 As we start, Linda, I'd like to ask if you could just
14 introduce yourself for our new folks here. We did that
15 earlier and explained that you were tied up with a couple of
16 other things today, but welcome now.

17 COMMISSIONER HALL: Thank you. And I would apologize,
18 but I had a prior commitment. I've done two speaking
19 engagements already, so I'm not going to talk much.

20 I'm Linda Hall. I'm the Director of the Division of
21 Insurance. I have been in that role for almost eight years,
22 and with that, have a lot of involvement in this slide
23 Deborah's got up here and have worked with this group. I was
24 on the Commission last year as the representative from the
25 Executive Branch/Governor's Office, and I'm really pleased to

1 be back. Last year, I thought it was going to be a chore, and
2 I've found it was a really wonderful experience. So I am very
3 pleased to be back with all of you this year. Thank you.

4 CHAIR HURLBURT: Thank you, Linda, and we're pleased to
5 have you back. In our next section, we want to talk about the
6 current Federal Health Care Reform Bill, a little about the
7 implications for Alaska. And we said earlier, part of my bias
8 is that we not allow ourselves to become totally engrossed in
9 this, but we clearly have to be cognizant and aware of what's
10 going on because it will impact on opportunities for real
11 health care system improvement in Alaska. And as Deb
12 mentioned, Mark has done some economic analytic work for us,
13 has met with the Commission before and with other groups.
14 Some of you probably, I know, have seen Mark's presentation,
15 but he has some very interesting analytic work. It looks like
16 you're going to go first Mark, I guess, and then -- or no,
17 Deb's going to go first. Deb's going to go first and give a
18 little background on health care reform, so please?

19 COMMISSIONER ERICKSON: Yeah, I'm going to go ahead and
20 go first. I asked Mark to go ahead and join us up at the
21 table here, so we can just easily transition into his
22 presentation, but I think it will be helpful for folks in the
23 room who haven't seen this presentation three or four times
24 before. Apologies to folks who have seen it. But I'm just
25 going to try to give a brief overview of the major components

1 of the bill that provide a little bit of a framework and
2 background for -- then Mark's presentation where he has done
3 some of the analysis on projected impacts to Alaska's economy.

4 And I just wanted to note for Commission Members, if you
5 got your extra handouts and put them in your notebooks, you
6 should have a copy of this presentation behind tab six -- I'm
7 sorry -- behind tab five in notebook. And for folks in the
8 room, there are extra copies, hard copies in the back of the
9 room. And for anybody who is on the phone listening, there is
10 a copy of the Federal Health Care Reform Overview presentation
11 on the Commission's website on the October meeting page.

12 So I'm going to go ahead and get started now. First was
13 talking just briefly about federal implementation. The
14 Patient Protection Affordable Care Act -- they are -- actually
15 what constitutes what is being referred to as Federal Health
16 Care Reform right now today consists of three different
17 federal laws. The main law, the Patient Protection Affordable
18 Care Act, was passed by the Senate December of 2009. Then the
19 Health Care and Education Reconciliation Act essentially are
20 the changes that the House made to the initial Act passed by
21 the Senate in December. That was passed in March and signed
22 into law by the President March 30th. The Patient Protection
23 and Affordable Care Act was signed into law March 23rd of this
24 year. And then following the passage of those two Acts, a
25 small just little one-page Act called the TRICARE Affirmation

1 Act was passed and that provides clarification because there
2 was some debate going on immediately after the passage of the
3 first two federal laws about whether TRICARE would qualify as
4 meeting the essential benefits definition. And so this
5 TRICARE Affirmation Act does explain that, clarifies that.

6 So in just the past few months since March, really
7 getting started in April, there are numerous new funding
8 opportunities for state and local governments and communities
9 groups, health care provider organizations, and universities.
10 So far to date, there have been at least 31 funding
11 opportunities released, mostly by the U.S. Department of
12 Health and Human Services, and at least ten regulation
13 packages, as much of the early implementation work is around
14 the insurance reforms and most of these regulation packages,
15 but not all of them, are related to those insurance market
16 reforms.

17 A new federal office has been created. At least one,
18 again, new federal office has been created specifically for
19 insurance oversight in the Department of Health and Human
20 Services, and I've counted at least four new boards or
21 committees that have been formed over the summer as well
22 related to public health, the new Public Health Council,
23 National Prevention of Health Promotion and Public Health
24 Council, a committee that was created to review criteria for
25 shortage designations and medically underserved area, health

1 manpower shortage areas, an Advisory Board specifically to
2 guide the creation of new co-ops for insurance, consumer-
3 operated insurance plans. And most recently just last week,
4 the GAO created a new national Health Care Workforce
5 Commission. Additionally, the Feds had a requirement to
6 establish a website by July 1st where they provide health
7 insurance information as well as other information, state-by-
8 state insurance information as well as other information about
9 health care and about the Affordable Care Act, and that
10 website did go live, although it's still under development, on
11 July 1st. It's www.healthcare.gov.

12 I thought it would be helpful to go over the different
13 components of the Act, just the way it's structured, before --
14 I'm going to take a little bit different approach than this to
15 talk about some of the major components. But just to give you
16 a sense of how it's structured and the major areas it covers,
17 I've paraphrased the titles here. But the first two titles --
18 there are ten titles to the main Act and then the
19 Reconciliation Act makes amendments to the main Act.

20 The first two titles are devoted to health care coverage.
21 As Dr. Hurlburt mentioned in his presentation this morning,
22 this law is very much about health insurance reform as much as
23 anything and that's where the majority of the significant
24 changes to our system are addressed. The first title is
25 around private insurance. The second is around public

1 coverage, and it's focused mostly on Medicaid.

2 Title III, I've titled Health Care Delivery. I believe
3 the actual title is related to quality and efficiency, and
4 it's where a lot of changes that the Act hopes to drive in the
5 delivery and financing of health care through new payment
6 methodologies and pilot projects, testing new care models,
7 those sorts of things mostly as pilot projects through
8 Medicaid, but then some opportunities for demonstration
9 programs through Medicaid. Those all, for the most part, are
10 under Title III.

11 There is an entire title devoted to Prevention and Public
12 Health, Title IV. There's a title devoted to Health Care
13 Workforce Development; that's Title V. Section -- I think
14 it's called Transparency. I just called it Fraud, Waste, and
15 Abuse. It's where a number of programs and provisions meant
16 to address those problems are all included under Title VI. A
17 few minor -- well probably not minor to some, but a small
18 section in Title VII that addresses certain drug programs.
19 And then the CLASS Act, Community Living Assistance Services
20 and Support, is Title VIII and that title creates a new
21 insurance plan for long-term care, a new national long term
22 care insurance plan. We'll talk a little bit more about that
23 in a minute.

24 The financing provisions, the new taxes and fees that pay
25 for the new programs and services under the bill, are all

1 covered under Title IX of the Act. And then Title X is where
2 the amendments were made to the main body of the Act. As it
3 was brought forward from Committee, the amendments that were
4 made on the Floor are captured under Title X.

5 It's important to understand both how the Reconciliation
6 Act -- if you're going to go and look at the bill, the
7 Reconciliation Act and Title X, if you're not looking at a new
8 consolidated version of the bill and looking at the original
9 bill, you're going to miss some really important changes that
10 are made in those different amending Acts and Titles. So
11 that's it for just the major structure and some of the
12 components they cover.

13 This bill really is meant to drive the system towards
14 universal coverage. And just so we're understanding -- we had
15 a debate about this with our initial Commission -- or not
16 debate but discussion about what we mean by universal
17 coverage. It's not necessarily that government will provide
18 all coverage for everybody, but will facilitate and drive
19 through new requirements, a move towards everybody having
20 insurance coverage at some level.

21 And what I've done is laid out here in this little graph
22 kind of the seven major strategies that the Act uses to move
23 towards universal coverage. And starting on your left if
24 you're looking at the screen, the first two in blue and pink
25 on my screen anyway and on the printout, I put first the

1 Insurance Market Reforms and the Employer Subsidies because
2 those are strategies that are starting to take effect right
3 now. But for the most part, most of the major provisions in
4 this bill don't take effect until 2014, understanding that
5 there's a lot of work going on already to move towards being
6 prepared to implement those provisions in 2014. And so
7 starting now with Insurance Market Reforms and Employer
8 Subsidies for the smallest employers, then in 2014 Medicaid
9 expansion, the new Health Insurance Exchanges for states. The
10 Individual Mandate will take effect then. Subsidies will be
11 made available to individuals to support purchase of insurance
12 and then the Employer Mandates requiring employers to provide
13 insurance take effect in 2014 as well. And so I'm going to go
14 over some of the main provisions around each of those
15 strategies next here.

16 For Insurance Market Reforms -- and we have the experts
17 in the room here between Jeff in the industry and Linda who is
18 responsible for enforcing at least the state laws related to
19 Insurance Market Reforms and where there might be some overlap
20 here. You guys can keep me honest and provide clarification
21 if anybody needs it on these, but I'll just list the ones that
22 are taking effect right now. And by taking effect right now,
23 the Insurance Market Reforms that take effect in 2010 apply to
24 new insurance plans with the benefit year starting after the
25 effective date for the Insurance Market Reforms, which is six

1 months after the passage of the enactment of the Bill, so
2 September 23rd. Probably most of you saw some of the media
3 flurry around that towards the end of the past month, that
4 these new provisions were taking effect. Well they were
5 taking effect just for those new plans starting on or after
6 September 23rd and then new benefit years that will start
7 after that. There are other technicalities that I'm not going
8 to try to explain or clarify right now around plans that are
9 grandfathered in. And then somebody was mentioning even this
10 morning how HIPAA actually excludes -- I think it was during
11 our public testimony time -- certain retiree plans from the
12 Insurance Market Reforms as well. So it's not an across the
13 board everybody has this today or as of September 23rd. It's
14 really important to understand that, I think.

15 So starting in 2010, now that we've clarified what that
16 means, exclusions for pre-existing conditions are prohibited
17 for children, the extension of dependent coverage for up to 26
18 years of age. Lifetime limits are now prohibited. Annual
19 limits are restricted. They'll be prohibited started in 2014.
20 There is a prohibition on rescissions now.

21 Medical Loss Ratio, which is sets the percentage that
22 insurance companies have to restrict administrative and other
23 costs that aren't direct medical costs to a certain
24 percentage, they are just starting to have to report that now,
25 and I think, the rules are still being written. They're not

1 finalized yet for how they're going to define the Medical Loss
2 Ratio, but then that restriction will be imposed in 2011.

3 Guaranteed issue and renewal rules, new rating rules for
4 how premiums can be calculated won't take effect until 2014.
5 And then also in 2014, the exclusion -- the prohibition of
6 exclusions for pre-existing conditions will go away for adults
7 as well in 2014.

8 Some of the other things that are taking effect
9 immediately related to the Insurance Market Reforms, there are
10 new federally subsidized temporary high-risk health insurance
11 pools related to the prohibition for exclusions of pre-
12 existing conditions for adults, not taking effect until 2014.
13 This is meant to provide a pathway to help folks who cannot
14 get insurance now because they have a pre-existing conditions,
15 such as diabetes, to be able to buy into insurance and have
16 that subsidized by the federal government. So those pools
17 have been created. We have one here in Alaska now being
18 operated by ACHIA.

19 New multi-state health plans, I'm not sure when these are
20 to take effect and where the federal government is with this,
21 but the Office of -- the Federal Personnel Office is required
22 to set up and to contract with health plans that cover at
23 least one state boundary, include at least two states for
24 every state. And I haven't heard how and when that's going to
25 -- they're going to start working on those, but those are the

1 new multi-state health plans the federal government will be
2 establishing.

3 Health Care Cooperatives, a new program will create non-
4 profit member-operated health insurance companies and will
5 support the creation of those through loans and grants. I
6 mentioned earlier that that's one of the new Advisory
7 Committees that's been created to help guide the creation of
8 this new program.

9 And then Health Choice Compacts are to take effect in
10 2016 and this is meant to allow the establishment of compact
11 states for regulating insurance and to try to facilitate more
12 multi-state insurance plans is my very simplified
13 understanding of it, so that Linda Hall, our Insurance
14 Commissioner, could enter into a compact with her counterpart
15 in other states to facilitate the creation of these cross-
16 border plans. Again I'm really simplifying this stuff quite a
17 bit, but if you have questions, we can try to get a little
18 more clarity to it.

19 The Employer Subsidies. One of the things that I'd
20 especially like to mention for business audiences is that
21 small business is defined in different ways for different
22 provisions of the bill, so it's really important to understand
23 that. For the purpose of employer subsidies, the cutoff for a
24 small employer is 25 or fewer employees. The employer mandate
25 is 50 employees, and there is another provision related to the

1 requirement to automatically enroll employees in an insurance
2 plan for businesses of 200 employees or more. There is
3 another cutoff for another program. The Health Insurance
4 Exchange says a large employer is defined as 100 or more. So
5 it's important to understand the different provisions define
6 small business and have cutoffs for employees at different
7 levels. But for the employer subsidies again, the smallest
8 employers of 25 or fewer employees provide tax credits. This
9 took effect in this tax year, so back to January and 2010.
10 There are worksheets available on IRS's website for small
11 businesses to go on and be able to calculate, one, whether
12 they qualify for the subsidy and what extent they might expect
13 to be able to receive benefits through that program. Another
14 factor for qualifying for that tax credit is those businesses
15 have to have average annual wages of below \$50,000.

16 And then the Temporary Early Retiree Reinsurance Program,
17 another program that some of these temporary programs were
18 meant to provide the bridge between now and when the major
19 provisions take effect in 2014. So the high risk insurance
20 pool again is good until 2014. This Temporary Early Retiree
21 Reinsurance Program is good until 2014 as well, and it's meant
22 to incentivize employers to provide or continue providing, if
23 they are considering stopping, retiree health plans. And it
24 specifically covers folks, retirees from 55 to 65 years of
25 age, and employers who are enrolled in this program will be

1 reimbursed at 80% of retiree claims for each individual in the
2 plan between \$15,000 and \$90,000.

3 Just a side note about that, Alaska's retiree plan, state
4 of Alaska's employee retiree plan was accepted into this
5 program, did apply and was accepted into this program. The
6 benefit consultants for the State's retiree plan estimate that
7 that plan will be able to bill for as much as \$44 million in
8 the first year. And now I'm not sure how many -- I think
9 there have been at least 2,000 employers now enrolled
10 nationally in this program, and there's about \$5.0 billion
11 available. So I don't know how long it will last and how
12 successful any of these businesses.....

13 COMMISSIONER LAUFER: How many employees does the state
14 of Alaska have?

15 COMMISSIONER ERICKSON: Well we have -- does the state of
16 Alaska have more than 25 employees? Oh I'm sorry. The
17 subsidy -- the employer -- the tax credit subsidy is only for
18 small employers. The Temporary Early Retiree Reinsurance
19 Program is a different type of employer subsidy, and yes, the
20 conditions are -- the criteria for meeting the qualifications
21 for that program are laid out in the bill, and I'm not going
22 to remember all of them. But in addition to providing a
23 certain level of health insurance coverage for retirees, there
24 are some other conditions around providing certain preventive
25 benefits and those sorts of things as well.

1 The Medicaid Expansion, starting in 2014, will expand
2 eligibility to all individuals and families under the age of
3 65. On this slide, I have up to 133% of the federal poverty
4 level. It's actually 138%. There's a 5% income disregard
5 included in the bill for calculating eligibility. So in
6 effect, it is up to 138%. Dr. Hurlburt spent some time this
7 morning talking about some of the characteristics about the
8 Medicaid population and how it's primarily women and children
9 but also some aged and disabled. This really changes Medicaid
10 to be the new floor for health insurance coverage in the
11 country and will cover everybody, including childless adults
12 up to this new standard.

13 The federal government will fully fund the expansion up
14 until 2017. Right now in Alaska -- I'll throw another acronym
15 out at you -- FMAP, Federal Medical Assistance Percentage,
16 that is the match that the State has to provide for the
17 federal funds that come through Medicaid, and right now, it's
18 at about 50%. So again leaving out lots of details, but
19 generally 50% of every dollar that the State spends on health
20 care in the Medicaid program is matched dollar-for-dollar by
21 the federal government. The federal government, for the
22 expansion population, will pay 100% until 2017 and then the
23 State's share will start phasing in, but the maximum that it
24 goes up to by the year 2020 is 10%. So the federal government
25 will continue paying 90% of the bills for the expansion

1 population, and the State's share will be 10%.

2 The State's Medicaid Budget Office's early estimate --
3 they actually are coming up with a whole range of different
4 estimates based on different series of assumptions, but so far
5 they've just put out kind of their midrange estimate, and
6 they're estimating that for Alaska it will expand to 30,000
7 new enrollees. There are some national groups that have
8 developed state-by-state estimates based on national models,
9 and I've seen as high as, I think, 42,000 based on some of
10 those national models. So if you see a disparity there, it's
11 because of that, but I'm sure our State Medicaid Budget Office
12 would say that they're using models developed specifically for
13 Alaska and know more about our population here and that these
14 more generalized national models might not be as accurate.
15 But I just wanted to explain some of the disparity there.

16 Then starting in 2020, that would be the highest year
17 out, the first year of the State's maximum share anyway; \$13
18 million in GF to support those 30,000 new enrollees is the
19 preliminary estimate.

20 One other thing I thought I would mention too is that
21 there is an option for states provided in the bill to expand
22 early and that would be done at the State's regular FMAP. So
23 if the Department were to forward a recommendation and the
24 Governor and the Legislature were to agree and the federal
25 government would have to approve the special option for the

1 State to go ahead and expand early, potentially, they could
2 try some things with some smaller populations to start testing
3 some things out, but it would have to be at the State's 50%
4 share cost.

5 Health Insurance Exchange is one of the strategies for
6 facilitating expansion of insurance coverage. These will be
7 again kind of a simplified explanation, but Electronic Market
8 Places for Purchasing Insurance, they are to be state-based.
9 The states have options for participating in multi-state
10 exchanges. They're meant to be for individuals and small
11 businesses of less than 100 employees to participate in
12 initially. And then starting in 2017, larger businesses,
13 those with more than 100 employees, will be allowed to
14 participate.

15 There are grants made available under the Act, funds
16 appropriated for states to plan and begin working on
17 implementation of the exchanges. I'm weaving in just a little
18 bit of what we know about what's going on in Alaska throughout
19 this presentation. Then we can talk more about that
20 afterwards. I think it will be helpful for the Commission to
21 understand. But Alaska was one of two states, actually, that
22 chose not to participate in the first round of planning
23 grants. There's \$1.0 million made available for every state.
24 Again we'll talk about that more in a few minutes. But right
25 now just under the federal guidance and with the federal

1 dollars for beginning planning, Alaska is choosing not to do
2 that at this time.

3 They're meant to be administered by a government agency
4 or a non-profit. It could be set up a number of different
5 ways, different governance structures. They're required to be
6 self-sustaining by 2015. There is a state opt-out provision.
7 Basically the law requires the federal agency, U.S. Department
8 of Health and Services, to make sure that there is an exchange
9 set up for every state, and for those states that do not have
10 an exchange set up or are not prepared to have an exchange
11 operational by the required start date of January 1, 2014, the
12 Secretary of Health and Human Services is required to
13 determine in 2013 which states will be ready and which won't
14 and then will be required to set up an exchange for those
15 states that aren't prepared to go live in 2014.

16 There is also a waiver provision for the exchanges. If
17 the states can demonstrate they have something innovative in
18 place that kind of meets the intent and certain criteria of
19 having an exchange, then the state can seek a waiver of that
20 provision and that requirement.

21 The Individual Mandate. Individuals will be required to
22 have a qualified health plan or pay a tax penalty. This is
23 incorrect on your slide. I'm sorry. That will take effect in
24 2014. I have to correct that. And this is where when I was
25 explaining the TRICARE Affirmation Act earlier, that Act

1 explains that TRICARE meets the definition of a qualified
2 health plan for those individuals who are covered by it. The
3 tax penalty is phased in over a three-year period starting in
4 2014, but the tax penalty will, at the highest level, be
5 adjusted for inflation after it reaches the highest level, but
6 \$695 per year, per individual, and families are capped at
7 three times that or \$2,085 per year or 2.5% of household
8 income, whichever is greater. And there are a number of
9 exemptions provided for in this provision as well for
10 financial hardship, religious purposes. American
11 Indians/Alaska Natives are exempted, and there are also some
12 other exemptions tied to cost.

13 The Individual Subsidies take effect in 2014 as well.
14 They're premium credits that are, I think, primarily meant to
15 be available through the Insurance Exchange, refundable but
16 also advanceable through Exchange for purchase of insurance.
17 They're available for individuals between 133% and 400%
18 Federal Poverty Level, and the amount of the credit will be
19 tied both to the cost of plan and will be set on a sliding
20 scale based on income level.

21 Cost Sharing Subsidies will also be made available to
22 individuals and families between 100% and 400% of the Federal
23 Poverty Level as well.

24 The Employer Mandate will apply to employers with more
25 than 50 employees. Those under 50 employees will be exempt.

1 Something that's important for employers to understand about
2 this new requirement is that, even if they offer coverage if
3 one or more of their employees receives a federal subsidy
4 through the Exchange, they still will be required -- if there
5 are other things -- if they are not providing coverage -- if
6 the employer is not providing coverage that meets a certain
7 standard and the employee receives a subsidy, that the
8 employer will still be required to pay a fee, a fine.

9 For employers who do not offer coverage, the employers
10 will be required to pay a fee of \$2,000 per FTE and that's
11 with -- the first 30 will be excluded from that, but for all
12 employees over 30, \$2,000 per employee.

13 I'm leaving out again lots of real important details,
14 like how they calculate FTE, in the interest of trying to get
15 through quickly and summarize this.

16 And then those employers that do offer coverage, have an
17 employee who receives a subsidy, the employer's coverage isn't
18 meeting the certain standards, that employer will be required
19 to pay a fee of \$2,000 per employee for all of their employees
20 or \$3,000 per subsidized employee, whichever amount is less.

21 Employers with more than 200 employees will be required
22 to automatically enroll all their new employees that they hire
23 into their insurance plan. And employers will be -- there is
24 a provision for employers to provide vouchers to employees who
25 have incomes of less than 400% and who choose to participate

1 in the Exchange, buy their insurance through the Exchange
2 rather than participating in the employer's program.

3 And just another relatively minor note but important for
4 employers included in this presentation, starting in 2011,
5 January 1, 2011, employers will be required to report the
6 value of health care benefits on their employees' W-2.

7 Some of the changes related to health care delivery.
8 Again these are mostly pilot programs and some new national
9 programs that are working towards driving greater efficiency
10 and higher quality in health care delivery, mostly through
11 Medicaid, some through Medicaid. There is a new national
12 program for evidence-based practice, the Comparative
13 Effectiveness Research; a new national strategy for quality
14 improvement; a number of programs that are driving towards
15 greater care integration, care coordination and service
16 integration; a program to fund improvements in trauma systems;
17 some primary care enhancements, a 10% bonus payment for 2011
18 to 2015 for primary care physicians through the Medicare
19 program; a Medicaid Medical Home State Plan Option that will
20 provide an enhanced FMAP rate, federal match rate, for a
21 couple of years; and a provision that does not apply to
22 Alaska. And I think there may be just three or four other
23 states in the country where the Medicaid program is actually
24 more generous in terms of fee schedules than the Medicare
25 program. Those states that have fees for primary care that

1 are lower than the Medicare fee schedule are required to bring
2 their fees, their Medicaid up to the Medicare level, and that
3 bonus, that bump will be fully funded with federal dollars.

4 And then some payment reform activities, Medicare Pilots
5 and Medicaid Demonstration projects around payment reform, on
6 bundled payments specifically and Medicare continuing and
7 expanding the Pay-for-Performance Program.

8 I won't go over all the Prevention and Public Health
9 programs. I think Mr. Morgan, you were referring to one of
10 these earlier, the Nurse Family Partnership Programs, but
11 there are a whole series of programs. Some of them are
12 existing programs that have been in place for many years that
13 are just reauthorized and funded under this Act, but there are
14 some new things as well, such as the new National Prevention
15 Council and a new National Public Health Fund. And there are
16 some requirements in addition to new Prevention and Public
17 Programs, some other requirements meant to address prevention
18 and community health more generally, requirements for
19 nutrition labeling on menus for chain restaurants now,
20 requirements for coverage of clinical preventive services and
21 public and private insurance plans are just a couple examples
22 of those.

23 Health Care Workforce. I mentioned earlier just last
24 week -- this was created, actually, in the GAO. The National
25 Health Care Workforce Commission was just appointed this past

1 week. They're required to create a National Health Care
2 Workforce Assessment, I believe, in the first six months after
3 they are created, very quickly, and then regularly thereafter.

4 The National Service Corps was increased substantially.
5 There is a whole series of new recruitment and retention
6 programs, support for different training and education
7 programs, including Graduate Medical Education.

8 New provisions related to Fraud, Waste & Abuse. There
9 are new enrollment processes being put in place for providers
10 for Medicare and Medicaid. There's increased data sharing
11 that is being required between federal programs, disclosure of
12 financial relationship between health entities. Health care
13 providers who own health care facilities, for example, will
14 need to disclose those relationships. Increased penalties
15 related to findings of fraud and abuse. Just again, I'm
16 generalizing a lot different provisions here, just to give you
17 a sense of what's covered.

18 There also is a new demonstration grant program for
19 states for medical malpractice reform. Those funds, I
20 believe, were appropriated but haven't been released yet.

21 Community Living Assistance, it's referred to as the
22 CLASS Act, again Community Living Assistance Services and
23 Support. That's the new long-term care insurance program, a
24 voluntary program. Folks are supposed to be able to purchase,
25 buy into it as a payroll deduction. So employers have to

1 participate if an employee wants to participate in this
2 program. Five-year vesting. After five years of paying into
3 the program, folks will be able to draw benefits. And the
4 cash benefits are meant to incentivize community-based
5 services to the greatest extent possible but will also cause -
6 - just to help people to be able to stay at home and to stay
7 in their community but will also cover nursing home costs as
8 well.

9 So there are a number of new fees and taxes that are put
10 in place to help pay for the Act, and I thought I would just
11 cover a few of those real quickly.

12 The one that took effect immediately that's in effect now
13 is a new 10% tax on indoor -- sales tax, an excise tax on
14 indoor tanning, but there are a number of fees on the health
15 care industry as well. An annual fee starting at \$2.8 billion
16 and increasing over time, this will take effect in 2012 on the
17 pharmaceutical industry. A new annual fee that's being
18 imposed on the health insurance industry starting in 2014,
19 again it starts at \$8.0 billion a year and that increases over
20 time. A new sales tax on medical devices will start in 2013,
21 2.3%. As far as taxes on individuals, there is a new Medicare
22 payroll tax or an increase, really, in Medicare payroll tax
23 only on the employees' part. The employer won't participate
24 in this increase, a 0.9% increase from 1.45% to 2.35%, and
25 that will be applied to individuals who make more than

1 \$200,000 a year or couples more than \$250,000 a year. And
2 then a new -- it's being called a Medicare tax, but this is a
3 new tax on unearned income for individuals who are in that
4 same tax bracket, making over \$200,000 a year as an individual
5 or over \$250,000 as an individual. It's a new 3.8% tax on
6 unearned income.

7 And then finally the Cadillac Tax. The Cadillac Tax is
8 the nickname for a new excise tax on high cost insurance, high
9 value insurance plans. That is one of the latest provisions
10 in the bill, if not the latest provision in the bill, and
11 won't take effect until 2018 and that tax will be imposed on
12 plans valued at more than \$10,200 for individual plans,
13 \$27,500 for family coverage.

14 And then in terms of savings, there are a number of
15 provisions that have -- part of the calculation of the overall
16 more than \$900 billion cost of the bill. The way it's paying
17 for itself again is partly through savings on the other side.
18 There are a number of provisions that -- maybe not rate cuts
19 to Medicare, but they're caps on the allowable increase in
20 spending for some Medicare services, penalties that will be
21 imposed on hospital for readmittance for certain conditions in
22 certain situations, and a series of other payment reforms that
23 I referred to earlier that are being tested that are projected
24 to lead to some additional savings to help pay for the bill.

25 I think -- well I shouldn't skip over at least a couple

1 of these. There is enhanced funding for the bill, just some
2 of the other provisions I thought I would mention. And I'm
3 just to pull out a couple of these.

4 Enhanced funding for Community Health Centers is
5 appropriated through the Act. There will be \$3.6 billion.
6 This doesn't seem like enough. There is several billion more
7 dollars, and I don't think I have the right amount here so I'm
8 not going to try to quote it. And some of the money was just
9 released this past week, some of the new funding for Community
10 Health Centers.

11 Notably, the Indian Health Care Improvement Act was
12 reauthorized. It's significant for Alaska, since the tribal
13 health system serves so much of rural Alaska, non-Natives in
14 many of these communities as well as American Indians and
15 Alaska Natives.

16 And one thing I probably just should note, there also is
17 a new national Elder Justice Act that's meant to provide more
18 protections against fraud and abuse for elders.

19 I have, at the end of this slide, but I'm not going over
20 right now the end of this presentation. You can review these
21 slides later if you want to get a sense of the timeline
22 referencing when most of these provisions are going to be
23 taking be effect, but they are laid out here in a timeline
24 fashion over the next few slides. And I think what I will do
25 is stop there and allow Mark to spend some time going over his

1 economic impact, but then maybe we should wrap up with a brief
2 discussion about where Alaska is at with both participating in
3 the legal challenges to the Act, where state agencies are at
4 in terms of implementation of provisions of the Act, and what
5 that means for state government for the Commission and for
6 Alaskans. Questions for me about this presentation before --
7 Mr. Morgan?

8 COMMISSIONER MORGAN: I've conferred with our Community
9 Health Center brain trust at the back of the room. The total
10 amount -- and don't get excited -- was actually about \$11
11 billion.

12 COMMISSIONER ERICKSON: That's what I thought.

13 COMMISSIONER MORGAN: Nine-and-a-half for building,
14 construction, but it has to be new and expanded. It's not to
15 support current activity, then the balance for construction,
16 but it's all new. It's all expanded services. It does not go
17 to support current Community Health Center operations or
18 activities that are going on right now.

19 COMMISSIONER ERICKSON: Thank you for that additional
20 information and clarification. Any other questions about just
21 the overview of the bill? Mark?

22 MR. FOSTER: Thank you. And thank you for the
23 opportunity to present this afternoon. First thing up will be
24 the next slide, which will be Disclosures in keeping with the
25 prior presentation from the Attorney General's Office.

1 I'm a business consultant for economically regulated
2 industries, and I think of note, I was on the Board of Marine
3 Pilots once upon a time when the EXXON Valdez hit the rocks so
4 I'm familiar with some of those issues as well. And I was a
5 Commissioner on the Public Utilities Commission in the early
6 '90s during the early telecom wars, so I have some economic
7 regulation background in that sense.

8 My most recent work in health care started in about
9 2004/2005 with the University of Alaska ISER looking at the
10 health care industry and have subsequently done work with
11 ANTHC, the Small Hospital Association, in looking at the
12 health care industry in Alaska telemedicine business models,
13 workforce development issues, and have done some work for the
14 State looking at the economic impact of the health reform on
15 the state of Alaska.

16 I am currently on the Board of Alaska Power & Telephone
17 and HydroWest International, and I've served recently on the
18 ML&P Board of Directors. So I also kind of come to health
19 care from the perspective of a Board member looking at costs
20 that increase substantially year-over-year and sort of have
21 that as well, as I come to the table.

22 This analysis that I'm going to present to you today is
23 very preliminary and high level. It basically ties back to
24 the CMS Office of the Chief Actuary and his numbers and other
25 actuarial studies to try and get to what's the national sort

1 of impact of the health care reform and then scale that to
2 Alaska and make market adjustments where we have enough
3 knowledge where we can make sort of an informed judgment. And
4 this presentation does assume the Act is fully implemented,
5 you know, based on the terms. So I'm not doing any, if you
6 will, handicapping of what provisions may or may not last. So
7 it really is an attempt to capture what health care reform
8 would mean for Alaska, fully implemented out at 2019.

9 The overview of the presentation today, I'm going to
10 basically say here is our baseline projection of health care
11 expenditures without health reform. What do we see happening?
12 Then look at the incremental impact of health care reform on
13 that baseline projection. Next slide, please.

14 Basically, how much do we spend on the Health Care Sector
15 in Alaska? This is a decade-by-decade sort of look, looking
16 at billions of nominal dollars. And I'll try and do this
17 without hitting anybody in the eye. So I've got billions of
18 nominal dollars here. You'll see the decades across and then
19 what's the annual growth rate in health care expenditures in
20 Alaska over those decades and what we've projected out to
21 2019.

22 So today you know, we believe we're somewhere around the
23 neighborhood of about a \$7.0 billion industry in Alaska, and
24 we're headed to about \$13 billion by 2019. The underlying
25 assumptions in that basically track the U.S. assumptions about

1 health care growth from the Office of the Chief Actuary.

2 The one significant difference that we employ is, because
3 our population growth in the over 65 segment is growing much
4 more rapidly than the rest of the country, we've specifically
5 taken that into account in our growth rate. Now it's a
6 significant growth, but when we really boil it down, what does
7 that sort of create for a multiplier in Alaska versus the
8 U.S.? When I go from 2010 to 2019, it's not that large, but
9 nonetheless, it's a significant factor when I'm looking at the
10 impact on the overall increment of spending that would occur.

11 Next slide, please.

12 So the other way I like to measure the health care sector
13 is as a percentage of oil value at the wellhead as our primary
14 economic driver in this state to see how much health care
15 basically takes up relative to the other big economic driver
16 in this state. And interestingly enough even in 1980, we were
17 under 10%; in 1990, 15; 2000 about 32%; 2010 43%. The
18 baseline projection we have shows health care expenditures
19 basically coming up to somewhere around 70%/72% of that oil
20 wellhead value. Naturally, they are two things going on.
21 There's the continued growth in health care expenditures and
22 the decline in the total value of the oil at the wellhead.

23 Next slide.

24 Where do Alaskans obtain health care coverage compared to
25 the U.S.? And this gives you, I think, sort of the preview of

1 how health reform impacts Alaska and how it is different from
2 the rest of the country. Employment provides somewhere around
3 56% to 57% of the insurance coverage in Alaska. Direct
4 purchase of plans in Alaska versus the U.S., number two,
5 you'll see we're behind the U.S. in that category. Medicaid
6 and Medicare again lower than the U.S. averages by significant
7 market share points. Military and Tribal Health/Indian Health
8 Service significantly larger. And so when I combine those two
9 federal programs, I think you'll see that roughly a third of
10 the Alaska population is covered by Military or Tribal Health
11 compared to 1/25th in the U.S. So we have a substantially
12 different overall mix when we look at the total population
13 coverage. And when I look at, roughly, the percentage that's
14 not covered by insurance when I look at the current population
15 survey data and adjust that to include Indian Health Service
16 only as coverage as opposed to deleting it under the current
17 population survey statistics, we get an uncovered population
18 of somewhere around 14%/15%. Next slide, please.

19 That we had pretty well covered from the prior
20 presentation by Deb. Next.

21 So five years after the individual insurance mandate
22 begins, where do we think it might land in Alaska and where
23 does it land in the U.S. based on the Office of the Chief
24 Actuary? You've probably heard numbers that somewhere around,
25 you know, how many millions of people are going to get

1 covered, Medicaid expansion, maybe 20 million in the U.S. in
2 that 2019 timeframe by then and another 32 million will go
3 into Health Exchanges nationally. Employer coverage will
4 decline. Other private coverage will decline, and the
5 uninsured declined by about 34 million.

6 Roughly in Alaska, we expect the Medicaid expansion
7 somewhere around 30,000 by 2019. Employer coverage, you'll
8 note, we expect more of a decline compared to the national,
9 but in absolute numbers, not all that significant, maybe
10 15,000 to 20,000. Other private, perhaps a little bit less.
11 The Exchanges expect pretty good coverage there, but not as
12 much as the other states. And then the uninsured to drop
13 somewhere around 50,000.

14 So what are the real differences here that we're taking
15 into account? The health insurance mandate also comes with
16 subsidies, and the subsidies are based on the Federal Poverty
17 Level determination. In Alaska, we've had a generous Federal
18 Poverty Level determination basically since the late '60s, and
19 I think, those additional subsidies offset some of the, what
20 I'll call, independents and people who may be inclined to pay
21 the penalty rather than sign up. So those two counter-veiling
22 factors are really coming to bear here. And the other thing
23 is, because of the generosity of the subsidies in the
24 individual sort of market in the Exchange, I expect we'll see
25 price-sensitive employers moving more of their folks into the

1 Exchange because of that subsidy relative to the U.S. Next
2 slide, please.

3 All right. So we get those shifts in coverage. What
4 does that mean to spending in Alaska? This is a percentage of
5 the Alaska Health Care Expenditure, and I've a net change in
6 Health Care Expenditure and then I've broken that out into
7 various components. The change in utilization associated with
8 the newly insured getting covered -- in the tradition if you
9 have more costs covered, you tend to use more of the service.
10 Between the Medicaid expansion and the individual mandate and
11 people basically getting more insurance coverage, an uptick of
12 about 4% in total spend is what I'm projecting in this
13 preliminary level.

14 Improved coverage occurs, especially in the individual
15 market, where there are mandates for a variety of things that
16 are currently not mandated in the individual market and so
17 that will improve the coverage level in, essentially, first
18 dollar coverage. So you'll see more spend associated with
19 that.

20 Those are offset by changes in utilization basically due
21 to that excise tax, what was commonly referred to as the
22 Cadillac Tax. Those taxes on health insurance coverage will
23 tend to retard the growth in that coverage, and the result
24 will be a slight decline in the spend as people have less
25 money covered by the insurance compared to what they had under

1 the baseline projection.

2 Some provider discounts, I think, will come to bear
3 potentially in the Insurance Exchange and in Medicaid going
4 forward, relative to baseline. And the other big item on sort
5 of the cost of breaking side is the Medicare savings,
6 particularly in the hospitals. There's some in home health,
7 in various other areas. Keep in mind this does not include
8 any adjustments to the sustainable growth rate formula that
9 impacts the Medicare spending on physicians' fees. Next
10 slide.

11 Overall, what's the impact on federal spending on the
12 Health Care Expenditures when I look at total dollar amounts
13 here at 2019 nominal dollars? Something on the order of \$200
14 million less in employer sponsored private insurance.
15 Medicaid Expansion -- excuse me -- total somewhere around \$200
16 million, of which, you know, 10% maybe is something the State
17 would be exposed to. The Medicare cuts you'll see on the
18 order of \$160 million. Out-of-pocket will decline overall,
19 and the new Insurance Exchanges, depending on the rate of sign
20 up and all the other variables -- this is basically assuming
21 about a 50% sign up rate -- in 2019 after five years of being
22 exposed to the penalty and insurance tradeoffs that people are
23 going to make and our generous subsidies because the Federal
24 Poverty Determination coming in at somewhere in that \$600 to
25 \$700 million coming into the market through that vehicle.

1 Next slide.

2 Drilling down and looking specifically at federal
3 spending, Medicaid, the Exchange Subsidies and Cost Support,
4 those subsidies coming in, a preliminary cut at the Indian
5 Health Service/Community Health Center/National Health Service
6 Corps/VA/TRICARE, a lot of uncertainty on that, partly because
7 we really don't have a good handle on it yet, and I think that
8 number could be higher than that. The Medicare cuts we just
9 talked about. We'll look in detail at that a little bit
10 further on and the new taxes and fees. So overall if you
11 assume that people will take the new insurance mandate, and
12 you know roughly, half of that market will buy insurance
13 coverage and the other half will pay penalties, the net change
14 in federal spending in Alaska is a plus \$200 million/\$300
15 million, somewhere in that range. Next slide.

16 When we look at taxes and fees -- and we believe those
17 get rolled through to households over time, maybe not
18 immediately but over time; so as a long run factor, we look at
19 that as an impact on the house -- millions of nominal dollars,
20 you'll see the miscellaneous fees on drugs, medical devices,
21 and things you've heard about earlier, the fee on health
22 insurance providers, the excise tax on coverage in excess of
23 the thresholds -- and we'll look at that in a little more
24 detail -- and the Medicare hospital insurance.

25 So if I look at the Alaska economy, the taxes, really the

1 big tax, it's, I think, an interesting consideration for
2 policy makers is that excise tax on the coverage in excess of
3 the threshold. Because those thresholds are not indexed for
4 high cost states in the final program that was planned, Alaska
5 gets hit quite early. Next slide.

6 And we tried to get a handle on that by looking at
7 household incomes greater than \$200,000 across western states
8 to give you some idea of how we stack up, and Alaska stacks
9 up, at the highest, close to Washington State, and you'll see
10 Oregon, Wyoming, Idaho, Montana falling off considerably. So
11 the impact on the Alaska economy for that high tax occurs both
12 in that Medicare hospital tax and in other taxes, so we get
13 hit pretty hard. Next slide.

14 Looking at the excise tax on health insurance, if I try
15 and project out and get a handle on a single premium in
16 western states knowing what we know about the trends, it looks
17 like Alaska's health care median values will be well above
18 that threshold. So easily more than half of people who are in
19 single premiums with their employer will be subject to the
20 beginning of that excise tax. And in other western states
21 though, they won't have that. And so we have one of what I'll
22 call the early and heavy exposure to that excise tax, and
23 we'll see, you know, how do employers and employees work out
24 what they're going to do as a result of now having a 40% tax
25 on those incremental benefits above \$10,200 in the single -- I

1 don't even have the number on the top of my head in the family
2 plans. But I think in both of those cases, we're going to get
3 hit early and so it will be a very interesting conversation to
4 see how people adjust compensation -- employers and employees
5 adjust sort of their compensation arrangements as a result.
6 Next slide, please.

7 Looking at potential federal subsidies and household
8 costs, depending on household income. And here I'm trying to,
9 basically, look at the new Exchanges are going to have plans
10 in them and how much of that is going to be covered by subsidy
11 and federal cost support and how much still remains to be paid
12 by households, if they sign up for insurance. A family of
13 four in Alaska in 2019, that plan's going to be probably in
14 the neighborhood of \$30,000 nominal dollars. And if you want
15 to relate it back to 2010 income levels, that family of four
16 household is about a \$50,000 income level in 2010. Somewhere
17 around three-quarters of that health insurance premium will be
18 covered by a combination of premium support and federal cost
19 sharing support.

20 As you work your way up the income levels, you'll see
21 that the cost support drops down and the family gets exposed
22 to fairly substantial amounts of spending for that insurance
23 mandate, up to roughly 9%/10% of their household income. So
24 if you're currently insured, now you get subsidies. That's a
25 pretty good deal, if you're in the individual market. If

1 you're not currently buying insurance, you'll get subsidies,
2 but you'll still have a substantial exposure to out-of-pocket
3 costs relative to where you're at today. Next slide, please.

4 Trying to look across subsidies and penalties to give you
5 a relative sense of the scale by income level, you know, we
6 were thinking that, you know if you assume 50% take up, you
7 get a pretty good chunk of change coming in \$200 million, \$180
8 million coming in, in the income levels up to about 250% and
9 then you get a pretty rapid tail off and then you have people
10 paying penalties who chose not to participate. Next slide.

11 This looks at insured versus uninsured households in our
12 baseline, and if you're currently insured, you're generally
13 going to benefit from health care reform in the subsidy flows,
14 especially at lower income levels. You'll be net ahead. If
15 you are currently uninsured at low levels of income, you'll be
16 net ahead in the Medicaid expansion. But as you creep up the
17 income scale even after the subsidies, you're going to tend to
18 be a net cash payment out, relative to the baseline, and
19 particularly as to get to high income levels, you'll see
20 there's some pretty substantial numbers here about the
21 exposure. For those, typically it's 5% to 7% of the market
22 who have high incomes who don't have health insurance, and
23 they, I think, are the most exposed of anyone to sort of a new
24 charge to deal with. Next slide.

25 The other thing that's of interest is the compression, if

1 you will, in the age bands that's mandated in the Insurance
2 Exchange in that individual and eventually the small group
3 market. And essentially what's happening is, instead of
4 having the insurance market as it is today which might have a
5 five-to-one differential between the older populations down to
6 the younger populations here -- we're looking at age groups
7 here -- the compression goes to three-to-one and so the net
8 change in nominal dollars winds up flowing to the 55 to 64
9 group. So they, in the individual market, will see a decrease
10 as a result of reform, but the younger population will tend to
11 see a pretty significant increase and that's where, I think,
12 you'll see -- in press reports, you'll hear big numbers about
13 insurance increases, and I think, a lot of those really come
14 from looking at drilling down into this kind of data here. In
15 that 27 to 34 age group, what might they see if they're
16 currently, you know buying insurance and what the increment
17 will be, and if they're not buying insurance, what the
18 increment will be, and that represents the average of that,
19 several hundred dollars a year at least relative to the
20 baseline. Next slide.

21 It's one just to remind me to talk about self-employed
22 individuals compared to the small employers and larger
23 employers. And basically self-employed who make more than
24 \$200,000 in net income really is the segment that's most
25 exposed to the insurance mandate, the costs that are going to

1 occur on the taxes, the excise tax on health insurance. And
2 so as a group really what's happening is they're being asked
3 to contribute to the pool; whereas before as a group, there
4 were certain individuals in that area that weren't making much
5 of a contribution to the overall pool of insurance, and
6 they're getting rounded up, if you will, to pay into the pool.
7 Next slide.

8 Insurance premiums. I tried to take an initial cut at
9 what's the effect of the Affordable Care Act on average
10 premiums for health insurance in 2019, specifically rolling
11 into the account the caps on deductibles. There is more first
12 dollar coverage, unlimited lifetime claims. And looking at
13 what we know in the data we've developed about what might
14 happen in the markets here -- and for those who are sort of
15 following the debate, this also ties back to the table in a
16 memorandum in November describing the impact that the CVO
17 developed on the non-group and small group markets.

18 Bottom line is, because of all the market changes in
19 insurance that affect the non-group, the individual
20 purchasers, I think in Alaska, that could easily amount to a
21 25%, 30%, 35% increase in those payments. You're going to get
22 more coverage. The deductibles are going to change relative
23 to where the market would have been. There's more first
24 dollar coverage. There's unlimited lifetime claims. But all
25 of that stuff gets paid for, typically, in that small market

1 segment and so you see a higher increase in that market
2 segment relative to the other markets. Next slide, please.

3 So net effect of all this when I look at total
4 expenditures and compare it to my percent of wellhead value,
5 you know, we might be spending \$250 to \$300 million more in
6 health care. So it's not a big impact on the overall growth
7 rate in the Health Care Expenditures in the baseline, but I
8 think it's significant at the margin and it also shifts a lot
9 of costs around. So I think they'll be, you know, clearly
10 some who will benefit, tend to be the sicker, older population
11 as a net beneficiary. The younger, healthier population is a
12 net payer into the new system, if you will, presuming it all
13 goes into effect as outlined.

14 I think that concludes the slides. Any questions on that
15 quick overview?

16 COMMISSIONER MORGAN: I guess I'll go first. I'm
17 probably getting too far down into the weeds, but my
18 professional organization, HFMA, has been sending materials
19 out and some of the provisions, especially for
20 disproportionate share hospital, are gone. Marketplace basket
21 inflation rates, which are computed in the rates, are capped
22 or reduced significantly. The one I can't figure out is they
23 also did the same thing to home health agencies. So those are
24 seen as saving, the effect estimated nationally, is \$147
25 billion, give or take. But when I look at that as someone who

1 has worked in that end of the hospital business is those types
2 of disruptions create great problems. I don't know if the
3 Hospital Association has tried to compute or computed the
4 effect on the revenue stream to provide services. I know most
5 hospitals up here don't have big, like our insurance brethren,
6 thick margins to absorb these hits. Have you started working
7 on the effect of that yet?

8 MR. FOSTER: Yes is the short answer, and I have sort of
9 a separate slide show I presented earlier that has information
10 that looks at the CMS. Again that's my baseline projection,
11 flowing those through the Alaska market, looking at hospital,
12 home health, and others and sort of what that is in millions
13 of dollars of cuts relative to the baseline projection. You
14 know overall, Medicare cuts, based on the provisions that you
15 just outlined, somewhere around \$160 to \$180 million less than
16 what we would have had without the change in 2019.

17 COMMISSIONER MORGAN: But my point, I think, you
18 understand is, when you do that, where you don't have margins
19 to absorb it, it affects the institution itself, either
20 massive changes or looking at what services they provide.

21 MR. FOSTER: Yes.

22 COMMISSIONER MORGAN: Especially the disproportionate
23 share hospital change is a little scary for our rural
24 hospitals. I guess my other question is -- and this is purely
25 a technical question. I'm not saying, nor have I ever said,

1 that we don't have a problem with cost increase and the growth
2 of Medicaid, but when I look at your slide on -- and this is
3 just a pet peeve on my part, not on anybody else -- how much
4 do we spend on Health Care Sector in Alaska, I guess (a) a
5 third of what the health insurance coverage or purchases is
6 Indian Health and Military. Those are really not -- those are
7 managed self-contained systems. Doesn't that skew your data
8 on the chart? It doesn't have a page number, but it's your
9 72% chart of the wellhead price. And I guess I mean, I don't
10 think you factor that in or maybe in your mind you shouldn't.
11 It's just a question.

12 The second part is, have you ever plotted other types of
13 industries on the charts, like education, over the same time
14 period?

15 MR. FOSTER: Education, energy, total wages, sure.

16 COMMISSIONER MORGAN: Do they have the same kind of
17 trajectory, or are they flat, or how does that work?

18 MR. FOSTER: The only market price that I see tracking
19 health care is post-secondary education tuition and private
20 institutions. Everything else falls off, relative to health
21 care and basically private colleges, private universities.

22 COMMISSIONER MORGAN: That's just for (indiscernible -
23 simultaneous speaking).

24 MR. FOSTER: Yeah. So those are the two, if you will, at
25 the head of the horse race on the cost side.

1 COMMISSIONER MORGAN: Thank you very much.

2 MR. FOSTER: Sure.

3 CHAIR HURLBURT: Val, a question?

4 COMMISSIONER DAVIDSON: Thank you. I'm going to come at
5 this from exactly the opposite perspective, that I'm not a
6 finance person. I'm not a numbers person, and it's great
7 data. It's really incredible. I guess the question I have
8 is, what are the most significant implications for Alaska?
9 Out of all of these slides, out of everything that you know,
10 and I understand it's your best educated guess based upon
11 actuarial data from CMS that's been extrapolated for Alaska,
12 but what are the top three issues that you think this Health
13 Care Commission should be concerned about?

14 MR. FOSTER: I'll make it easier. There's one. It's
15 workforce. I believe we're at a competitive disadvantage
16 relative to 45 other states or thereabouts at attracting and
17 retaining workforce under health care reform. Yes, there's
18 money available nationally through national programs, but we
19 don't have any edge over them with respect to our cost
20 structure and the challenges to attract and retain people.
21 And because of the provision in the bill that bumps Medicaid
22 up to Medicare in many other states, they're going to see,
23 roughly, enough money to fund 15,000 FTE physicians in the
24 Lower 48 relative to Alaska.

25 So I think of all the issues that we have, it really is

1 workforce. How do we get enough providers to serve the
2 population we have, the aging demographic, and now the
3 Medicaid and individual mandate expansion? I think that's the
4 fundamental challenge we have between now and 2014, keeping in
5 mind I'm trying to look out and normalize what this might do
6 in 2019. I think the real challenge we have is workforce
7 between now and 2014.

8 COMMISSIONER DAVIDSON: So can I follow up? So I guess
9 with that in mind, that would be true, assuming that we used
10 our existing workforce model, but if we had the opportunity to
11 develop alternative workforce, alternative health care
12 providers whether they be dental health aide therapists,
13 behavioral health aides, et cetera, then we might be in a
14 better position, especially if we're training local folks, to
15 be able to take over those functions in ways that will be able
16 to allow Alaska's health care needs to be met. And it's not a
17 question; I'm throwing that out there.

18 The other issue, I just wanted to let you know,
19 unfortunately I have to leave. I have an appointment on
20 campus at five, which is so sad because I feel like I'm
21 missing the juiciest part of this day. So thank you.

22 MR. FOSTER: Thank you.

23 CHAIR HURLBURT: Thank you, Val. Other questions or
24 comments? Yes?

25 COMMISSIONER DAVIS: Thanks, Mark. This is good stuff.

1 So just to kind of clarify because there's a lot there, you
2 know, in total what you're saying is -- I just want to feed it
3 back to you and see if I've got this. In total, we end up
4 kind of in about the same place in terms of overall
5 expenditures as post-health care reform as we are pre, but
6 there is a lot of redistribution of that. And so we have
7 certain people now, particularly younger healthier folks, who
8 are paying, you know, significantly less than others who will
9 be paying significantly more. And those who are paying now
10 more will be paying significantly less. And so there is
11 likely to be some significant disruption or a change in who is
12 covered and who is not. I mean, it's almost as if we can
13 anticipate sort of a turning upside-down of those who aren't
14 covered today end up covered and those who are covered today
15 end up not covered because they see their costs not going up
16 just the 35% because of the benefit plans but also because of
17 adjusted community rating. They might be looking at, you
18 know, 200% increases in what their plans cost. Am I getting
19 the picture that you're painting here?

20 MR. FOSTER: I may take issue with the 200% increase. I
21 haven't seen anything in that range yet. I think it's fair to
22 say that there are segments of the Alaska market that could
23 easily see increases on the order of 30% or 40% relative to
24 the baseline in the younger healthier population, especially
25 those who, essentially, choose not to buy insurance, and you

1 know, take their chances. When we look at the demographic
2 data, you have a lot of young males who don't buy in, and you
3 know, take their chances. And at some point you know, they
4 may be healthy enough they really don't have a cost impact
5 until later in their career or when they get married and have
6 children and have to sort of think through those issues.

7 Conversely, there are some older less healthy folks who
8 are paying a lot out-of-pocket and will have better coverage
9 under this in general than they do now, and they'll be net
10 ahead. But as you know, you can sort of slice the data and
11 get closer to it and you'll find other variations, but that's
12 the overall, I think, effect. And yeah, there'll be a lot of
13 transitions, I think particularly as we go through the
14 2013/2014 cycle, and I think in Alaska in particular, given
15 the small size of the insurance penalty at first, there will
16 be this slow reaction. It won't occur quickly, but between
17 the insurance penalty, the excise tax on health plans in 2018,
18 and sort of the insurance penalty ramping up, I think, we'll
19 see sort of this delayed reaction and then what could be very
20 rapid shifts in the marketplace. So somewhere out, you know,
21 2016/2017 suddenly we're all scrambling around to figure out
22 what's going on as people make different choices, employers
23 and employees renegotiate wages, benefits, what's important in
24 my market and so I think that's really sort of the transition
25 phase that, I think, will be the most challenging to try and

1 get our arms around. The Medicaid expansion, at some level,
2 is a relatively, I think, simple market analysis compared to
3 the other shifts that are going to occur later in the game.

4 COMMISSIONER DAVIS: Thank you very much.

5 CHAIR HURLBURT: Go ahead, Representative Keller.

6 COMMISSIONER KELLER: I probably won't ask this question
7 very clearly, but the Medicare cuts or the Medicare savings or
8 whatever you want to call them, is that going to be money that
9 is just not spent? I mean, do the providers just eat this;
10 therefore, it's not spent? Or is there an offsetting area of
11 the Medicare cuts or savings, whatever you want to call them?

12 MR. FOSTER: Yeah. I think the best way to think about
13 it is, based on technology, we project an increase in health
14 care costs, call it, you know, 7% to 8% per year. Basically
15 we learn new things and we apply them to the health
16 populations. That's our base. And what the health care
17 reform has done is started to tap the brakes on Medicare for
18 hospitals, the disproportionate share payments, productivity
19 adjustments, and so they're tapping the brakes. And then the
20 question becomes now, what do the providers do in response to
21 that?

22 Some will be exposed -- basically if they stick on
23 business as usual, they're going to get a lot of pressure on
24 their bottom line. Some will probably be exposed to having to
25 figure out what am I not going to do in order to stay in

1 business. The CMS Chief Actuary, you know, their modeling
2 suggests there's -- you know, easily 10% to 20% of the market
3 will be faced with not being profitable compared to what they
4 would have been otherwise. So there's going to be a squeeze
5 there now. So what do I hear from providers? They're trying
6 to say I know, in the long run, I have to be more efficient.
7 And so at some level, the productivity pressure from Medicare
8 may actually give me more of an incentive to start down the
9 road to reorganizing health care and making it more efficient,
10 recognizing not everyone is going to be able to achieve those
11 efficiencies and stay in the game. So I think, you'll see
12 some consolidation in, you know, different markets depending
13 on, you know, how serious it is in those particular markets.

14 COMMISSIONER KELLER: Just a follow up there. It just
15 seems like a formula, to me you know, and I'm maybe looking at
16 it too simplistically to make emergency room frequent flyers
17 increase the number of those that are on Medicare, and
18 ultimately, what it is is a decrease in services to the
19 elderly, potentially. I mean, I don't want to go there and
20 say that's what it is because, you know, you just can't go
21 there. But it just seems like, practically speaking, that's
22 where -- depending on what the providers do, you know
23 ultimately, it seems like the over 65 crowd is exposed to use
24 your words.

25 MR. FOSTER: I think they're exposed to more cost

1 pressure, but at the same time, I think, when I look at CBO
2 projections and I look at other projections, I think the cost
3 growth in the Medicare program is a serious problem that we
4 have to do something about. So I want to give some credit to
5 folks taking a run at it. It may not be the optimal solution,
6 but at least they're taking a run at trying to formulate
7 something to get their hands around it.

8 As someone who tries to look at sort of overall
9 demographic and economic trends, it's, I think, important to
10 realize that when Medicare came into being we probably had
11 about seven workers for every one who is on the retirement,
12 and now, we're getting close to two-and-a-half to one. So
13 it's hard to sustain the cost growth that we've seen, so we've
14 got to do something. The question, I think, is what and how.

15 So it's in that context that I come to this, and I think
16 okay, some people are going to be exposed on the provider
17 side. They're going to try and make adjustments. Some aren't
18 going to survive. Others will consolidate and become more
19 efficient. So in some sense, I think, that's probably a
20 positive development. The downside is there will be, you
21 know, people who will inevitably -- in Alaska in the Medicare
22 population, they'll be still struggling to get access. And so
23 how successful are the Medicare clinics and the Community
24 Health Center expansion going to be about filling in that
25 population. I think that's really, I think, the real rub

1 here, and I think the other question becomes, you know, are
2 those reimbursements on the sustainable growth rate going to
3 stay up or not, and I think that's the problem we're going to
4 see in Alaska.

5 CHAIR HURLBURT: Yes, Noah?

6 COMMISSIONER LAUFER: I'm a primary care doc at a large
7 private primary care practice, and I think there's a dangerous
8 assumption being made and that is that we are an economic
9 being entirely. Medicare has been a huge loser for us for
10 many, many years. It costs me, individually, over \$100 to see
11 a Medicare patient. We still see 11% Medicare. This is 6,000
12 visits a year. It's our part. If it becomes more onerous, at
13 the next Board meeting, we will opt out. It's not that we
14 need to be more efficient. It is woefully underfunded, and we
15 do it because we're family docs and we want to serve our
16 community, but there is a limit to the penalty we're willing
17 to suffer. Have you looked at the models for the Medicare
18 clinics, you know?

19 MR. FOSTER: Yes.

20 COMMISSIONER LAUFER: They're not clinics in the sense
21 that people believe they are. I've been part of the planning
22 for some of them, but we're talking mills would be a more
23 accurate term; 60 patients a day, one problem, five minutes,
24 two minutes' of face time with the physician who is terribly
25 overworked. And not surprisingly, there have been no doctors

1 here or in national searches who have stood up who are willing
2 to man these clinics.

3 MR. FOSTER: I think they will present an interesting
4 sort of experiment to see what they can accomplish, whether
5 the Providence Clinic or Dr. Rhyneer's clinic and the
6 Community Health Center as they pick up more and more of the
7 population.

8 COMMISSIONER LAUFER: The Providence Clinic is seeking
9 patients 55 and older, 55 to 65 as you saw, the most
10 politically active and those likely to benefit the most from
11 this is the most lucrative decade in life. This is not a
12 Medicare clinic; it's a stab at controlling the primary care
13 market for other reasons, like bundled payments.

14 MR. FOSTER: NACO type arrangements.

15 COMMISSIONER LAUFER: Yes, but it is not an altruistic
16 move to cover a need for Medicare patients.

17 CHAIR HURLBURT: Mark, let me ask you to take something
18 you said and maybe ask it in a different context. The number
19 you were using as our current level expenditure was a little
20 over \$7.0 billion a year for health care in Alaska with a
21 projection that we go up to 13-something by the end of the
22 decade. The health care reform would add \$250 to \$300
23 million, which you described as marginal or modest or some
24 minimalist term. And this was in the constant dollars, in
25 adjusted dollars?

1 MR. FOSTER: These are nominal dollars.

2 CHAIR HURLBURT: Nominal dollars?

3 MR. FOSTER: Nominal dollars.

4 CHAIR HURLBURT: Nominal dollars, okay. So that might
5 change it a little, but if you take that, say, \$300 million
6 and look at that in terms of a percent of the total Permanent
7 Fund Dividend payout in this state with that being a
8 significant part of the State's economy -- you know,
9 equivalent to one of the biggest employment agencies in the
10 State, it's, what, 40% of the total PFD payout and that's not
11 a marginal amount of money, is it?

12 MR. FOSTER: No, clearly not. The reason I characterize
13 it as a relatively marginal amount is, if I look at the total
14 spend over a decade of time, the increment is something that
15 conceivably could be adjusted for by the providers over that
16 amount of time. Clearly some, you know, won't be able to make
17 the adjustment, but many are likely to be able to do that.

18 CHAIR HURLBURT: Yes?

19 COMMISSIONER FRIEDRICHS: Thank you, sir. A two-part
20 question, if I may? First, this is clearly an economic model
21 that you've laid out for us and you've presented a great deal
22 of data on the cost involved. Embedded in there, I'm
23 assuming, is some calculation of a change in the quality of
24 care, since that was part of the justification for doing this.
25 Is there a translation of what you showed in cost that speaks

1 to a change in the effectiveness of care that's being
2 provided?

3 MR. FOSTER: And that's beyond my ability to forecast
4 accurately. You know inevitably, some providers will change
5 quality. Others will, basically, not take on as much new
6 technology and diagnostic abilities to capture more care, and
7 the real question becomes, how do we do relative to the rest
8 of the country and other markets? I think that's the -- it's
9 that incremental question about, you know, do we expand, you
10 know, prenatal care relative to what they're doing in Seattle
11 or not? You know, how much technology do we really
12 incorporate in? And I think that's where I would see
13 providers making decisions about, can I really provide that
14 level of care? I don't expect a lot of erosion on what we
15 normally think as quality and outcomes. I think it really is
16 how much service do I provide in the market I'm in.

17 COMMISSIONER FRIEDRICH: So if I understand you
18 correctly, the promise or the implicit statement in some of
19 these reform acts that this would improve the care is not
20 something that we can extract from the data that you've shown
21 here?

22 MR. FOSTER: I wouldn't want to make that general
23 statement. I'll tell you why. I do think there are efforts
24 within the reform program to shift more emphasis onto primary
25 care, and in some parts of the country, I think that will

1 improve care in those areas. I also think it tends to tap the
2 brakes on specialty care. And for populations who need that
3 care, I do think they'll see an erosion relative to what they
4 would have otherwise. So I think it's really a shift rather
5 than an overall characterization. I think that would be more
6 accurate to characterize it as a shift.

7 COMMISSIONER FRIEDRICHS: With that in mind then, if the
8 goal of the state of Alaska is to attract additional
9 taxpayers, as my colleague laid out earlier this morning in
10 his comments -- as the taxpayers generate the revenue that
11 allows us to do a variety of things here in the State, what
12 model would you suggest to the Commission in light of the
13 research that you've done that would not only affect the
14 workforce in the health care industry but would attract
15 additional residents to the State?

16 MR. FOSTER: I don't think I have a good answer for that
17 today, quite frankly. I think I've got to listen to more
18 physicians, hospitals, clinics, you know, in various provider
19 groups to get a better understanding of what they see and how
20 they're going to adjust in order for me to have an informed
21 opinion about that. It's just too early for me to take a stab
22 at that, I think. My anxiety today is, how do we get the
23 health provider workforce here in place to absorb the
24 expansions without creating really long queues to get in to
25 see people, and I think, those long queues will have sort of

1 follow on effects, emergency room being one, and I think,
2 people going Outside for more care will be another.

3 COMMISSIONER FRIEDRICHS: So the reverse trend of people
4 going to Canada for care -- if that is, indeed, the case
5 within the scope of this Commission as we look at generating a
6 report in the next eight weeks here, essentially, what
7 forecasting or recommendations are you able to make about
8 workforce development then that would help us explicitly
9 improve the workforce today?

10 MR. FOSTER: I think I'm really waiting for more input
11 before I have anything that would be really particularly
12 useful for you, and you know, it's late in the afternoon after
13 a long day. I think a general characterization beyond it's a
14 key problem to solve, I think, I'm not at a spot where I can
15 give you a good outline. I'm just not there yet.

16 CHAIR HURLBURT: Other questions? Mark, thank you so
17 much again.

18 MR. FOSTER: Thank you.

19 CHAIR HURLBURT: You always bring us good information and
20 create a lot of interesting questions and some answers, so we
21 very much appreciate what you've done.

22 MR. FOSTER: Thank you very much.

23 CHAIR HURLBURT: Do we have anything else today, Deb?

24 COMMISSIONER ERICKSON: Do you want me to speak briefly
25 to the legal challenges and some of the political realities

1 that we're dealing with right now in terms of federal reform
2 and what that means for today's state agencies? Don't want to
3 hear that?

4 CHAIR HURLBURT: The feedback that I'm getting is let's
5 hold it until the morning.

6 COMMISSIONER ERICKSON: That sounds good. That sounds
7 really good to me.

8 CHAIR HURLBURT: So we start at eight again in the
9 morning, and will you have breakfast again so folks.....

10 COMMISSIONER ERICKSON: We will.

11 CHAIR HURLBURT: So there will be breakfast here in the
12 morning. Thank you, everybody.

13 4:52:32

14 (Off record)

15 **SESSION RECESSED**

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