ALASKA HEALTH CARE COMMISSION

DENA'INA CIVIC & CONVENTION CENTER

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P R O C E E D I N G S

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(On record)

CHAIR HURLBURT: As we start off both for the record and just for folks who -- anybody who may be new this morning, just go around and have everybody introduce themselves again, both the Commission and in the audience here. So for equal opportunity, we will go clockwise today maybe starting with Pat, if you could start?

COMMISSIONER BRANCO: Good morning, my name is Patrick Branco.

(Pause - recording interference)

COMMISSIONER STEVENS: Good morning, Wayne Stevens.

COMMISSIONER LAUFER: Good morning, I'm Noah Laufer, a primary care doc here in Anchorage.

COMMISSIONER MORGAN: Dave Morgan, Primary Care Association/Community Health Centers.

COMMISSIONER ERICKSON: Deb Erickson, Director of the Commission.

CHAIR HURLBURT: Ward Hurlburt, Director of Public Health and Chair of the Commission. I'll just mention that Paul Friedrichs sent an email that something came up last night that he said he was not going to be able to be here with us today.

COMMISSIONER DAVIS: Jeff Davis, Premera Blue Cross.

SENATOR OLSON: I'm Donald Olson, the State Senator from Nome.

COMMISSIONER DAVIDSON: Valerie Davidson, Alaska Native Tribal Health Consortium.

COMMISSIONER STINSON: Larry Stinson, a physician with offices all over the State.

COMMISSIONER ENNIS: Emily Ennis representing the Alaska Mental Health Trust.

COMMISSIONER CAMPBELL: Keith Campbell and I hold the consumer seat on the Commission.

CHAIR HURLBURT: And I'll also mention Linda was off for a meeting in Texas, that she's not going to be here today. And Representative Keller, likewise, is still tied up in another meeting. The folks in the audience, if you can just speak loudly? You don't need to come to the microphone unless you want, but just introduce yourself and say who you may represent. And Tanya, if we could start with you?

(Audience introductions indiscernible - away from mic)

CHAIR HURLBURT: Mike, we're just introducing?

MR. LESMANN: Mike Lesmann, Office of the Governor.

CHAIR HURLBURT: Thank you again. Thanks for everybody being here today. We'll have a full morning as I noted. If you can pull out your planning process -- the meeting planning guide that Deb prepared for us, and we'll look to page 11 there with slide 21 and kind of look at that this morning as

we look at the planning process. Do we have the projector working or how do we get that? Maybe Deb knows?

COMMISSIONER ERICKSON: No. The Imig guys have it on.

(Pause - technician works on projector)

CHAIR HURLBURT: We all have copies of that. Until we get the technology working here, we can just use those.

COMMISSIONER ERICKSON: So if you want to turn to slide 21 in your copy -- maybe before we get started, just a reminder to folks to -- so folks on the teleconference can hear -- make sure that the volume dial on the side of your microphone is turned all the way up and try to keep your mouth pretty close to the mic every time you speak. It makes a big difference for the folks listening on the phone.

Let's see. When we left off yesterday, we were just going to start going through those questions that we had sent out in the homework assignment a couple weeks ago, and the first couple were related to our planning process and just wanting to make sure that we've clarified what it means, since there was some confusion. Maybe not confusion, but a little lack of clarity and some questions at our first meeting last month. And I had taken a stab at writing a little bit more of an explanation out about what the five-year planning process -- to describe it in a little more detail and included that in that homework document. And if you wanted to reference that, look back to that, that's behind tab six in your notebook. So

I don't know if you all had a chance to look at that. I got a couple of responses from people.

The first question is, if it wasn't clear to you in the first place, was the additional explanation on page seven of that homework handout -- did that help clarify in your mind -- again this is just the process, kind of the framework for how we're approaching health care system improvement by first developing our vision, diagnosing the problems with the system, making sure that we have an accurate description of the current system as we build the foundation for a reformed system by focusing on Improved Workforce and Health Information Technology and Statewide Leadership and then working on designing the transformation elements, the different strategies that are going to transform this system to achieve our vision. And then along the way, we'll measure our progress and make sure that we're engaging the public and various stakeholders in the process.

And then I lined out all of the things we accomplished in the first year and bulleted out what some of our next steps and what we'll be working on in years two through three, continuing to gather information and develop a better understanding about the current system and then continuing work on recommendations related to building the foundation in the transformation strategies. Go ahead?

UNIDENTIFIED MALE: I just want to let you know the

screen is ready for you.

COMMISSIONER ERICKSON: Thank you, sir. For those of you who had questions about the planning process or planning framework, did that help clarify what we're about?

CHAIR HURLBURT: Keith?

COMMISSIONER CAMPBELL: I understand what we're about, but the word transformation, I wonder what happens to certain stakeholders if they don't want to be transformed in this whole process and how we go about encouraging them to come onboard. After all, it's going to be some sort of a collective vision, but there may be major segments that don't want to be transformed.

COMMISSIONER ERICKSON: The engagement, stakeholder engagement part of our process. As we start working on some of these strategies, I think we should make sure that we're considering that, to the extent we're developing recommendations and advice related to policy changes for the Governor and the Legislature. Certainly depending on whether stakeholders support it or not are going to make a difference in whether that gets adopted or not, but I guess I'm just thinking that, generally again just a very, very high level overview of the process, that's the part of the process that should be addressing stakeholder concerns. But do you have suggestions for the process to make sure that we're doing that in an optimal way?

COMMISSIONER CAMPBELL: No, other than, as a part of this process, we probably ought to try to find those incentives that get people in and keep them in the pool with us.

COMMISSIONER ERICKSON: Incentives for change. I'm just going to make a note of that. Any other questions or comments about the process?

One of the other things that had caused some questions was what five years meant. One of the questions was, are we assuming that we're going to achieve the change within five years? And the other question was, why do we need to take five years to plan?

I thought that -- my suggestion was we could layout -- remembering the comment was, well, the system took decades to build, and it's going to take a long time to affect some real change and so are we assuming we're going to affect that real change in five years, but then are we going to just keep planning for five years?

So I was hoping that laying out the process in that way that it would help describe the five-year planning process a little bit better, but another suggestion I had was maybe we could be more specific in our goal statements that we would achieve measurable progress on our four goals within five years. So does anybody have any comments, any response to that suggestion? Do you think it helps? I'm seeing a couple heads nod, three heads nod, a fourth head nod.

So since I'm seeing nodding heads and nobody has any questions or comments, I'm going to assume, unless somebody speaks up and they have a problem.....

COMMISSIONER MORGAN: I can see having a five-year where you measure your progress, but I don't think it would be too bad of an idea to have a snapshot at two-and-a-half years just to see what the trajectory is. Who knows, you might be beating it or not getting anywhere.

COMMISSIONER ERICKSON: I'm actually hoping that we will measure every year, but I don't know how realistic that is. We're going to have to finalize our set of indicators for how we're going to measure whether we're achieving these goals or not and that will be one of the criteria. They do need to be measurable.

And depending on how much work, how much money we might have to put into gathering the data, that, I think, will affect whether we're able to measure annually. But my dream is that we would have a set of measures that we could update every year and that we would be able to see that change then, see that we're turning some curves within a five-year period.

CHAIR HURLBURT: I think looking at the Commission as being a creation of both the Governor and the Legislature that there is an appreciation that the challenge that the Commission has is a mess and that the battleship is not going to change direction abruptly. But to echo what Dave said, if

we wait five years to say we've done something, I think that, hopefully, the Legislature and the Governor would have long since pulled the plug on us if we're not seeing something. So I think the accountability that we have is that things aren't going to change in a year. Some things are going to take 20 years, but we do need to see progress. And it is change, and change is difficult. And relating to what Keith said, we are making some challenges.

If you had come to me as a surgeon 30 years ago and if Dr. Olson had been practicing at that time and sent me a patient from Shaktoolik with gallstones, I would have said, of course, we have to take that gallbladder out if it's totally asymptomatic because the weather might get bad and they might get acute cholecystitis or they might drop those stones down their common duct and they'll get jaundiced, and you know, they might cancer because they lead to cancer. Well that was not what the evidence was. I just didn't know it at the time. So the Ward Hurlburts of the world do need to be challenged to use more evidence-based practice.

We talked about cost issues. The *Wall Street Journal* this morning had an article that said, of all of the industries in the country, the highest average compensation is in the health care sector. That's speaking broadly, delivery, health insurance, whatever. Ten million dollars a year average compensation for CEOs from salaries, stock options,

one thing and another. Well we're challenging that. We're saying we can't afford to do that, and it's not right to do that, but it's not going to be easy. So I think you know, the challenges that we have are tough. We're not going to do them in a year, but we need to show that we're making some progress in a year. So I would agree with Dave in kind of a long-winded way, I guess. Yes, Noah?

COMMISSIONER LAUFER: I wish Dr. Colonel Friedrichs was here because he has been trying to keep us on track. This is a lot like a patient. We're standing outside the room. We're a bunch of internists. Yeah, they're looking bad. Their vitals have been getting bad for a couple decades. We know they're sick. Now what? And we can't prescribe the medication that kills the system. It is a vastly complex, organic system which probably will live, despite what we do, but we do have the potential to kill it.

I was just upstairs listening to this Resource Development Council, and the economist was saying how the only thing that saved Alaska's economy was federal spending and he said, and inexplicably, medical or health care spending. No one knows why, but it keeps going up. I mean, I guess that's a heroic role, but -- I mean actually, it's a good point. We are spending all this money, but it's also the biggest employer in the state and a huge part of the economy. That's not bad. The money doesn't go out of the country, at least.

It's not going to China.

COMMISSIONER ERICKSON: And that was actually something I asked. I didn't mention yesterday. I asked Mark Foster, our economist who is doing the big cost study, the expenditure study, if -- and we do, especially with the reports from the Department of Labor -- they always put the medical industry out as the hero. That's the one place where the jobs keep growing, the labor market keeps growing when other places are declining. And I got some sense that folks had a question about, well, we expressed concerns about the fact that GDP in the country is up to -- the share of GDP is up to 18% and 20-something percent now in Alaska.

I asked Mark if he could, just from an economist's point of view, identify if there is some sweet spot or a turning point where, at some point, the growth in the medical industry is actually going to hurt the economy and where is it actually supporting the economy. So he is going to play with that a little bit for us.

COMMISSIONER LAUFER: It's hurting the economy now. We pay 32 cents on the dollar actually as a form of a hidden tax for what I'll call protection money, insurance against one of our employees getting sick enough to bankrupt the business.

COMMISSIONER DAVIS: Thanks, Noah. I was going to just comment on behalf of my customers and the people Wayne represents that, every time I see those growth in jobs in the

health care industry, I think, yeah, and their employers and their health insurance and the State, through the coverage, et cetera, are paying for it. And I wasn't at the meeting, but Director Hall, I think it was two weeks ago at an Association of Independent Agents, was quoted as saying that it is getting to the point where businesses cannot afford to do business in Alaska. So that's the other side of that. We're in danger of killing the goose that laid the golden egg.

COMMISSIONER STEVENS: Mr. Chair? To follow along that, we're already there. I mean, business is not investing in this state for any number of reasons, not the least of which is the cost of doing business. The regulatory environment, whether you're in health care or trying to start a mine or to drill an oil well, is out of control, and I don't know that whatever we do in this room is going to change that. I think it can bring focus to the problem. The doctor's analogy is absolutely correct. Everybody knows the patient is sick. They don't know what to do, but they don't want to end it. So we just keep pumping resources to it, but we're going to hit the proverbial brick wall in the not too distant future because businesses are going to say, I am simply sorry; I can no longer afford to provide you this benefit, and either you can pick up the benefit in greater and greater amounts or we're just going to do away with providing the benefit, which then is just going to shift the cost to the Government, and

where does the Government get their money? It comes from businesses who take risk and invest and create jobs for people who pay taxes, and ultimately, hopefully, businesses who are profitable and pay taxes. And we're at a very close tipping point in this State. I mean, oil is declining at 6% or 7% annually. I mean if they started pumping gas today, it only brings in about 25% of the revenue that the oil line does. And so we're all wrapped around the axle on finding gas, but it doesn't do what we need to do. And circling back you know, we're already at that point where the health care industry, if you will, is pulling resources away from every other industry, and we're in deep doo.

COMMISSIONER ERICKSON: I was just going to say on that cheerful note, why don't we move on? And I will add that statement, unless you had concerns about it. I'll add that to the diagnosis of the system, the fact that we will achieve measurable progress on and then list out the four goals within five years.

Let's move on to the goal statements. It was one of the things I pointed out yesterday, if you look behind tab two. Sorry to send you all over your notebook this morning. I included the full goal statements. Last month when we met, I was taking too much for granted and just had bulleted out the words of increased access, controlled cost, improved quality, and increased prevention, but we actually had, as a Commission

back in May of 2009, approved the Vision Statement, these full goal statements and these full value statements, and I just wanted to point that out to the group. And the questions we were getting last month, I think folks were just -- my sense was they just wanted to move beyond the goals and get to some of the specifics, what does this really mean, what are we really going to do. But I did think that it might help to have those full sentences, description of what we meant by increased access, for example, or controlled costs.

And then the other thing that I thought would help bring some clarification -- understanding we haven't finalized this set yet. It's still a work in progress, but we had just proposed an early draft of four key measures, four each for each of the four goal areas, and thought that might help bring some clarity to what we're trying to achieve. We'll talk for a minute about how we want to work to finalize these indicators.

But then the third thought I had related to this question was I got a sense that folks would have appreciated actually setting targets for these indicators as well, not that we're just going to track a percent of Alaskans who are uninsured, just taking the first one as an example, but we'll set a target for what we think an optimal and also realistic percentage would be that we want to shoot for.

So does having these sentences spelled out for each of

the goal statements, looking at this proposed set of indicators and thinking about what they might be, whether they're the ideal indicators or not, the right indicators or not, does that help clarify in your mind if you had any questions about what our goals were?

And then the second question is, do you want to make sure we're also setting targets for these indicators when we get to the point of finalizing them and approving them? Keith?

COMMISSIONER CAMPBELL: What sort of data are we going to be using to set these goals? I guess I'm a little fuzzy on that. Undoubtedly, we're going to have pull numbers, but do we use somebody's gut feeling on some of them or are we going to have enough solid data to -- or are we going to achieve 2% of this and 5% of that? Enlighten me how we're going to set those.

COMMISSIONER ERICKSON: How we're going to set the targets?

COMMISSIONER CAMPBELL: Yeah.

COMMISSIONER ERICKSON: Well I think we'll have to finalize the list first and then -- and one of the decision making points will be is if the data is available and we're able to measure each of these indicators. And then once we have the measures, we can talk about what the targets should be, and we have it in front of us. Any other questions? Do you think this helps? Don't get too bogged down in what the

indicators say right now because I think we need to spend our 2011 year working on these. Well I think we can move on. I'm seeing heads nod.

CHAIR HURLBURT: Yeah, that's my sense. This is okay for starters for now, a place to start from.

COMMISSIONER HURLBURT: Well let's move on to the general strategy then. And if you will recall the question that was raised at the last meeting and the concern was, in our Health Care Transformation Strategy Pyramid, it seemed as though we were leaving something out. This is just a picture of the main areas of focus where we'll be addressing how we're going to transform the system. Again the how of how we're going to transform the system is working on Workforce Development, Health Information Technology, ensuring statewide leadership, and enhancing the consumer's role in health, both through innovative primary care models and incentivizing healthy lifestyles, supporting healthy lifestyles for individuals.

The concern that was raised was that we were leaving something important out by focusing just on primary care, and we didn't change it at the meeting. There were some suggestions about changes that could be made, but my concern was we didn't have enough time to really engage in a conversation. And the initial group, the 2009 group, was very intentional in those two aspects of both enhancing primary care and supporting healthy lifestyles were the two most

important things we could do to support the consumer's role in health.

I didn't want to just make that quick change without really having a conversation about that and making sure that we weren't losing something important, if we had made a decision early on to have a focus on primary care. So then the question is though too, are we missing something really important if we don't have some aspect of our general strategy that is pointing to improving care across the whole continuum of care and not just in primary care? Yes, Emily?

COMMISSIONER ENNIS: One of my concerns is, of course, long-term care for vulnerable populations, and I would certainly like to see that included in there. I've looked to see if it's folded in anywhere along the way, and I don't feel comfortable that it is. So I would suggest that we consider the continuum of long-term care. It's a great cost to our state and only going to get greater with our senior population for a number of years, probably the next couple of decades. So I do believe we need to look at valued and cost-effective options for long-term care.

COMMISSIONER DAVIDSON: Deb, is slide 26 -- how.....

COMMISSIONER ERICKSON: Slide 26 is just one suggestion. So slide 25 is what our current Transformation Strategy looks like, and do you want to just look at this real quick before we go through those other questions? We could.

COMMISSIONER DAVIDSON: Yeah. I guess slide 26 really -- in terms of the consumer's role in health, innovative patient-centered care, and healthy lifestyles is really a broader scope that's beyond just primary care.

COMMISSIONER ERICKSON: Yes, it is.

COMMISSIONER DAVIDSON: And I think that's appropriate, given our leading causes of death, our leading causes of hospitalization, and our leading causes of accident-related injuries. I think that's probably appropriate.

COMMISSIONER ERICKSON: I'm seeing lots of nodding heads. So you like that suggestion? Folks are wanting to make sure that we focus on the full continuum of care and not just primary care. So the suggestion -- on slide 26, it changes the peak of our pyramid from consumer's role in health being about innovative primary care and innovative patient-centered care and healthy lifestyles.

And then another point that I thought might bring more clarification, we were so focused in that first year on the possibility that Commission might go away and that we had seen groups, bodies like this, over the past 25 years in Alaska last six months to two years at the most and not really get any traction because of that, that we needed statewide leadership that would be ongoing. And the main recommendation had been to continue this Commission, which seemed a little self-serving, but we thought -- we recognized how important it

was for somebody to focus on this on an ongoing basis. So it was real specific to statewide leadership, but thinking about the base of the pyramid as the infrastructure support for changing this system, I wondered if it broadened it and made more sense to change statewide leadership to the policy environment that supports the health care or system or not, or that doesn't support -- that hurts -- supports or harms the health care system, and just to make it was clear what I was thinking about in terms of the policy environment or what are the reimbursement systems and the regulations that affect the health care system. Noah?

COMMISSIONER LAUFER: I think aspects of regulation and reimbursement already clearly benefit parts of the health care system too much. This is where I would like to see a focus on primary care and the individual who actually provides the care and not all the other stuff involved, not just doctors. But you know, the regulation is influenced by politics and lobbying. I don't have a lobbyist, and it would be nice if it -- this is where the primary care focus should be. I'm sorry. I think I made the point.

COMMISSIONER DAVIS: Thanks. I don't think that our focus on statewide leadership was self-serving. These jobs don't pay that much. The coffee is good, but you know. And we are sunsetted in 2014, so I think we need to continue to call this out, that there needs to be ongoing leadership. And

I do believe, Deb, that what you've put on slide 26, policy environment, reimbursement, and regulation, are important parts of statewide leadership, but I'm wondering if they aren't others that also we need to focus on and maybe leaving it broader in this case is better, knowing that those things on 26 do fall under statewide leadership.

COMMISSIONER ERICKSON: Any other thoughts on that? Hearing one Commissioner suggest we keep statewide leadership rather than change it policy environment -- now I'm seeing heads nod. So I will leave that at statewide leadership.

So then my final question was going to be -- and then getting back to Noah's point -- are we missing something important if we somehow take out the focus on primary care and how might we bring that back into our general strategy picture?

CHAIR HURLBURT: Well would it be maybe correct to say that the suggestion, like from Emily, is not to remove a focus on primary care but to remind us that we don't want to solely focus on that, but we want to focus on the whole continuum of care. You specifically mentioned long-term care, which you could amplify more, saying we don't mean just institutional long-term care; we mean long-term care in whatever setting, whether it's provided in the home or what, so that we're dealing with the whole continuum of care, but that doesn't contradict saying that focusing on patient-centered -- buzz

word -- medical home type primary care isn't going to be maybe as critical as any element. That's not to say that -- just don't forget that that's not the whole thing, that the financial incentive, as Noah said, really drives behavior that's somewhat antithetical to what I just said now. Does that sound reasonable and fair? Larry?

COMMISSIONER STINSON: The whole continuum of care is triggered by primary care, be it the family practice physician, be it PA, be it nurse practitioner, but the person who talks to them about their diabetes, changing their diet, maybe sending them to a dietician, talking about it's time for grandma to go to the long-term care facility. It's all triggered by primary care. So I see it as integrally involved. I don't think you can separate the two.

COMMISSIONER ERICKSON: Very good. Any other questions or comments? So what I'm hearing is that you all would like to change consumer's role in health so that it reads innovative patient-centered care and healthy lifestyles and then leave the statewide leadership piece of the puzzle the way it is. Yes, Wayne?

COMMISSIONER STEVENS: Given the earlier comment about statewide leadership being misconstrued as self-serving, perhaps it would be good to maybe -- there is an asterisks or a subset of statewide leadership on policy environment, reimbursement, regulation as bullets below it, just so that

people understand what that is intended to mean because I don't think I got a sense that the only reason we put statewide leadership in there was so that we could have a job to come back here and sit here for hours quibbling over policy verbiage. I just take exception to that. So statewide leadership -- if there is that misconstruction of what that was intended, then perhaps including some of those bullet points that were in your previous blue diamond triangle thingy-maghingy there in the center might bring focus to what we mean by statewide leadership.

COMMISSIONER ERICKSON: Larry?

COMMISSIONER STINSON: I interrupted statewide leadership if there is only X number of dollars for health care and then you included the reimbursement and regulation. It's going to take the Legislature/the Governor to decide what is priority. When you reimburse for some things and not for others, if you reimburse some things well and some things not so well, and you can influence that on the Medicaid level or on other levels, you are going to get a change in behavior of practitioners. It's inevitable. There is no question about it. So if you say that immunizations are very, very important to the State -- and they are -- and that you're going to reimburse those at a certain rate or that people who include that in their well child checks get reimbursed slightly more -- for example, that they discussed immunizations -- you'll see

that behavior reflected. There is no question about it. So that's how I interpreted it, but I understand that there are lots of different ways to interpret it.

COMMISSIONER ERICKSON: Any other thoughts or comments? And I could add those, regulatory and reimbursement environment, underneath, too. Very good. Good. Well I'm feeling as though we have consensus and don't need to vote on this either. Good.

Well we can move on now to what was going to be the first part of our agenda today, and that's 2010 recommendations. And the one area where we spent some learning together around was evidence-based medicine, and we posed the question before, what should the Commission recommend to the Governor and the Legislature in the 2010 report to advance the use of evidence-based medicine in Alaska? Does anybody have any suggestions they want to throw out? If I'm not hearing anything right away, I'm going to go back to -- I'm remembering Dr. Hurlburt had a general recommendation at the last meeting. Yes, Larry?

COMMISSIONER STINSON: I think evidence-based medicine -- again getting back to the same point on X number of dollars -- is ultimately the way that a lot of these recommendations are going to have to go, but whose evidence, how much evidence? We have to be very, very careful about making draconian changes in the health care system because somebody publishes something somewhere that says you shouldn't do that. I think

it's always -- the problem is in the details, but if there are clear consensus on certain aspects of health care -- for example involving primary care as much as possible, does that save money, does that improve health care outcomes? I think that that is something that the vast majority of people would agree with. And so funding towards that makes sense. To me, that is part of evidence-based medicine. Certain procedures, some of them are very, very expensive. In Canada, they have a very different way of looking at a lot of these things, and I know that because my uncle is one of the physicians on the Canadian National Board that makes these decisions. Talking to him is frightening, on occasion. And if you're over 60 and you're going to an ICU, you should be given morphine at a home site and left to die, and he strongly feels that way and he has got lots of statistics that bear that out.

The flip side of that, I just had a patient of mine who is 63 who had an overwhelming infection and multi-system failure in the ICU and has pulled out and lives in Wasilla, and she was there for a long time, and she's going to do well. I have no idea what the staggering cost of her bill is going to be. She would not have gotten that in Canada.

So when you're looking at evidence-based medicine, instead of just saying here is a study that says this, we need to do this, I think you have to look for consensual studies, maybe multiple studies. But again if you're looking at the

most value for your dollar, this has to be part of the equation.

CHAIR HURLBURT: Yeah. I would say that evidence-based medicine, as I understand it, protects you against what you're saying. Just because somebody -- and just because with a big name publishes an article that says you should do this or you shouldn't do that, following the precepts of evidence-based medicine, it allows you to look at the article and see is it garbage or is there really strong evidence there. And there is a lot of garbage in the literature, both ways. And sometimes good articles are suppressed if they are funded by pharmaceutical companies and the results aren't what they want to sell their product.

So as a straw horse, in response to Deb's question, the State is a significant purchaser of health care services in Alaska for Medicaid, for employees, for Workman's Comp, Corrections, retirees, a number of areas, and we are accountable to the State, to the Governor's office, to the Legislature. We could recommend that, as a purchaser or services, the State engage in understanding the process of the use of evidence-based medicine, of high grade medical evidence and in making policy determinations that are guided by that. I'm throwing that out as a straw horse. I think it's a good idea, but I think we should all engage in that discussion. Noah?

COMMISSIONER LAUFER: I agree, and I think in particular, parameters that are going to be measured need to be looked at frequently. I'm reminded of one of these, you know, the classic first week of medical school quotes: half of what you learn here is going to be proven to be false in ten years, but we don't know which half so you have to learn everything. I don't have that much confidence in any regulatory body, whether it's an insurance company or a state, to be up-to-date on really what the data shows, and there are many classic examples of this. So it can't -- my fear, as a practicing doctor, is that these things tend to be used depending upon the bias of whoever is using them to support not paying for things or paying for things or whatever, and the experts in this scenario often lag by a decade. And then they'll say, well, we've decided that's approved or not approved or whatever, and this is well-known phenomenon in expensive health care. It comes out. It's experimental. It's not approved. It suddenly gets approved. It's paid for at a very high rate for a period of time before the pressure goes down, and it's a big enough phenomenon that a specialist may have a very successful career financially just because they ride one bubble, and that's not using the data correctly. But everybody involved in doing the study usually has a stake in it that biases the outcome, and I don't trust it completely.

COMMISSIONER BRANCO: During your presentation last

month, Dr. Hurlburt, one of the enlightening moments for me was the scoring and grading process of the evidence. And so building that into a structure lead me to -- because I live in a world of analogies, if it's new information, I can't quite swallow it all in one bite. So I went to the old hospital formulary process in which you somewhat constrained the use of drugs or new drugs, but they have to be trialed. There is a process for evaluating the efficacy of a new drug, adding it to the formulary, taking it off as evidence changes or the practice of medicine changes. This can -- in my view, it can never be a static moment or a bureaucratically-imposed standard. It's a fluid process that requires constant change and update. So somehow building that into our recommendation too, I think, would be worthwhile.

COMMISSIONER CAMPBELL: Well I think caution is the better part of valor here because, in part one of going through that myriad of words that Deb sent out, it says that, as of several years ago, there was over 10,000 articles per week logged into the National Library of Medicine. Well you know that no one can keep up with that volume, particularly a lot it is junk -- it's bound to be -- and self-serving. So my question is we've got to really be careful how we recommend use of some of this data or whatever.

COMMISSIONER LAUFER: Like I mentioned before, evidence-based medicine is not really a new phenomenon and there are

many groups that collect this data and look at them for value and validity and publish them. The *Cochrane* is the one that I was weaned on -- what's the -- anyway I grew up with, but this isn't as daunting as it sounds.

CHAIR HURLBURT: And there are entities, like *Cochrane*, like *Hayes*, that do take this plethora of articles and you can subscribe to their services and sort it out and show you what does the evidence really support there when you use the high grade evidence. And it's not just about saying no. It's just about saving big money. It's about doing the right thing and that will, more often than not, save money.

Just a personal example, if you have a tear of your meniscus which is not a bony tissue in your knee and it causes your knee to lock and it causes pain, it may cause swelling, and so the treatment may be for the orthopedist to go in there and to take out the part of that tear because, in most people, it doesn't heal because cartilage is not very well-supplied with blood. But that doesn't show up on an x-ray, and I can remember having a conversation with a woman who was a family practice physician in Eastern Washington who wanted to get an x-ray of the knee for a meniscal tear. Now the symptoms may be -- the findings may be exact enough that I would be comfortable having an orthopod go and do the surgery without getting any diagnostic imaging, and I think that that's probably a point to get, but she wanted to get the x-ray. And

I called her up to say that an MRI is the test that you should really have there, as all the physicians in the room would recognize here. And she said, well, I was just trying to save money and she was. She was being very sincere. She wasn't seeing a lot of the problem. She was a good doc, very conscientious about, you know, the resources of the State and the insurance company, where sometimes the relations are like that. But the evidence really indicated, no, you need to spend more money, that's the quality thing to do, that's the right thing to do. So it really is geared toward quality care, but there are resources where you can sort out this (indiscernible - voice lowered). There's no way any individual physician can keep track of these 10,000 articles. Jeff?

COMMISSIONER DAVIS: So Commissioner Davidson yesterday was talking about world peace, and this is kind of a potential world peace subject as well. Maybe if we thought about starting a little smaller, there are things that are not controversial, care for diabetics, right? Smoking, diabetes. And we know from studies that we don't do very well on delivering the things that have been shown to help people live healthier lives and not end up in renal failure and amputations, and blindness, et cetera, et cetera, et cetera.

So maybe if we just started there as a way to -- or as part of the recommendation, as a way to move into this and not

try to eat the elephant, you know, all at once but just take a bite of it because there is a real -- I mean, it's a perfect example of saying you need to have this, not you don't get this, you need to have this and working with physicians and other providers to make sure that people are getting the care that they need to leads to better outcomes and saves a lot of money, but more importantly, leads to better outcomes. So just a thought about where to start with this.

COMMISSIONER STINSON: That goes to my point when I was talking about sticking with the consensual things at the beginning, but to go along with what Keith said, you know every six months or so, the State Medical Officer should be reviewing maybe some of these other things through a subscription to these review services or whatever. And someone has to make the decision somewhere along the line -- and I know we're supposed to do the 50,000 and not the three foot look, but Ward, I mean, somebody like in your position every six months or so might be put in a position to recommend to the Governor's Office or to the Legislature we should start considering covering X or maybe stop covering Y or change how we cover X or Y, too. So we do have to build in some kind of flexibility.

CHAIR HURLBURT: And I would say that actually, in reality and probably in practicality, is more operational. Probably none of us, including Senator Olson, want to see the

Legislature making the clinical decisions, specifically we're going to do this, that, or the other thing, but policy-wise, that can be an operational thing, and I think that's exactly right. That should be a part of my accountability for the job that I do with the Chief Medical Officer and working with Bill Streur and with his folks or maybe Department of Administration on coverage.

COMMISSIONER ERICKSON: So Dr. Hurlburt, it's on the screen behind your head. I don't know if you can read it on my computer more easily. I captured, I think, the first strawman suggestion you had made, and I'm assuming I got this right and we can fix this statement. Do you think in a narrative explanation about what this means about the issue and concerns that were raised and the examples of how this policy would be applied with the Chief Medical Officer working with the State Medicaid Director to identify and continually update policies related to evidence-based medicine that that would be sufficient? I'm seeing heads nod.

So our plan for today was just to come up with -- see if we could get consensus on the general concept behind what the recommendations should be and then I'm going to go away and write something for you and get it back to you in a week to ten days, probably closer to ten days with the holiday coming up, but that we would look at that together on a quick teleconference and then send it out for public comment for a

period before it was actually finalized and you voted on it in final form at our January 7th meeting, just so you understand the process and what I have in mind for how we're going to use this. So we're not making any final decisions today, but I'm just trying to get some direction from you on what to include in the first draft. Jeff?

COMMISSIONER DAVIS: Deb, that sounds great to me. I was also thinking about the reports of the Governor and maybe the possibility for us to give a glimpse as to where we're going in '11, particularly with the studies. I think that a heads-up around those in the report might be valuable to the Governor and whoever else is the audience for that, that here's what we're saying in this report in January of '11, but here are the things that we're really focused on and here is the information that's going to be coming in and maybe (indiscernible - voice lowered) some framework that kind of interim communication before the January 12 report to them. You look puzzled. Maybe I'm not making sense. For example, here's what we know now, evidence-based medicine -- you know, this is our recommendation. However the Commission's coming attractions, we're looking at cost and whatever and we're looking at, you know, these things, and this information will be available on these dates, and we'll be producing interim reports and giving them to the Governor. Something like that, just so that folks are thinking down the road that we're going

and not just saying, well, that's all you got. No, that's all we have today, but this is what we're doing.

COMMISSIONER ERICKSON: I get it now. I didn't get it at first. We'll make sure that it's clear that this is a work in process and that we're going to continue looking at evidence-based medicine as a Commission and we'll, potentially, have additional recommendations in the future; is that right?

COMMISSIONER DAVIS: Well that -- but I'm thinking back to yesterday's discussion about the studies that we're going to be commissioning. By then, we will have done that. And so I think we should be saying to the Governor, and these studies have been commissioned, and these are the purposes, and this is what we're looking for, and this is when they're going to be delivered, that that be a part of our report as well.

COMMISSIONER ERICKSON: Absolutely. Good. Thank you.

COMMISSIONER DAVIS: Thanks.

COMMISSIONER ERICKSON: Any other questions or comments? So I'm going to take this recommendation then and play with it and add some explanation around it, and we'll get that out to all of you in the next ten days or so. Sound like a plan? Twelve days. Actually I did pick a date that I was going to get it out to you, but we'll talk about that at the end of the meeting today. It's on your last slide in here.

So I had suggested yesterday I was a little concerned with coming up with additional areas for recommendation, since

we haven't really had time as a group to learn more about other issues yet. But that being said, are there any other areas where you want to include a specific recommendation related to a strategy in this next report, understanding that we will layout and it will be not a recommendation but an explanation about where we're at in the process as well for the public and for the Governor and the Legislature to understand, both in terms of the studies and the continuing and evolving work on the strategies that we're looking?

CHAIR HURLBURT: Noah?

COMMISSIONER LAUFER: The technology aspect of the -- or the Health Information Technology aspect of the pyramid, I don't know, but I suspect that the landscape is going to be transformed five years from now and I suspect that that's going to be why, and it might be useful to have some specific -- you know, at least a body that's looking at health care information technology and aware of what's going on with it because that really offers a lot of promise from my point of view, if it really works.

CHAIR HURLBURT: I'm not sure what you mean by a body? You mean a Paul Cartland body or do you mean a group?

COMMISSIONER LAUFER: No, I mean as far as, if the part of the job of the Commission is to be looking forward and understand what's happening and have the 50,000 foot view, you know, it's not hard for me to imagine a time where a primary

care doc -- say more than 50% of primary care docs were women who graduate and want to have children could practice, in a sense, without an office, without defined office hours, could via computer do everything from bill a person, keep track, keep a medical record, check data, have their statistics followed, provide patient information. You know, all of this could be done, and I've become a fan of my iPhone because it does amazing things. And I think that, within a year or two or five years for sure, technology is going to be vastly improved and this will be a new truly transformative force, and it would be kind of silly if we weren't watching that. I don't know how you do that, but you know, this wasn't mentioned yesterday. I think there are 27 vendors who have sold products in Alaska, and it's hard -- when we went through the selection process to even figure out which way is up and we may well -- I was just talking to our Administrator -- have spent, you know, a quarter million dollars on the wrong product. You know, I'll get a new phone in three years, but still, ouch.

CHAIR HURLBURT: Deb, how does the contract that's let with Paul Sherry's group address what Noah is talking about?

COMMISSIONER DAVIS: I am on the Board of Alaska eHealth Network, and sometimes, I tend to have Pat speak to this. He is a more regular attender. But yesterday you had some questions, really, that Paul Cartland didn't have a chance to

answer, so let me take a run at this.

There is the electronic medical record in an office, and there's a group, EHR Alliance, in Alaska that has now gone through -- and I believe either has or is in the process of saying, you know, kind of vetting the vendors because there is a plethora, but saying these pass muster, three or five. Great. So a practice selects an electronic health record vendor for their office and so that's where they capture their information and the record is all there, but it's captured in that office. And so then the Alaska eHealth Network's job is to be the connector. It's the Internet, if you will, for these records. So the eHealth Network, as Paul went through, has been selected by the states that has a (indiscernible - voice lowered) entity and has selected eHealth Network as the non-profit to do this. They're purchasing the system that interfaces with the different vendors. So you don't have to all be on the same one, but you know, the proof's in the pudding. But apparently this company that is the -- the frontrunner has done this, and they are able to do that. So then, you know, Noah has a system in his office that connects to that. Larry's got a different one; it connects to that. And it doesn't -- it's not taking the information and capturing it. It is just the conduit. So Larry's patient goes to see Noah. He wants to access the information he can through the eHealth Network, pull it from Larry's to his, you

know with appropriate approvals and all of that good stuff, but there's those two things, and until I figured that out, I was really confused, like what are talking about. So an electronic health record and then the eHealth Network that ties them together.

COMMISSIONER LAUFER: Just very quick, like the phone isn't just a phone anymore, I'm thinking something, you know, much bigger than a medical record that helps me document what I did at a visit. This could be, you know, a patient's health diary over decades. Here's where I was. This is what I was happy about. I was happy with whatever, my marriage, my career. This was my weight. This is the trending of my cholesterol. This is where I can go and look. Here are articles cited on my last visit and why the doctor is worried about my weight. It really could be much, much more and is likely to be. It's going to be very frightening for us because, sometimes you know, I write in code that the person was really difficult and uncooperative, and they're going to read that in their diary and say, you know, I don't drink that much. Anyway but it will -- it is going to transform health care, and we're a small population. We could lead the way, if we have some vision. I don't know anything about how my phone operates. I just know the buttons.

COMMISSIONER DAVIS: So I think this is a really interesting trail that we're going down. There is an

experiment taking place in Hawaii, and I have not touched it in the last year-and-a-half or so, but the Blue Cross plan in Hawaii, which is one of the dominant players, is working with a company called American Well. And the idea is that you create this virtual office. And you know, Hawaii is a lot like Alaska with the separated, isolated populations and maldistribution of specialists and physicians, so you know, same thing. Air transport from one island to another to see if a patient, maybe you need to do that; maybe you don't need to do that.

So in addition to that you know, we all have times when it's the middle of the night and your child's crying and what are you going to do about it. You don't want to take them to urgent care or whatever. So there's X hours access, even if you live in Oahu.

So what American Well does is they have this technology that does kind of what Noah described. Physicians say, yeah, I want to be a part of that, and they have basically their PC and they can say I'm available. This is me. You know, I'm available for visits in these hours. Maybe it's 7 o'clock at night; I'm not doing anything; my spouse is gone for a couple hours. I'll do two hours' practice. I'm available. I'm online. And then there are people waiting in the queue to see physicians. So they said I need a visit with a primary care doc and I'm willing to do it any time. Call me on my mobile

when the doc's available. So I mean, it connects patients and doctors at the times that they want each other and they're available, and it takes care of the medical record. It takes care of the reimbursement. It does all of these things.

So maybe -- and we looked at it and it was too expensive, but maybe it's something we, as the Commission, should look at and see, you know. I mean, we could volunteer to go to Hawaii and check it out, right? And see is this working and is it something that maybe there is a role when we talk about access and quality and cost that -- because it sounds really, really good, but I don't know how it's working on the ground.

COMMISSIONER LAUFER: How many people would like to see the return of house calls? You know, that's something that I got flawed, you know, all the time. Your dad used to do house calls before you guys became, you know, whatever. But it really, really is interesting. If you think about this, you know, maybe nursing home care could be better because, right now you know, I've done a couple visits, and oh my God, they called me at home and night and day, you know, are you interested, are you interested because there is a tremendous need. The problem is there is no money. Maybe hospitalizations might be -- could be shorter because there is a doctor available who can visit you at home. Maybe you don't even need to be hospitalized. A lot of really important things. I picture someone very -- with what gets called a

blended lifestyle now, where your work and life are somewhat blurred. But a mom drops her kids off, then she does some sports physicals, stops by the nursing home, goes to someone's home, goes to your business and does three physicals on employees that need it. You know, it really could change things. I'll stop.

COMMISSIONER DAVIDSON: So what's our task right now? Are you looking for items to recommend? Are you looking for items to include in our 2010 report to the Governor?

COMMISSIONER ERICKSON: Yes, but I think we might be actually moving on in this conversation to the next point of our agenda.

COMMISSIONER DAVIDSON: But before we go there, I'm not clear what our 2010 report is going to say so far.

COMMISSIONER ERICKSON: So far -- I had actually outlined for you all in a presentation last month and I've refined it since then. Can I, over our break, outline what I think is going to be included in our report because there are multiple things and I don't want to muddy up the waters?

I think what we're talking -- one of the things that will be included in the report, in addition to an explanation of the studies that we're going to be doing over the next year, is an explanation of the potential strategies that we're going to be studying. So we're going to be studying the current condition of the system some more with our cost and

expenditure and pricing and all of that. And we're also going to be studying potential strategies, like the idea around how this use of Health Information Technology could be expanded. And we're going to talk next about other potential and continuing strategies that we'll be studying. So the report will include an explanation of both of those two things.

In addition to that, it'll include a specific recommendation to the Governor and the Legislature about evidence-based medicine. And then I'm planning on probably just as an appendix, maybe with a short summary in the body, an overview of the federal health care law just as a background informational piece. Off the top of my head, those are the main points I'm thinking that we will include.

COMMISSIONER DAVIDSON: So then after the break, we're going to have a chance to review the 2010 list of things that are going to be included in the report?

COMMISSIONER ERICKSON: Yes.

COMMISSIONER DAVIDSON: Thanks. Just to make sure that it's.....

COMMISSIONER ERICKSON: Yes.

COMMISSIONER DAVIDSON: Thanks.

COMMISSIONER ERICKSON: So does.....

CHAIR HURLBURT: And that won't be the last time you'll see it before it goes to the Legislature?

COMMISSIONER ERICKSON: Oh heavens, no.

CHAIR HURLBURT: It's just where we are.

COMMISSIONER ERICKSON: No, I think Val just wants to have some context for where all of these pieces are fitting and what we're going to be -- what they're going to see in a draft pretty soon.

COMMISSIONER DAVIDSON: And thank you for clarifying that. I mean, that's exactly what I was looking for because I feel like we were answering a very finite question without necessarily the larger context and the quality of the answer that we provide is completely dependent on the quality and the context of the question that we're asking. So I just wanted to make sure that we're all aware that answering the question on evidence-based medicine, it's a given that we're going -- the implication is that it's a given that it's included in the 2010 report without asking the question, should it be included in the 2010 report.

COMMISSIONER ERICKSON: We had moved past that, I thought, but if we need to go back and.....

COMMISSIONER DAVIDSON: No, it's okay. So after the break, we're going to review the list and after everything we've learned yesterday and then we're going to review it once more?

COMMISSIONER ERICKSON: Yes.

COMMISSIONER DAVIDSON: Thanks.

COMMISSIONER ERICKSON: And my sense is, from this

conversation we were just having, that we need to add this use of potential for evolving uses of Health Information Technology as one of the strategies you all want to study over the next year.

CHAIR HURLBURT: And that's a part of the list of things that the Legislature asked us to look at in the bill, so it's very consistent.

COMMISSIONER ERICKSON: Yes. Let's take a little bit longer break, but I want to make sure, did anybody have any other specific -- so we're going to have evidence-based medicine, at least, as one area where we're going to have a specific recommendation, policy recommendation to the Governor and the Legislature. But then in addition to that, we won't have specific policy recommendations for the Governor and the Legislature, but an explanation of what we're continuing to study, both in terms of current status of the system and potential future strategies where we will be looking at developing recommendations. So that makes sense?

So the question regarding whether there are any other areas where you all feel as though you are prepared to make a specific policy recommendation to the Governor or the Legislature, beyond the one for evidence-based medicine, is there anything else that you want to propose for a specific policy recommendation that will included in the 2010 report? Val?

COMMISSIONER DAVIDSON: I'd recommend that we have that conversation after we see the full list.

COMMISSIONER ERICKSON: Okay. That would be fine. We're actually breaking early, if we look at our agenda. Let's see. We were scheduled to take a break at 10 o'clock and reconvene at 10:15. Is it okay if we take a 20 minute break to give me a few minutes to do a quick outline for you?

CHAIR HURLBURT: So we'll be back at 10:10.

9:50:10

(Off record)

(On record)

10:14:50

CHAIR HURLBURT: If we could get everyone around the table again, please? Before we come back to our agenda, Dr. Larry Stinson has a guest with him that he has invited today and she was going to be willing to share some observations. Larry, do you want to introduce Tanya?

COMMISSIONER STINSON: Absolutely. Thank you. Tanya is a fourth year medical student in the WWAMI program. She's an Alaskan resident, wants to go into OB/GYN and come back to Alaska, played for the UAF women's basketball team. Go Nanooks! I'm a UAF alum; I'll let that be known. And we are always talking about access, getting people back.

The WWAMI program has a high percentage of return, but how do we make that better? Tanya and the people that are

going through this program often have observations that we need to know about and maybe even do something about to enhance that return and to enhance the educational and training opportunities in Alaska.

TANYA (LAST NAME UNKNOWN): Thanks for giving me a chance to talk. If you have any specific questions about WWAMI issues, Dr. Stinson was mentioning that, sometimes, you don't necessarily get to hear straight from the horse's mouth and I'd be happy to be your horse if you have any questions about what is going with WWAMI.

One thing that my classmates and I often talk about is, on the first day of medical school, we were given a contract which I have here. Some people who are applying to the WWAMI program realized that there is a binding contract, financial contract with the State, but some people don't realize that and it's not something that's made known when you're applying and even interviewing.

And so in my case, I'm planning on coming back to the State. My family is here. My in-laws are here. I have no reason not to come back. It's my home. But some of my other classmates don't necessarily have the same connections here. And so on the first day of class when you've already rejected all the other schools that accepted you and you get a contract saying, if you don't come back, in addition to the $160,000 that you'll owe at the end of medical school, I crunched some

numbers and it ends up being about an extra $101,000 with 8.25 compounded interest starting back from your fourth year. So it, essentially, almost doubles your med school loan if you don't plan to come back to Alaska.

And so the WWAMI states each have their own twist on how they try to recruit students to come back. And I don't know if this is the way the administrators talk about it, but the way the students kind of see it is some people have carrots and some people have sticks. And carrots are more we're going to incentivize you to come back, you're a resource, and we want to recruit you rather than punish you if don't come back. And so as I said, I don't really have that big of a problem of with it because I'm planning to return. But for example, my classmates that are single -- if you meet someone in medical school or residency who doesn't necessarily want to come back, it puts you in a sticky situation having to decide between love and money really.

So I just wanted to bring that up. I don't know if this is something that's open to debate or negotiate, but if Alaska really does want to recruit solid physicians, I think there will always be, at least, a couple people, like me, who have solid roots here, but I think having more of a carrot rather than a stick program -- I just think being positive will consistently recruit more people than the negative side and also being transparent about it. I feel like this should be

known to people when they apply, when they interview, and so if there are other options available to them, that they don't turn them down to find out on the first day that there is -- if I didn't come back to Alaska, my loans would end up being about $260,000. And then the national average is $156,000, so I would have been better off going out of state rather than staying, if I didn't want to practice in Alaska.

CHAIR HURLBURT: Tanya, thank you very much for joining us. Larry, did you have a comment?

COMMISSIONER STINSON: Do you have any examples of what other states do for carrots or is Alaska the only one with a stick?

TANYA: I don't know the specifics. I believe it's Montana, although it might be Wyoming. What they -- actually it might be Idaho. So you can't quote me exactly, but one of the other WWAMI states what they do is each year the students are charged an extra amount as a part of their regular tuition. I think it's, like, $10,000 to $15,000 per year. So it's not an exorbitant amount of money, but all of that money gets put into a pool. And then everyone who returns after residency within a couple year period gets to split that pot. And so if you don't come back, you're just paying regular in-state tuition. And if you do come back -- say it's a class of 20 and ten people come back, you might each get an extra $80,000 if you're the ones who decide to return. And so

rather than being punished for not returning, you're rewarded for returning. And another question I had, I'm not sure if it was a part of the Health Care Commission, but there was a group of people that came down to University of Washington last year and specifically wanted to speak to the Alaska WWAMI students about ways to incentivize us to come back and practice and we never ended up having any follow up. There were probably six or seven students who came in and provided their feedback, and I don't know if it was you guys, but it sounds like people are very interested. The students definitely want to participate in that because, if we want to come home, then we get extra benefits, and for people -- we need colleagues too, so if we can recruit more people, that would be great. But just following up on things that happen, but if that wasn't this organization, it doesn't matter.

CHAIR HURLBURT: Yeah, I think that that wasn't us there. I think that your comment that you don't learn about your financial obligation if you don't return to the State until your first day of class points out a pretty serious omission. And while that is not specifically the role of the Health Care Commission, we will transmit that information because that should be made public.

I think I do have to respond to say the other side of what you're saying is that, in fact, the state of Alaska spends $50,000 a year, over and above your tuition costs, and

we really can't spend $50,000 a year for folks to go to Nevada or something. So I think there is an issue on both sides, but clearly not knowing until you get into class the first day is not fair. I think it's just an omission, but yeah.

TANYA: In my case, I knew, but classmates (indiscernible - away from mic).

COMMISSIONER DAVIDSON: So I mean, it sounds like whoever -- the folks need to do a better job of keeping you informed up front what the responsibilities are, et cetera, and so I totally agree with that.

I guess I'm a little bit confused by your example that the other state everybody puts in a certain amount, but then, essentially, you're also penalizing people who stay in the program because, if everybody puts in $10,000 a year and at the end of however many years it is -- let's say it's $40,000 per person, but two of your classmates don't come back to the State, even though you returning to the State a portion of your $40,000 is going to pay for that person who chose not to come back. So it's a little -- it's not really a carrot and a stick. It's really a stick, right?

TANYA: So for the two people who didn't come back, the $40,000 that they paid in would no longer be theirs. It would get distributed to the people who did return. So regardless, you would get your $40,000 back and then you'd basically just be rewarded for however many people didn't return. And I

think, pretty consistently, I don't know that any of the states has 100% return of their students. Some have pretty decent, but I don't think any of them are 100%.

COMMISSIONER DAVIS: Tanya, my son Chris is one of your classmates.

TANYA: Yep.

COMMISSIONER DAVIS: Thank you for being here. Are there other things that you all talk about as students that affect the decision to come back? I mean, Chris is in that category of going to be marrying someone who is from Washington, so it is a struggle for him. But are there other things, other than just the reimbursement, that affect what practice looks like when you're here or training that also we should consider?

TANYA: Well let's see. So I think Alaska has an awful lot to offer in terms of the people who are from here. I don't think it would take as much to get them to come back, but when you are torn between recruiting a spouse who might not have any love of snow, that can be difficult. And so I'm totally speculating, but I feel like most of the time when people don't come back it's because they have someone telling them not to. And so if you had some way to counter that, I don't know if -- yeah, global warming -- maybe, you know, they could go to the Oahu conference to talk about the American well with the spouse, but some way to incentivize the spouses if possible. I don't know if you're feeling like being that

strategic, but you know if the person's a teacher, helping them with job placement, or if you really want to recruit people to come back, you have to make it comfortable for both them and the person that is making their life either really good or really bad. So at least from the classmates that I'm most aware of, I think relationships are the reasons that they wouldn't return. And so if you have some way to counter that, that would probably be the strongest.

CHAIR HURLBURT: Noah?

COMMISSIONER LAUFER: When we're trying to recruit primary care docs, they have a lot of choices, and it's the quality of life in the community. How good are the schools? How safe is it? What is my life going to be like here? And these are not all, but you know, I suppose you could call them the liberal elite. They have expectations about open communities, tolerance, education, and nice communities. They're also big taxpayers. That's the real challenge for us.

I had a stickier question for you. You know when match day comes -- and this is, you know, an annual big event at every medical school -- everyone gets a letter telling them where their future is going to be and where they will practice and everything. Well the University of Washington is famous for primary care initiatives for decades. What's your sense of that? If, you know, somebody matches at the Alaska residency program in family medicine, are people going to be

congratulating them? Is it a top choice typically, you know, or is somebody headed off for CT surgery at Hopkins going to be really lauded?

TANYA: Well I'm not sure because I haven't been to a match day yet, but my sense is, at least two of my classmates out of 20, are really interested in coming to the Alaska Family Medicine residency. And I think there has been a pretty strong presence consistently throughout the years from Alaska WWAMI students, whether there is one or two per year. And so as far as I know for the people who match here, it's because they want to be here. It's probably their number one, maybe number two, choice. And so in that case, it would certainly be a reason to celebrate.

It does seem like that there is a trend, not necessarily at U-Dub but in general, a little bit away from primary care just because you're not going to make as much money, your stress is going to be much higher, what in the world do I do about my Medicare patients. You know having to work twice as hard to make half the money is hard to get people as excited about. And so I think for the people who have, anymore it seems like, the heart to survive in primary care, if they make that match, then that's certainly a celebration for them. But I feel like a lot of my classmates are choosing to go into more subspecialties because they don't want to have to deal with that challenge in climate.

COMMISSIONER LAUFER: Thank you very much.

COMMISSIONER HURLBURT: Tanya, we appreciate your coming. We probably need to get back on the rest of our agenda, but wish you well in your match and we appreciate your interest and willingness to come back and stay here in the best place in the world to live.

TANYA: I agree.

COMMISSIONER HURLBURT: Thank you. Deb?

COMMISSIONER ERICKSON: I took a stab at drafting what I'm imagining as the structure of the report, the Commission's 2010 report, given that we will have only met for two months our of -- in preparation for this annual report. But just a brief introduction with describing, again, the purpose of the report, background on the Commission, and a summary of the couple months that we had to meet our activities, and then a status report on the analysis of the health care system. I'm imagining a brief, no more than ten-page overview in description of the federal health care law, and to the extent we have any information on the impact of the law, maybe a two-page Executive Summary of Mark Foster's report will be included in that section of the report. And then his final complete report will be included as an appendix to this report. And then a discussion, as Jeff was suggesting, of the new studies that we have planned and underway, and we'll have contracts in place for, at least, two if not three at that

point. And then another section on the transformation strategies that we did address as an initial Commission in 2009 and started to address this year. So I thought it would be valuable to have a status report on each of the 2009 recommendations included in this section. And then our one recommendation related to evidence-based medicine will be included in this report.

And then what we're going to talk about next in this meeting are what other strategies, I'm imagining, we're going to include. Health Information Technology is one of those, but the strategies that we will be studying and considering for recommendation development in 2011 will be described as well.

So this is what I have in mind for the report? Does that, first of all, make any sense at all, and do you have any suggestions for improvement?

COMMISSIONER DAVIDSON: So we have one recommendation for 2010?

COMMISSIONER ERICKSON: One recommendation to the Governor and the Legislature.

COMMISSIONER CAMPBELL: Are we anticipating, as a part of the appendix, a status report? It seemed, to me, we talked about it yesterday or you talked about it on the status of if we determine what the federal legislation might be doing to us in the next year or something like that, the federal health

care, or are we just going to abandon that?

COMMISSIONER ERICKSON: I'm sorry. It's the first bullet under Status of Health Care System Analysis Overview and Impact.

COMMISSIONER CAMPBELL: All right. I spaced it. Thank you.

COMMISSIONER ERICKSON: So I mean, that's what I was asking question earlier this morning, are there other policy recommendations that you feel prepared to make to the Governor and the Legislature in the 2010 report? So Val, is there something that's.....

COMMISSIONER DAVIDSON: Yeah. So now that I've had an opportunity to formulate my thought, I guess I'm wondering in the 2010 recommendations -- and I recognize that we should have something, but I don't know that I feel like I have enough information to say the one recommendation that we have enough information on to move forward is evidence-based medicine. And I guess I would recommend that we do something a little bolder. If we're going to choose one thing, I would look beyond primary care. I would look at substance. I would look at behavioral health issues, and I would look at long-term care issues. I don't know that -- you know, maybe that's a strategy for consideration for 2011, but.....

COMMISSIONER ERICKSON: This is the one area where we have done some common learning together was around evidence-

based medicine with the presentation that we had in the last Commission meeting of the 2009 Commission and then the first Commission meeting of the new Commission last month. And so I mean, I imagining that the section on Strategies Under Consideration for 2011 is, basically, information to the policy leaders but a recommendation to this Body, this is what we're going to continue studying. And so if you want to make sure we add behavioral health and long-term care and substance abuse either for an area for further study or if you have specific strategies -- because what we're looking at next this morning are areas of potential strategies. So if you have specific strategies related to those three areas that you want to propose next or if you want to add it to the list of areas that need studying, that we need to understand better what's going on with those systems, that's there that would go. Jeff?

COMMISSIONER DAVIS: So I'll give you a chance to think again, Val.

COMMISSIONER DAVIDSON: Thank you.

COMMISSIONER DAVIS: So given that we were reconstituted two months and this is our second meeting, I think to me, the only candidate on the docket for a possible recommendation is evidence-based medicine because, as you said, that's the only one we've studied. And it makes sense to, you know, follow down the line of the strawman that Dr. Hurlburt put out -- to

me, it makes sense -- and let you draft something for that and then we can react to it. And then we don't really have to decide today if that's where we end up, but that's, at least, seems to be directionally correct. And then to spend our time really thinking about where will we focus in '11, whether it's studies and/or strategies, and I think when we're saying studies, we're not saying hire a consultant to -- I mean in long-term care for example, we haven't used our own resources to bring people who are knowledgeable in that area to talk with us or to really examine, I guess maybe is another word for it. So the direction that you've put up here makes sense to me, Deb.

COMMISSIONER ERICKSON: And that's a good clarification, too. Just because we've picked a new area for study doesn't mean that we have to hire a consultant to study it and so I might clarify there. I'll write something, but I don't want to imply that these are just the studies. We need to identify areas for studies, and we have enough expertise in the State for some of these areas that your learning will involve -- and this is really what we did, since we had no money in 2009, for learning opportunities were bring local experts to the table. So we had long sessions and multiple presentations on Health Information Technology, on Workforce Development from our experts in the State who know what's going on and could tell us what -- both give the information about the status of the

problem, as well as information on the status of work that's happening in the state right now around planning and development and those areas. So I'll clarify that. If we have other areas for study that we want to learn about as a group in 2009 [sic], some of that will involve just bringing experts to the table, our own experts.

CHAIR HURLBURT: Larry and then Dave?

COMMISSIONER STINSON: I was thinking -- I agree with what Jeff said, but to get back to what Val said, I mean, you could also say supportive in certain areas. For example, Dr. Von Hoften (sp) was here yesterday and I don't think he had a chance to testify, but he is developing a psychiatry residency in Alaska. That is something, I think, we definitely need to endorse. I mean if we're going to be talking about different things, long-term care, behavioral health.....

COMMISSIONER ERICKSON: I'm sorry, Dr. Stinson. We actually in our 2009 recommendations supported the psychiatry residency development and so the Status Report will remind folks of that and explain where that program is at in that process of being developed.

COMMISSIONER STINSON: Good. But again kind of what she was saying too, we could come up with a specific recommendation, but we could also say supportive and still developing in these following areas. And you could even subtitle it the psychiatry residency but behavioral health. I

mean, there's a few things that we're still looking into for behavioral health before we come out with a specific recommendation, but to show that we're also looking at long-term care/behavioral health. We're looking these different things maybe without a specific recommendation, such as the evidence-based medicine, but not putting it exactly in limbo or on the back burner. That would be something that, if the Legislature took a look at it, if the Governor's office took a look at it, they can see that maybe these are the incoming priorities or probably the next things that we're going to address.

COMMISSIONER MORGAN: I believe there were some recommendations on community health centers in the last report, but I think one of the things that I'd just like to remind everybody, since I really like to gum up the works as best I can at any time, community health centers, basically the 25 programs and there are 146 or 147 side, are a system that is taking Medicare patients dealing with the access problem for that, have a sliding fee scale, and could be leveraged to meet some of the challenges for the Affordability Act. And you wouldn't need a study to look or find out about particular things or concepts because you have a Primary Care Association that just loves to do that stuff.

So since we're talking about behavioral health and maybe some other programs, since we have sections on the

Affordability Act and it's impact, access for Medicare patients, and you have a system that basically covers virtually most of the state, that looking at leveraging those assets -- I mean, you really don't have to build that much. The buildings are there, and the equipment is there, but looking at how they connect up and how that's looked at.

We tend to think of community health centers separately, but it is -- if you take the map of Alaska and put all the dots there where they are, it covers, especially in the rural areas, most of the state. I think they're virtually everywhere.

So I don't know what the feeling is of the Commission and I guess it's a little self-serving, since I'm here representing them, but on the other hand since I'm filling the seat, I thought I'd, at least, put it on the record that you have a huge asset there and that it could be leveraged to meet some of your immediate goals and problems you're outlining so far with very little capital investment. At $225 a visit with a whole bundle of services from nutrition to behavioral health to dental in these centers, you may have -- we constantly talk about doom and gloom, but you may have a little -- some diamonds here that you could work with to help, at least, deal or make recommendations to deal with some of the problems we've outlined.

COMMISSIONER ERICKSON: Emily and then Larry?

COMMISSIONER ENNIS: In our first meetings, I heard several times about how behavioral health needs are overrunning the primary care physicians' clinics and offices, that they are treating folks at a high level with a high need. We need to remember that the behavioral health centers in our state are primarily serving those with greatest need, those with severe mental health concerns and needs, and are not getting to those who, perhaps, haven't risen to that level.

So as we look forward with the development of primary, I think behavioral health is a big issue in how to integrate those services, perhaps, at the primary care level to relieve the behavioral health centers and to meet the need. And I would recommend that we consider in our strategies for 2011, again as we've already heard, further study at how to integrate behavioral health services in the primary care system as well as how to fund that.

COMMISSIONER STINSON: I agree with what Emily said. I also think, if Dave could get a proposal or a some kind of an outline how to best transfer what he said into reality that we could look at, maybe we could include that as a recommendation in addition to evidence-based medicine. But I think we need to look at that as a group, which we could actually do between now and the next meeting, even potentially. I would like to look at it. And if there is a good foundation there and it's economically feasible and if it helps an under-served

population, I don't see why that doesn't fit with everything that we're trying to do.

COMMISSIONER MORGAN: I was trying to set up a kinetic transfer -- I was speaking hypothetically. I guess we could probably put something together. I'll get with the Primary Care Association this afternoon on a phone call and see what we can do. They do provide some behavioral health services on an integrated basis. I don't think it's in every community health center, but I know several -- many of them do have a bundle of services and do that. But like I said with these other array of problems, you may have places that can, with some recommendations and some funding like what you're talking about and some connecting here, we could move on some problems at low cost but get a lot of visits. You know, you don't have to build anything. You basically have to fund the veritable costs of doing it kind of, but I like the mind think there. But I will follow up today and get an answer to Deb and the Chair exactly what can be produced and how fast, if that's okay.

COMMISSIONER ERICKSON: I don't know if this is something that I could include in the 2010 report, especially since we won't have met on it. What I'm doing right now is going back and revisiting the list of areas that we want to study in 2011 in terms of understanding the issues in the current system, not in terms of what we study for potential strategies. And

I'm just about to add 330s to that.

CHAIR HURLBURT: Pat?

COMMISSIONER BRANCO: It's really important to note that not every community has a community health center and some of the smaller hospitals are picking up that role, and one of the new phenomena with primary care docs who are, for the lack of a better word, starving to death come seeking employment at our hospitals. And now the Medicare coverage is built into the structure. There are not people turned away. So as part of this analysis, it's important to remember that not all communities are the same.

CHAIR HURLBURT: Yes, Val?

COMMISSIONER DAVIDSON: So I guess one of the reasons I asked the question is, one thing I learned last year is, really, a lot of these conversations that we're having today will drive the final report and so this is our opportunity. And I'm looking at the our last report, and on page 69, there is a 2010 Work Plan for the Health Care Commission, and it seems like a lot of the things that are this proposed 2010 Work Plan aren't necessarily on these lists. And so I'm wondering how.....

COMMISSIONER ERICKSON: So what's missing that needs to get carried over to 2011?

COMMISSIONER DAVIDSON: So one of the things was the behavioral health focus there. There was also receiving a

quarterly report on the development of the Health Information Exchange, MMIS, use of ARRA funding for electronic health record deployment, prioritize, analyze, and develop recommendations on potential access, value, and prevention strategies that was described in part four of our 2009 report.

I guess I could continue to run down the list, but I guess I'm wondering at what point do we continue to reinvent the wheel without taking a look back and saying these were our recommendations from the last report after, you know, hundreds of hours of time and effort and are any of these things on this list still relevant. If they're undone, how do we capture them for continued work in 2011, since we, apparently, missed the opportunity in 2010 due to a lot of restraints, et cetera? Nobody's fault, but how do we make sure that we pick things up and this becomes a moving, living, breathing document that continues to move us forward, rather than spending more time studying and not acting upon our previous work?

COMMISSIONER ERICKSON: I guess I felt as though we were continuing the previous work. The first bullet on this Work Plan was analyze variations in pricing. The second one is analyze impact to national health care reform. The third one was track implementation of 2009 recommendations. So we're doing all of that. The next bullet was implement 2009 recommendations requiring Commission action.

COMMISSIONER DAVIDSON: I'm sorry. You asked for things that weren't on the list. (Indiscernible - away from mic)

COMMISSIONER ERICKSON: So continue studying and develop additional recommendations that support healthy lifestyles, so we can add that to the list. Working on a patient-centered care model, we got just a start with that with hearing from Department of Health and Social Services yesterday what they're doing with that workgroup or workforce. The workforce we were still doing. So I guess -- and maybe we can talk offline because I thought we really were doing these things that you're noting here, and maybe I'm just not being specific enough and asking too many questions. Health Information Exchange and Health Technology, so these last two sets of bullets were related to Workforce Development and Health Information Technology, and I guess I just assumed that we were continuing with that in 2011.

So I don't believe we've missed anything in picking up where we left and moving forward, which isn't to say we can't add things. That's why I've started this list up here, again, to make sure we're not losing them. It's probably just a communication issue. I feel as though we're saying the same thing but disagreeing. So what do you see as missing?

I'm restarting the list of studies for next year, and what I was really trying to get yesterday was making sure that I had direction from you in terms of contracting that I needed

to get started, but was just assuming that we were continuing with these other areas for future study as we went into the next year. But again I've said several times today I've made way too many assumptions and I need to be way more clear and specific in my communication, but I'm capturing them now and they'll be on the list and described in the report.

CHAIR HURLBURT: Wayne?

COMMISSIONER STEVENS: I would follow along with what Val was saying and just caution us that we're going to put so many things on our agenda and our focus is going to quickly get diluted that we're not going to get things done because we'll continue to add to the list, add to the list, add to the list, diluting now our focus of our limited resources and very limited staff resource, and we then are not able to articulate very clearly that this is the singular or three most important things that the Legislature or the Administration or the consumer should be working. And lots of things on a list doesn't necessarily make one successful. So I just would caution, I guess, that we -- identifying lots of things to work has some benefit, I guess, if you have lots of resource, but I don't see lots of resource. And if we don't stay focused and narrow in our attempts, we're going to just spin our wheels in a way that is meaningless.

COMMISSIONER ENNIS: I think that's an important point, Wayne. I'm continuing to feel a little overwhelmed by all the

work to be done, and I have to remind myself that Deb has offered to put some timeframes on some of the work, but I do believe we'll need to prioritize.

On the other hand, I hate to lose some of this, too. So it's a conflict here. I think what we have added -- the items we've added are extremely important and they have implications for our first priority. So part of what we, I believe, need to do is to be practical and prioritize but understand that we have five years. We want to show we're doing something along the way, that some of these other elements that are so critical will be folded in, perhaps, in a planful way.

COMMISSIONER LAUFER: I'm going to beat the drum again. On the pyramid, the patient-centered primary care/innovative care issue really needs to be the center of it. Well the community health centers are helpful. That's designed as a safety net. It's expensive, taxpayer-funded, and not where -- if we're successful, fewer people go to those clinics. And if we're successful, fewer people go to very high end expensive hospitalization clinics. The answer to that is primary care. I mean, there are political forces and financial forces pulling people to the extreme, which are expensive, and what we need is to push people back towards the center. If I am involved in a person's care, I refer them and I try to get mental health care for them. I definitely am in favor of long-term care. I would infinitely prefer that over expensive

hospitalizations until death, which are easily a million dollars per person. You know, it has to be patient-centered and a team and that's really why we keep coming back to this. How about, you know, we stick to that and then say, because of that, all of these other things follow? It just makes sense.

CHAIR HURLBURT: Dave?

COMMISSIONER MORGAN: Well but we also have other considerations, such as access, dealing with the access for Medicare patients that can't get a physician, and I know that the community health centers are currently redesigning to become patient-centered operations and it's their highest priority. In fact, I know they went down to the national meeting to work on that. But everything you say is not false. It's just that there are other things on the plate, such as Medicare's getting access to primary care, mental health activities getting access to an integrated system, and individuals who are not insured being able to get in for primary care and physician care. And I think though the 330s are not the first on the list, I think next year we should have recommendations for the State in order to leverage those assets to meet those needs. Maybe financially after looking at it and looking at the data, they are not cost-effective, but I think they should at least be looked at. A study doesn't have to be done. We have a very competent Primary Care Association that can pull together the information needed

and the numbers to come in to do that, but we do have those other things on our agendas and on our list. And I think we should, at least, have some recommendations to help move us along in the area of those two other areas.

CHAIR HURLBURT: Noah?

COMMISSIONER LAUFER: This issue of access to primary care for Medicare patients is a really critical one and it is an excellent example. I'm a member of the APS Board and put together the Medicare clinic. It's a terrible issue. We see about 11% at my clinic. We don't not see them because we discriminate against them. We don't see them because we are not fairly compensated for them.

The Medicare clinic, which may possibly survive, got a million dollars from the State, is getting in-kind services from the hospital, gets a higher rate of reimbursement than we do, and is getting rent for free for two years. This is to possibly make this model work. If we were adequately compensated, we would open the doors, but we can't. I have a financial responsibility to my partners and employees and patients to stay alive.

Providence advertised a Medicare clinic. It's now a Senior Care clinic. They're recruiting 50 and above. It just happens to be the most lucrative decade-and-a-half of your life to care for people, and they know they're going to subsidize it. You don't have to reinvent a new clinic, if

there's just fair compensation for it.

The bill that was introduced by Mark Begich and then Les Gara wrote about in the paper this week is very helpful, but it's not enough. The Boomers have the largest accumulation of wealth ever in the history of the planet. If we were allowed to balance bill or whatever, that would solve a lot of problems in Alaska. We would write off the rest of it. We are trapped by legislation designed to protect vested interests, and if that goes away, there will not be an access to care problem. I would love to see them. I mean, I grew up in this community. My parents, all my retired partners are on Medicare. I would like to see them, but I can't go out of business. We don't need to have a substandard clinic built up that the taxpayer pays for at high cost to do what we are already set up to do cleanly and efficiently.

I can't -- you know, you can't overstate it. It gets said again and again and again, but we have pushed people to the margins, rather than just let the problem solve itself.

I'll tell you one more. I saw a patient I've known for a long time. He's a long-term patient at the clinic. He was my father's patient. He came to see me. He left a tip. He left $40 on the table. I told him not to; I have to give it back to him. It's Medicare fraud. But people realize what the problem is, and if they were allowed to, you know whatever, some salmon would be fine, but we are not allowed to do that

and that's why it's not happening. So we're going to create separate additional layers of complexity and expense to deal with the problem that, if you get out between the patient and the doctor, would be fixed.

CHAIR HURLBURT: Thank you.

COMMISSIONER LAUFER: Clearly, I'm upset. Sorry.

COMMISSIONER ERICKSON: We're getting ahead to debate about recommendations we'll be working on a year from now. So we will study this over the next year and continue this discussion.

So now I've listed up here on the flip chart the two areas where we know for sure we're moving forward with the contract. I did not put the Federal Reform Impact Study because I'm thinking of that of a 2010 study. We'll have the report by January, and you all had a presentation last month on, basically, the information we're going to get in that report.

So then the consulting work that we'll have done on health care expenditures, on health care pricing and reimbursement are listed. It's still a question whether we're going to forward with some sort of consultant study on health care service utilization, but we'll be answering that at some point in the future. And Workforce and Health Information Technology and Patient-Centered Primary Care were givens, in my mind, that we would be doing some learning around, but I

have added now too long-term care and behavioral and defining mental health and substance abuse and both of those things together in behavioral health. And so what I'm imagining these things that don't have a C next to them -- C for contractor; we'll hire somebody to do a study for us -- is that, at future meetings, we will bring experts in these areas to the table to make presentations to us. And if we decide we need additional consultant help in the future to learn more about those things, then we can do that.

So for further study in 2011 just so we understand the system better -- and then the next list that we were going to go over was areas of potential study to consider as specific strategies for health care system improvement.

And so I'm going on to slide 33 and this was a ten-page section of our report from last year. This is a bulleted list of the potential issues, and it was not meant to be exhaustive at all.

I'm sorry. I forgot I've been adding slides as we've been talking this morning. Sorry about that. So it might be easier -- I don't know what's easier to see. Either one.

So the color-coding here, green was two areas that were a given that we were going to continue. Evidence-based -- and again I was making assumptions that I probably shouldn't have made, but assuming that we were going to continue studying that. I didn't think we were going to be able to get too

specific in this year's recommendation and that folks would want to learn more. Analyzing the cost of care really doesn't belong in this list of strategies. We just didn't want it to get lost in terms of the cost concerns and understanding that. Fostering primary care innovation is something that we'll learn more about this next year under this plan.

And then I mentioned I'd received two responses from you all before this meeting asking -- in response to my question about what you want to focus on next year in terms of potential strategy. One was just a general access to care, which we need to get more specific in terms of strategies. I have some suggestions on the next slide. Actually not suggestions, just ideas, again, to prime the pump.

And then this other area here under value, leverage state purchasing power was the highest priority. Bundled payment systems was the second. And then increased cost and quality transparency was the third potential strategy that this particular Commissioner suggested we study next year.

So I will open it up for discussion. Does anybody want to add anything to this list? I'm inclined to, just based on the conversation yesterday -- and maybe this is a specific strategy under public health and community-based prevention. I sensed some real interest from all of you in the conversation yesterday in pursuing -- potentially learning more about and maybe developing a recommendation around the

health information, the online health data and information system. Is that something that you would like to add as a potential strategy related to public health and community-based prevention?

CHAIR HURLBURT: I see several nods. Anybody that has a different take on that?

COMMISSIONER ERICKSON: So I'm just adding it to the list now. I'm not prioritizing it. I just don't want to lose it. And we also -- Workforce, in developing Workforce, there is no specific strategy there, but as a placeholder, but we probably should have a placeholder. And because of the way it's located in our statute, I'm just going to throw it under value for Health Information Technology.

So this is our list of potential strategies. We did not -- as information for the folks who weren't with us last year and a reminder for the folks who were, we did not, in our first year, spend much, if any, time talking about access to care primarily -- at least my understanding was the reason that that kind of got set aside was especially specific to access to insurance.

One of the questions that kept coming up early on was, well what about what's happening with national reform right now? And bills had been proposed. Halfway through the year, the Senate passed the bill. Actually no; it was December. It was just as we were ending that that bill passed, and we

didn't know it was going to happen, but we knew that federal reform was very much focused on access to health insurance. And it didn't seem as though it would be a good use of our time, just in prioritizing how we were spending our time, to investigate the issues related to health insurance coverage and develop strategies related to that because we didn't know how our world was going to change, if it was going, and how it would change. We got a start with Workforce as an access to care issue. We did not get into any specific services, access to care for specific services, such as long-term care or behavioral health.

So I just wanted to explain why there are no specific strategies, ideas for specific strategies that were included in last year's report -- and if we're going to start looking at some specific strategies and studying them next year. And I just threw down some ideas on the following slide which, I guess, would be your slide 32 related to increasing insurance coverage. That might be one we would just want to keep set aside for now until we understand how federal law implementation is going to play out and just thinking about the resources we have available. Developing the Health Care Workforce, I think it's a given we're going to keep working on that. But if you want to suggest a particular strategy that we study for this coming year now, we can do that. And then I just listed some areas where we might have questions about

access to specific services. Yes, Wayne?

COMMISSIONER STEVENS: Just a quick question on the Workforce. Why would we undertake studies on Health Care Workforce when we've got another group already working on it?

COMMISSIONER ERICKSON: Well for the area for further study in 2011 where we referred to Workforce, one of the things that I want to do is sit down with the Workforce Coalition folks and talk about where they're at with developing the strategic plan to implement their more comprehensive plan and identify -- if nothing else, bring that additional learning to all of you, but then to see there is something that this Commission could do to add value to what they're doing and vice versa, if there some way we can align forces to continue learning and maybe share some resources.

COMMISSIONER STEVENS: So we're going to avail ourselves of their expertise and their work and dovetail whatever we do with them so we're not replicating or duplicating?

COMMISSIONER ERICKSON: Exactly. And I think is where, yesterday when we talked about what our coordination role is, we're identifying specific areas of focus that we're working on that one of my responsibilities in our coordination role is to be scanning the landscape and making sure that I understand what other groups are doing, but this one is really obvious. We definitely don't want to duplicate any of that great work and want to make sure that we're supporting and working

alongside them and learning from each other.

CHAIR HURLBURT: Pat?

COMMISSIONER BRANCO: Are you going to go back to the previous slide after we -- because I have one question from slide 33 on your list and now I can no longer read it?

One area of clarification is -- and it was submitted by another Commission member -- the increased cost in quality transparency. I think it's really, really critical, to me, that we add price in there. Jeff's illustration yesterday of that air ambulance cost, the price was at issue, not the cost and so adding the transparency there.....

COMMISSIONER ERICKSON: You know, I've been using -- and I shouldn't -- that's why I was, at least, clarifying when I was talking about costs that, in our big picture study, what I was imagining was expenditures. So I think I will just change this from cost to price, rather than add it.

COMMISSIONER BRANCO: I appreciate it.

COMMISSIONER ERICKSON: Thank you for that clarification.

CHAIR HURLBURT: Jeff?

COMMISSIONER DAVIS: So I've lost total track of which slide was which, Deb, but the one you just had up. I think for 2011, you were just throwing some things down. Two thoughts on that.

One is, you know -- well there's more than two, but I'll try to limit myself to that. One is, yes, federal reform is

all about -- it's really insurance reform. It's not -- that's the majority of it. So we don't need to spend time really on that, unless we get to the point of saying how should it look, how should federal reform be articulated in Alaska?

I was having this conversation earlier that there are 5,000 open at HHS if anybody is interested right now. Probably may be de-funded, but the ability for HHS to promulgate specific regulations on a lot of areas is just not going to happen and so that nature (indiscernible - voice lowered) a vacuum there for -- it will be left to states to fill in a lot of things, and this is going to be like anything else. You can do it in way that may work and be sustainable or you can do it way that's going to be a disaster. I mean, we only have to look at Washington State in the '90s and the collapse of their individual market to see what the danger is. So if those things are left to us, we may have a role as a Commission in helping to define how a sustainable system would work, for example, guarantee issue. We all know guarantee issue is non-workable. If I could drive home today and see my house is on fire and call Allstate or whomever and say I want full replacement policy on my house and they had to sell it to me, they would quickly be out of business. I mean, we all understand that. Well if I get diagnosed with cancer or the call is being made for the Medivac and I sign up at the moment for, you know, insurance and get a $157,000 bill, and then

after I get out of the hospital, I drop it after paying my $500 or whatever for a month, that's not a financially viable model. So if Alaska has the ability to say, you know what, you can sign up regardless of condition, but it's between January 1st and January 15th or -- I'm making this up -- July 1st and July 15th, and by the way if you drop your coverage in less than two years and you're out for two years -- you know, things like that that would make it a financially sustainable model -- if we have a chance to weigh-in on that, I would like to see us not lose that opportunity. So that aspect of insurance may be in our prevue.

I also wanted to just point out though that access to insurance is not access to care, and I appreciate what Dr. Laufer said, that it is -- you know, access for a Medicare member is I cannot get care where I want to or where I have before I turned 65. I don't see that on our list, and I think we should keep it on the top of our list. I know it's a David and Goliath issue, you know, taking on the federal government, but that's a very real problem today and I would like to see us focus on that.

And this is the third point, and I said I was only going to do two. Access to insurance exists today for every single Alaskan in existing Alaska law. That's not the problem. The problem is affordability. Anyone, anyone, regardless of condition today, can buy a policy. Now you may have a pre-

existing condition exclusion for six months, but you can buy a policy, but people can't afford so that's the issue. So enough said. Thank you.

COMMISSIONER ERICKSON: Jeff, could you clarify for me or maybe make a specific example of a new bullet I could add related to your second point?

COMMISSIONER DAVIS: I'm not sure what it would like, but it's a continued focus on Medicare or access for Medicare patients. We talked about that last year. A couple things have happened, but I think Dr. Laufer said the root of the problem. You know, there is this -- I was sitting here trying to think now why is that the rule, and I don't think a lot about Medicare in my real job. But if I'm the federal government, why do I make it illegal for a patient to pay more than what Medicare will pay? It's not illegal for a Premera Blue Cross patient to pay more than Premera Blue Cross will pay, so why would I do that? Well maybe I'm trying to create access, regardless of ability to pay as the federal government. Well in fact, I've created the opposite. I've created a lack of access, regardless of the ability to pay more. Or maybe I'm doing it to prevent greedy providers from, you know, overcharging poor Medicare patients.

In 1964, what was life expectancy, 67 years old or something along those lines? It's not 81 or whatever it is today. And so you know, that articulation was the clearest

articulation of kind of the structural issue behind what we are facing that I've ever heard and I appreciated it. So I think that needs more exploration.

CHAIR HURLBURT: The second bullet here on the flip chart, I think, is intended, in part, to address that issue, to understand the issue of pricing and reimbursement, and you know, why can't we see patients based on Medicare reimbursement rates? But I think you're saying this is clearly such a big issue, particularly in the Anchorage area, with lack of access for Medicare enrollees related to the federal reimbursement structure that we do need to keep that on our horizon because that's been a very prominent issue here and continues on. Val?

COMMISSIONER DAVIDSON: So I really appreciate this -- the whole first category of bullets of increased insurance coverage and tying that back to the health reform Affordable Care Act implementation because, I think, knowing that it may be available federally and that it may be authorized federally doesn't mean that Alaska is going to implement it, nor does it mean that we know how those things are going to be implemented.

I'll sort of relay a conversation I had. Just the other day, I was asked by a person I know, so how is the State planning to implement the Affordable Care Act options and et cetera, et cetera, and I said, well I think that's still a

work in progress; I'm not really sure. Her response to me was, but aren't you on the Health Care Commission? Isn't that, like, a major issue? Isn't the implementation of the Affordable Care Act the biggest health issue that Alaska is facing right now and so how much time are you guys actually spending on that issue? And it was a little bit of an eyeopener. So I'm glad to see that those things are on, and we could get into a very healthy, hearty, lovely debate about whether that person is right about whether it's the biggest issue. I think it's one of several, but I think the issue of what this Health Care Commission's role in determining and helping to shape how the State will or won't implement certain provisions is something that we should not lose sight of.

CHAIR HURLBURT: Noah?

COMMISSIONER LAUFER: I'm sorry. There are these things. That's exactly what I meant yesterday by, you know, we're flying 50,000 feet looking down on clouds. Who knows?

The big difference between what I'm asking for, and I think a lot of other things, is the private physicians and clinics, like us, we're not asking for federal money. We're not asking for state subsidies. We're not asking for any programs. We're asking for less regulation, fewer laws. Just leave us alone and let a patient come in and say, hey doc, you don't look busy; I've got $100. And I'd say, you're right; I'm not busy. What can I help you with? That's so much

cheaper than these many, many layers of things.

The other that is a crux question that nobody even wants to talk about -- you know 200 years ago, nowhere in the world was life expectancy greater than 40 years. And when people ask me about diabetes or hypertension or high cholesterol or whatever, if you only live to be 50, big deal. You know, it isn't a big deal. We do not live natural lives. We live extended lives of great luxury, in general, with access to food beyond what we should consume, et cetera, et cetera. If you take that model and you say we're going to live 90 years or 85 years on average and our goal is to have a high quality of life, it could well be that that costs 23% of the GDP to keep people healthy. But that would be fine, if that's what we're actually buying, and that needs to be redefined. You know, these are huge, huge issues that are going to happen nationally, but they have impact. That's really the question.

CHAIR HURLBURT: Jeff, did you have another question?

COMMISSIONER ERICKSON: I think Dave had.....

CHAIR HURLBURT: Go ahead, Dave.

COMMISSIONER MORGAN: I guess the issue over regulation versus fewer regulations -- but the whole concept of the Affordability Act, all 2,700 pages of it that mention the Secretary of Health and Human Services shall promulgate regulations on over 1,000 times, bodes, to me, that there will be more, not less. How much can the state of Alaska and a

Health Care Commission for the state of Alaska affect that? We can point it out. We can make recommendations, but the reality of the situation -- like we have a Medicaid Task Force that is looking on short-range activities, specifically the Medicaid. We're looking five years or one years or two-and-a-half years. But the issue of access and these other issues, sometimes you have to triage and do what you can with what you've got now and then try to plan out to change and make things better with our goals of higher quality and more access. But the reality is Medicares can't get access to primary care in a lot of situation, and we need to look at the short-term and the long-term. In a perfect world, yeah, but I think we have to -- as Buddha would say -- not Aqua Buddha but Buddha -- that we've go to take the world as it is and function as well as we can in happiness. If we try to change the world where we have no hope, unhappiness.

So there is room for all this, but on the other hand, we have to recognize that we have Medicare -- just one of many -- patients. We had one in the audience yesterday that was having great difficulty getting access and then he is working with Anchorage Neighborhood Health. So yeah, we all know the problem. I've seen the studies. The average cost -- a real cost of a Medicare visit is about 35% more than what they're reimbursing, if you take it statewide or regional-wide. And we can talk about it and do what we can, but that's a federal

issue, not a state issue.

COMMISSIONER LAUFER: The issue that the gentleman in the audience yesterday -- if I had said, boy, he seems like a nice guy, I really feel for him, and I'm going to see him, I have broken the law. I have breached an existing contract or policy that we have at our clinic. I turned away a doctor recently who I have known my whole life who grew up in this community who is like most doctors and ignores his health, and just at 70-something, realized he needs a doctor. I can't accept him. This is exactly the kind of law that should not be there. You know, I should be allowed to cherry pick. I cherry pick my patients as it is now. I take care of people who I like, who I work well with, who act like adults with me, who don't lie and don't abuse narcotics. That's a reasonable thing to do. It's therapeutic to them. And you know, you're right; we can't change the federal government. However we do have Senators. We have Congress people. They can be effective. Time is ripe for change. Every politician I have spoken to in the last decade is desperate for any suggestion that might provide any sort of relief and that needs to happen. And we're a body that was put together to provide advice. I'm going to stop.

CHAIR HURLBURT: Jeff?

COMMISSIONER DAVIS: And I won't pick up the course, but with respect to the Affordability Care Act, my point was, as

you pointed out rightly, Dave, 1,000 times it says the Secretary shall. The Secretary needs help to do that. The Secretary has got 5,000 empty positions. A lot of things aren't going to get defined, which, I think, creates an opportunity for Alaska to define them -- preemptive strike. We've already got it set up. It's done. Go away. Leave us alone. And I think a lot of states are going to be doing that. It's going to be very hard for HHS to corral that back in and that's where I was seeing the opportunity for us, as the Commission, to have an influence. Thank you.

CHAIR HURLBURT: Val?

COMMISSIONER DAVIDSON: Can I just clarify something? I agree with what you said. I wasn't recommending that we write letters or respond to every blessed regulation that comes out because none of us have that kind of time. What I was looking at -- my comment was I was glad to see that those things on your next slide that were dealing with increasing insurance coverage, that were related to the Affordable Care or elsewhere are going to be addressed as strategies by this Health Care Commission so that we could have a conversation out in the open about whether Alaska should or should not implement some of the potential options for the State and make those recommendations out here in the open, in a public meeting, rather than in some closed door somewhere by a small group of people. I think that these issues are significant

enough that the warrant some thoughtful consideration by someone in a very public way, and if not us, then whom? And I'm not necessarily a fan of making all kinds of new laws or new regulations, but we should all recognize that, sometimes, those laws, as challenging as they may be, are there for a good reason.

I'll give you one example, HIPAA. HIPAA is just so incredibly challenging, and God bless us all. When we were implementing policy changes where I work, we heard all kinds of challenges and complaints and issues with people. But as a child, I remember in the village that I lived an announcement that was made everyday on the radio that went like this at 4 o'clock, would the following people please report to the VD clinic, and would rattle off a list of names everyday at 4 o'clock. And so guess what everybody did at 4 o'clock everyday? Everybody turned on their radio.

My point simply is that laws and regulations are designed to address a perceived need and a perceived gap. Maybe sometimes they go too far. Sometimes they don't go far enough, but you know, I'm not suggesting that we comment on every new regulation that comes out. I'm just suggesting that as we, as a state, consider our future health care delivery system and what that might look like in the realm of the Affordable Care Act opportunities and challenges, how are we, as a group, going to influence that process and how we move

forward as a state? And I would suggest that it happens here in a public meeting, in a public way because the stakes are just too high.

COMMISSIONER MORGAN: I guess as I remember -- and I can't remember who said it, but there was -- it was someone from the State that was it was 200 or 300 different items that the State needs to address to meet those. I guess when you're talking about 200 or 300, I'm assuming what you're meaning is pick the major or the things that are good, bad, or indifferent that hit the most people or address the most things. So I guess probably our Chair would -- I don't know. Is that how the State is doing it, they have maybe a division or area or a checklist of what they're going to do and how they're going to do it? And then is that how they're going to process this internally?

CHAIR HURLBURT: As Nancy Pelosi said, we have passed a bill; now we can read it and figure out what's in it. And that was very true. It's a bill -- there are actually three bills. And depending on the font size and so on, it's 1,000 to 2,000 pages. The expectation is that there will be about 200 pages of regulations for each and every page of that bill. So it's going to be huge. And as Deb mentioned, it is primarily addressing an attempt to address health insurance reform with a bias that the health insurance industry is a predominant bad guy in the whole picture, and that if we can

reform them, that's what we need to do. I would say that there are certain aspects of it that have the potential for some health care reform, but really not much in that. And that's why, at our last meeting, I kind of let into, saying that, I think, there is the danger that, if we get into too much of the who (indiscernible - voice lowered) on the health care reform, that will consume us and that we clearly have to be cognizant of what's happening and what's in it and what's coming down the pipe. We cannot do that without exercising our function, but there is the risk that we can become consumed. And if we are to engage in looking at what are options, what are our opportunities for true health care reform here in Alaska so that our health care system serves the needs of Alaskans the best we can, that we need to guard against being so consumed in this other that it prevents us from doing that. And I don't think that's really taking exception to what Val said at all because we can't ignore it because it truly is there and we do need to be cognizant.

Now what is happening, there are other groups who are looking at it. There's a group with folks from, like, the State Hospital Nursing Home Association, Commonwealth North, I think Denali Commission, some others on there that are looking at that. They've brought in folks from various areas within the state government. As Deb mentioned yesterday, there is Alaska Patient Protection and Affordability Care Act Impact

Team that's looking at it, that's being cognizant. There are spreadsheets that are tabulated of the various grant opportunities that are available. We've found a lot of the early ones, a disproportionate share of the early ones really impacted on our Division, on Division of Public Health, but when you looked at them, most of them were really continuations of things that had happened. And so we have kept track of that, so we know what the opportunities are.

By and large, the State has gone after all the opportunities that were there. Most of them were ones that, as I say, were just continuation of what we had. There were three or so exceptions to that.

One was a million grant opportunity that had to do with looking at what is the pricing for insurance plans and what is being done in the commercial insurance field, and basically, Linda Hall took the stance that we should not go after that because she had a need for IT type system, an automated system to get information there, but the limitation of that grant was that no more than $50,000 could be spent on that.

Secondly in this state, Premera is the dominant commercial insurance carrier, has more than 70% of the business. She gets all that information from them now. And the number two is Aetna with, what, less than 10%, so they're pretty small. So that really wasn't going to help her. And the reporting requirements were going to be really onerous

there.

Second was the grant, a potential grant related to the exchanges there, and we decided to do that. Now as with some of the other governors of these 20-some states that are challenging the constitutionality of the law, Governor Parnell said we want to have oversight and be cognizant of what's happening because we don't want to look stupid that we have made a decision that we believe, as a state, that I as Governor, that Attorney General Sullivan believes that there are some aspects of this law that are unconstitutional and we're going to challenge it. So quite frankly I think, there had been some pressures coming from Health and Human Services in Washington to make it difficult for the states to do that, say come on, guys. But I think that there probably has been some intent to put the states that are challenging the law in somewhat embarrassing positions. So the Governor's office has said we want to look at that. That has not kept us from doing things, but I think that it has helped try to assure that the State, as one of the challengers, is in a more defensible posture there.

On the Exchange, there have on been a couple of states that did turn that down at that point, but that decision was made because it could compromise the State's position. The only other one that I'm aware of that we turned down was a relatively small grant that was an abstinence-only type

program, and this had significant reporting requirements that were going to be difficult. It also required matching money, which we did not have, and it was a small amount. In declining that, the reality is that our programs now with, like, teens is a comprehensive program which does include sex education, but it includes abstinence training. So we are doing abstinence training now with that.

And to my knowledge, there may have been more that I'm missing that Deb's aware of, but we have not missed the opportunities that were there, but we've been pretty diligent about trying to keep track of what the opportunities are.

COMMISSIONER MORGAN: Mr. Chair, you're misunderstanding where I was going with it. The State has a process. I'm assuming the process is these are the things, these are the grants to help you implement and transition into the national legislation, these are the things you have options to doing or not doing, and then there are some things you have to do. And I'm assuming that the state of Alaska has those lists and they're broken up, so there is -- the Governor or someone has a report that says here are our options. We've decided to take these options. Here are the things we have to do and here our timelines to meet those -- Deb's going like this -- and then here are some things, regulations or other activities, that are optional, and these, a third category, you have to do, and this is where we are, and some of them are

optional. They're not grants, but they're optional things. And some of them we do and some of them we don't because they're an option and that decision has been made. So someone is keeping a list, an inventory of the process. So it's not an issue of them missing -- I think the State missing anything. I think the issue is, how do we keep -- if the Commission is going to talk about these things, the process of finding out and then discussing them. And I know there is hundreds of them, and culling out the biggies versus the little ones, and I mean, that's another whole meeting, I bet you. But I'm not saying don't do it. I'm not saying to do it. I'm just trying to get an idea of process.

CHAIR HURLBURT: Yes. The lists are there. The list is there, an overall list. But in addition, each division, like Division of Public Health, keeps their own and monitors that to make sure that we're not omitting something that we shouldn't. There is a central that comes together and then that group keeps the Governor's office informed through Mike Lesmann.

COMMISSIONER ERICKSON: Can I offer what -- we've got about 20 minutes left in our meeting, assuming we're going to end on time, and we don't have lunch coming today since we're going to end at noon. So we can go late, as far as I'm concerned, but folks have planes to catch, meetings to be at, patients to see, so we will end at noon, but I don't know if

this is a compromise, but let me explain to you what I imagine we're doing.

I'm hearing pushback against an understanding of a suggestion that we get involved with analyzing and making recommendations about state implementation of Affordable Care Act provisions, but also hearing -- I guess this is what I heard at our last meeting when we made the presentations, Mark and I, on the Affordable Care Act. What I felt I heard from this group was that it's going to be important for us to understand how the health care world is changing as a result of the Affordable Care Act, but I did not hear a suggestion that we do anything more specific to the Affordable Care Act than understand it. I see nodding heads, and let me just finish my thought.

What I was imagining that we would be doing is, as we identify strategies that we think are important for improving the health care system in Alaska, that I was being especially mindful of pulling out information for all of you on how the Affordable Care Act impacts, in some way, that particular strategy. And the next step following, to the extent we've outlined -- now we have two pages on slides of potential strategies that we might consider. I'm fairly certain -- it's not down to a real detailed level. For example under public health, it doesn't list every single grant opportunity that's available through the Affordable Care Act, but at least in

terms of a general category, I think, we've probably listed here almost every strategy at a high level that's covered by the Affordable Care Act.

So to the extent that we are identifying the things we think are most important to study as a potential strategy and then understanding -- and if we think it's important to make a recommendation to the Governor -- for example on the Health Insurance Exchange, the State set aside, as Ward explained, the first opportunity for planning funds for the Health Insurance Exchange. But if you all want to identify Health Insurance Exchange as an important strategy to consider for Alaska, you may or may not want to make a recommendation to the Governor after you've studied that, and it may or may not be specific to the Affordable Care Act or doing our own thing. But does that make sense in terms of how we'll address the Affordable Care Act?

In response to the question that Val was asked, I've been asked -- I know I'm going to hear it in legislative hearings this year -- what is the Commission doing? This is the Commission's responsibility. So far my short response has been the Commission is a group of Alaskans identifying strategies that are going to work for improving Alaska's health care system, and we are and will be continuing to work to understand how the Affordable Care Act plays into the strategies that we'll consider and will impact our system, but

it's in our charge to analyze and make recommendations specific to the Affordable Care Act. So that's how I've been responding to it and that's how I've been seeing it play into -- and I don't believe that that's counter to what any of you are saying, but we need clarification. Val?

COMMISSION DAVIDSON: So I guess my struggle is that it's not knowing what's in the Affordable Care Act. I mean, I do presentations all the time about what's in the Affordable Care Act, how's it going to impact the tribal health system, et cetera, et cetera.

The piece that none of us knows is, what is the State's plan for implementing certain provisions? Are they going to go yes or no on this? What's our timeline for Medicaid expanded care? What's our timeline for -- is it something the State's interested in? What are the timelines for moving forward? What are those decision points? And I think that's -- knowing what's in the Affordable Care Act is a starting point, but it doesn't answer the question of, what's Alaska going to do with that, what's this Health Care Commission's role in influencing that process or making those determinations or making recommendations, and whether we like it or not, the whole Affordable Care Act is going to implement health care as we know it in Alaska. And the question is, how much information do we want to be able to make an informed decision? And I just want to make sure that we -- right now,

there are a limited number of resources that are made available nationally to implement the Affordable Care Act.

I just want to make sure that Alaska is not unintentionally subsidizing the health program of another state because, if we choose not to pursue a grant opportunity for whatever reasons -- and they may be absolutely legitimate reasons -- if we are not availing ourselves of those resources, that means another state has those resources. And given the incredible needs we have in our state, I just can't believe that we could possibly be contemplating that.

So again I want to go back to what I said before which is, what is our role in determining that? How do we decide, as a state, and how we make recommendations on some of the big things? And I'm not talking about, again, digging into, now today's meeting we're going to be on page 2,109, and by tomorrow, we're going to be on 2,110. That's not what I'm talking about. I'm talking about the big things, like Medicaid expansion for childless adults. Is that something the State should do? On what timeline? Should we do it early? Should we wait for the mandatory date? Are we going to avail ourselves of the early option incentives, et cetera? Those are really big considerations for us as a state, and if we're not having those conversations here in a public way around the table, we will have done our state an incredible disservice.

COMMISSIONER ERICKSON: This is getting back to prioritization within our resources. Using the example of the Medicaid expansion that's on our list, if we use as a starting point -- if you want the Affordable Care Act timeline to drive the strategies that you want to consider, then I will layout a timeline for you about how that will happen. But if you want to pick the strategies that you think are most important, we'll use that as a starting point. Look at both?

So what I will do is put together a table that will be kind of a crosswalk between strategies that we're considering now and implementation dates for -- at least one of the challenges we would have run into -- and I don't know how this will play out in coming years, but for the first federal fiscal year in which the law was implemented, these grant opportunities -- I saw, Val, you were just looking at the table of all of the different grant opportunities. Those grant opportunities were becoming available and were out on the street for three to four weeks, each one of them. You had three to four weeks to make a decision whether to apply, and then write the application if you decided to apply for it, and get it turned in, and there was no up front warning. One of the questions we kept getting was, give us a list of when all of the grants are going to be. It was, like well, we update this list on a weekly basis. We'll let you know when they're going to be, but we don't know until it happens. That might

change in the future, but part of the issue -- if we're talking about making recommendations on specific funding opportunities just operationally since we meet quarterly, it might not be realistic. But if you're talking about big picture policy questions, should we have an insurance exchange, should we and how should we participate in Medicaid expansion, I can have that timeline laid out, aligned with these big picture strategies and probably not in time for our 2010 report, maybe for the 2010 report. I don't think it's going to be that hard, but I've got a lot of writing to do.

COMMISSIONER DAVIDSON: That's exactly what I'm looking for, and I know those conversations are happening because that group of people is meeting. And so my question is, since they're already having those conversations and that group of people is meeting, a part of it is, in addition to what you just described there, have them come here and let us know here is sort of what we're thinking. These are the variables we're considering. Here's how this plays out. These are the implications for Alaska. By the way on these ones, we thought great idea, but the requirements and reporting requirements are so incredibly burdensome, it's going to cost us $2.0 million to get this $50,000 grant. That's perfectly reasonable. But my point is that those conversations are happening, and I would just like to hear some of those conversations and what folks are thinking here.

CHAIR HURLBURT: Dave?

COMMISSIONER MORGAN: At the last meeting, we did get some of that. As long -- I'm not saying and I have never said that we shouldn't deal with it. I'm saying let's deal with the 10% or 20% that affects 90% of the activity. It's the way everything is, and there's always 90% or 80% that affects 10%. As long as the State's reporting, which I know they will -- we all know they're working on it. They had short timelines to make a lot of decisions, especially up front. As long as we're dealing with the big things and we're not dealing with 256 different process points, if it's the top four or five that make up 90% of the big bucks where the big change is, yeah, but on the other hand, sometimes you can get into minutia and not get anything else done is the whole point I've been trying to make, not not do it because we sort of have. I mean, Bill Streur came in and talked and the guy in charge of the management information did. I can't imagine that there won't be a -- I never imagined that there would not be updates for the Commission, where we are on the big stuff, or am I incorrect?

CHAIR HURLBURT: No, I think that's correct and I think that that has been happening, to some extent, maybe somewhat informally, like I just answered your other comment with a much longer response than you were asking for. But you know in terms of these people, we've had a lot of these people

here, like Bill, like Deb, like the Commissioner would have been here, like myself. So I think that, as far as keeping us up-to-date as a Commission, that's been the intent and a part of being aware of the environment that we have, and I think you know, that's totally right and important to point that out.

COMMISSIONER DAVIDSON: So I think I have a recommendation that will solve this issue, that we have an Affordable Care Act update, implementation update at every one of our meetings. It should be on the agenda. It was not on this agenda, and it should be on every single meeting from here on out.

COMMISSIONER ERICKSON: For those of you on the phone, we've made an assignment sheet and flip chart related to the Affordable Care Act, and the first item is that I'll develop a matrix that will be a crosswalk between strategies that we're considering as a Commission and strategies proposed in the Affordable Care Act. And then after that, we will invite Department of Health and Social Services and Division of Insurance leadership to come make -- give the Commission an update on status of implementation and what the decision making process is, and that crosswalk will include a timeline as well. Sound good? Very good. Thank you. That's a very helpful discussion.

So just quickly back to our lists of potential strategies

on your pages 31 and 32 again of your slide handout, but I've modified it so I'm just flipping back and forth and hoping that, at least, folks around this table furthest away -- Keith and Pat, can you read the small print okay? Good.

So what we've identified so far is fostering primary care innovation, leveraging state purchasing power, increasing price and quality, transparency, exploring bundled payment systems and online health information system.

And the issue related to increase insurance coverage I added Jeff's comment, make health care more affordable as a strategy for increasing health insurance coverage. It's not real specific, but it still is a strategic issue.

And also based on Jeff's comments, I added insurance industry regulation just as a strategy and thinking, if you want to study specifically the different types of insurance industry regulations that were proposed in the Affordable Care Act and include an analysis of what insurance industry regulation in Alaska is right now, we have an expert at the table, usually, who could help us understand that, two experts actually at the table to help us understand that better, if you want to develop some recommendations around that. So that's what the insurance industry regulation strategy is.

And then under Address Specific Services, I just added Medicare services to that list.

So right now, you can see what I have highlighted in

orange are the main strategies you want to start off studying this next year, understanding with the potential for developing recommendations in the 2011 report. Is there anything else on this list that you want to add or include in the orange or green highlight, and is there anything missing from this list?

The green, I thought, was a given, based on earlier conversations that we were going to do anyway. I'm just changing them all to orange.

CHAIR HURLBURT: Pat?

COMMISSIONER BRANCO: I have nothing that I want to add, so I want to give everybody that great caution. These are broad enough topics that they can address some of the things that may occur during the year, but I never want folks to get too limited to the things that may occur as time goes on. So if we have an opportunity to modify this list as the year -- June of next year may hit us in the teeth with something catastrophic, and if we don't have it on the list, I don't want to have somebody come back and say, well, it wasn't on the list; we can't talk about it.

COMMISSIONER ERICKSON: And I think that's an important point. We certainly can add other things in the future, but what we're doing, basically, is prioritizing how we're going to spend our time and money going into the new year. And then as things change, we can evolve, if we haven't already

committed money or time.

COMMISSIONER BRANCO: Or prioritize.

COMMISSIONER ERICKSON: Right. Exactly. So I would like to actually prioritize these. Now I'm assuming that with the stuff that we have on our agendas already -- what I'm doing actually so you understand -- I keep making way too many assumptions, and you guys can't read my mind. I'm thinking ahead to what I think of as our first 2011 meeting, which will be in either, probably realistically, early March/late February. But thinking ahead because, you know in some of our past meetings, we had these slates of speakers lined up and lots of presentations, and it takes time to get that all lined out and identify if folks are available.

So I'm thinking ahead to that meeting of starting to work on that agenda now and identify the right people to come talk to you and make sure they'll be available and that sort of thing and thinking about how we'll spend our limited time in the next day-and-a-half long meeting.

So you understand what I'm asking you to prioritize, it's going to partly drive what you'll learn about at your first 2011 meeting. So I'll ask the question again, is there anything on this list that's not in orange right now that you want to make sure we're considering up front, not that we can't add it in the future?

COMMISSIONER DAVIDSON: So if it's not in orange.....

COMMISSIONER ERICKSON: If it's not in orange, you're not going to learn about it at your first meeting, and there's probably too many orange things to learn about in one meeting, understanding that there is -- this is the strategy side. And maybe we'll make a section -- if this makes sense to you, have a section where we're diagnosing the current system, continuing to work on understanding today what's going on, and then another part and that's where we'll hear from our analysts and the studies and the experts who can come tell us what it's like in the long-term care world, for example, today in Alaska. And not that those can't blend together. We'll ask those same folks, but have another section where we're learning about potential new strategies. And so this is just setting your agenda for the first meeting or two.

CHAIR HURLBURT: I think silence is golden. Keith?

COMMISSIONER CAMPBELL: I'm wondering if we couldn't preset most of the year's calendar. I'm retired and pretty busy. I mean, it helps for everyone around the table.

COMMISSIONER ERICKSON: Yeah, my plan is to do that. I think I promised that to you at the last meeting, that we'll set the calendar. I'm partly waiting for -- actually mostly the one that I'm waiting for right now is the -- well two things -- legislative calendar so we can accommodate -- one of the other things we talked about at the last meeting briefly, I'm imagining that that first meeting might be in Juneau.

That's what we did in our first year was hold the meeting that occurred during the Legislative Session in Juneau and that the rest would be in Anchorage. And we want to make sure that we're picking a date where the Legislators are going to be in town. So that's one of the things I'm waiting for.

The other thing I'm kind of waiting for too, Keith, so we might -- is the transition of -- I want to understand who our leadership in the Department is and then what their schedules might be, and hopefully, it won't get -- maybe I'll just pick a date. We're going to set dates, regardless of whether I have those two pieces of information or not, for that first meeting and then go from there. Does that sound good? I know, especially for our private providers on the Commission, it makes their lives a lot easier, too.

So I am not adding anything to this list at this point, in terms of I'm not highlighting anything new in orange, understanding that we can always add more, and I should get Health Information Technology. I'm going to highlight Workforce and Health Information Technology on there too because it's a given that we'll be working on that. Does anybody want to suggest some additional prioritization?

Hearing none, I'm going to just take what we have and might start with the one prioritization that I did get from one of the members, but we'll start looking into ways that we can learn more about these different strategic approaches to

improvement.

So I think just quickly, really, really quickly then, I'm going to go through our next steps and then we can see if anybody has any final questions or comments. I am going to get, at least, an outline of the report and the language around the recommendation to you all by November 29th and would like to hold a one-hour teleconference -- in the past, we would do a one-hour teleconference at 4 o'clock in the afternoon; it seemed to work well for folks to do it kind of late -- on the 30th of November just to review with you and to see if you have any preliminary comments about what you've received the day before, and then I'm going to ask you all to submit comments in writing back to me for any suggested improvements by the sixth of December. We'll have a one-hour teleconference on December 7th for you to share and explain your comments and to make some final decisions together about what we're releasing for public comment, and then hoping that within just a couple of days, I could make those tweaks and release what we have -- again it will just be a partial draft, but the most important point is getting some feedback from the public on areas that we're planning to study in terms of current issues, plans for studying future strategies, and then the one specific policy recommendation. So that's what we'll really be looking for comment from the public on. And so we're kind of squished up in the short amount of time that we

have. In the future, I'd like to make these one-month public comment periods and have a more complete draft report to the public. We'll meet then on January 7th to consider those and make some final decisions about what's included in the report, which will then be submitted to the Governor and the Legislature on January 15th.

So that's the timeline I have laid out right now. Does anybody have any questions or comments about that timeline? Is that clear what we're doing next, when and why?

And then I just wanted to make sure you were aware -- I'll send an email. I didn't want to bog you down with too many other emails, but we've been invited by the Commonwealth North Health Care Action Coalition to come meet with them. It's here in Anchorage Thursday morning from 7:00 until 9:00. I'm not sure where they're meeting. Usually they actually meet at ANTHC's boardroom, but they've invited us to come talk to them about what the Commission is doing. They would like to meet all of you. Dr. Hurlburt and I already have committed to coming and giving a presentation to them and talking with them, but the rest of you are invited to come and just sit and chat informally with this group. If you're interested, they have teleconference available too for folks who are out of town, but I'll make sure you all have all of that information and it's just -- if you're available and interested, you can come or tie-in on the phone, Thursday, December 2nd.

And then I was going to tell you all that there had been a Senate HESS hearing that had just been scheduled for December 9th, but that was just cancelled a couple days ago. I didn't know if you'd be interested. One of the things that was on the agenda was a discussion of the Affordable Care Act implementation, so I thought you all might be interested in listening in on that or coming to that. If it gets rescheduled, we'll let you know. That's it. Any final questions or comments before we adjourn?

CHAIR HURLBURT: Thank you all very much. Jeff?

COMMISSIONER DAVIS: I know we're past time and I'm one of the ones who asked to get going, but if you could permit me one minute in defense of the big, bad, evil insurance companies because, over the last couple of days, there have been a lot of things said and there was no chance for rebuttal, so I just want level that.

First of all, it is true we represent about 70% of the Alaskans who have health insurance. Blue Cross Blue Shield plans represent 100 million Americans, and the majority of those are non-profit plans. We're a non-profit plan, which means our members own us, a board of people who pick from the community, but let's talk about the dollars because that's what everyone cares about.

So out of a dollar of premium on average, 85 cents goes to pay for providers, devices, services, health care services,

85 cents. So what's the remaining 15 cents? We spend about six cents on that dollar on administration for everything we do, and of that, 1% of that 6%, so one-sixth of it, is spent on our entire management, including our CEO who doesn't make anything close to $10 million, I can assure you. So 6% of 1% is the total spend on management. You wonder what a well-managed company -- if you're one of our members. And then in addition, we have margin which is profit, but in non-profit, that means it goes back into the company to serve our members and build reserves somewhere in 1% to 3%, sometimes negative, sometimes a little better than that. So that's a total of 9% we keep. We're a taxable non-profit, worst of all worlds, so we pay 2% in taxes to the State, 3% roughly to support the high risk pool, so there's 5% of the remainder. And then the rest is what is paid to the people who consult to our members. But 85 cents on the dollar, you know, is not anywhere close to what the Speaker of the House would have had you believe. It's not anywhere close to what you read in the newspaper, and I think it's important because, you know as you heard from me earlier, it's about affordability, but because we consume too much care and it costs too much, not because the administrator of the program is keeping too much money. So thank you for that indulgence. I appreciate it.

CHAIR HURLBURT: Thank you, Jeff. We'll see you next time. Thank you all in the audience, too.

12:08:31

(Off record)

END OF PROCEEDINGS