ALASKA HEALTH CARE COMMISSION

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P R O C E E D I N G S

8:02:08

(On record)

CHAIR HURLBURT: So we'll get our meeting started. This will be a different meeting in that it's a single purpose meeting and the purpose will be for the Commission members to discuss and comment on the public responses that have been coming in over the last month, related to the draft report that will be delivered January 15th to the Legislature and to the Governor and that will be the only purpose of the meeting today. There will not be a public comment period during this meeting because that's what has been happening for the past month there.

You have the packet of material that Deb put together for us. There's one item in there that I want to comment on briefly before we get started, but why don't, just for the benefit of those on the phone, why don't we just start and first go around the table and have all of the Commissioners introduce yourselves and then we'll have the folks that are here in the public section also introduce yourself there. So Dave, could you start?

COMMISSIONER MORGAN: Yeah (affirmative), Dave Morgan, Primary Care Association Community Health Centers.

COMMISSIONER HIPPLER: Allen Hippler, State Chamber of Commerce.

COMMISSIONER KELLER: Representative Wes Keller.

COMMISSIONER HALL: Linda Hall, Director of the Division of Insurance, representing the Governor's Office.

COMMISSIONER CAMPBELL: Keith Campbell, I'm the Consumer Representative on the Board.

COMMISSIONER DAVIDSON: Valerie Davidson representing Tribal Health.

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

COMMISSIONER DAVIS: I'm Jeff Davis from Primera Blue Cross, Blue Shield of Alaska representing insurance and business.

COMMISSIONER LAUFER: Noah Laufer, (indiscernible - voice lowered) primary care physician representing primary care docs.

COMMISSIONER ERICKSON: Deb Erickson, staff to the Commission.

CHAIR HURLBURT: And we do know that three of the Commissioners will not be able to be here today, Dr. Paul Friedrichs is in Korea and won't be here. Pat Branco, the administrator of the Ketchikan General Hospital has his Governing Board meeting today and will not be here and Dr. Larry Stinson is out of state at a meeting and will not be here today, so -- but we do have a quorum, but those members will not be able to join us.

Could we start, Tom, maybe with you to just (indiscernible - interference with recording) and we'll ask you folks if you can introduce yourselves since you're pretty critical to the meeting, so.....

UNIDENTIFIED SPEAKER: My name is Rick. I'm with Imig Audio Visual.

MR. BAKER: Hi, I'm Ray Baker. I'm with Accu-Type Depositions.

CHAIRMAN HURLBURT: Thank you, Rick and Ray. Let's go ahead and get started. What I want to mention is this document that you have on the left side of the portfolio that Deb prepared for us and this was interesting. I don't want to take a lot of time on it, but I think you'll be interested.....

COMMISSIONER ERICKSON: Ward, can I interrupt for just a second? I just want to mention for the folks in the room that the document that Dr. Hurlburt is referencing is the Academy Health Report on states leading health care delivery system reform, and for those of you on the phone, almost all the handouts for today are posted on the website, the Commission's web page for the December 9th meeting. So you should be able to find most of the materials there.

We received a couple of last minute handouts yesterday afternoon that we weren't able to post to the web and there are no copies for those in the back of the room, but the

Commissioners all have copies and I will post those sometime after the meeting.

CHAIRMAN HURLBURT: Thank you, Deb. This document, I felt was interesting because what we're doing here in Alaska is obviously the kind of thing that's being done in a number of places around the country and this was just kind of a status report that came from the Academy Health that's been sponsoring what's called "The State Quality Improvement Institute," and there have been eight states, Colorado, Kansas, Massachusetts, Minnesota, Ohio, Oregon, Vermont and Washington and then initially, New Mexico and they dropped out there, that have been looking at the kinds of issues of affordability of access of value and quality of care that we have.

One of the things that's interesting as you look through this is, as the document says, their ideas began to coalesce around several strategies, including patient-centered medical homes, improved transitions of care and reduced preventable hospital admissions and readmissions, cost and quality measurement efforts, multi-payer approaches to payment reform, improving population health and achievement of the Triple Aim, and cross-cutting consumer engagement strategies. That sounds pretty close to a lot of the things that we're talking about and so we see that happening elsewhere.

One of the things they noted was that the role and

engagement of stakeholders varied significantly between the states, that states where the insurers were supportive of the delivery system reform efforts were found to facilitate their chances of having success and bringing change. The importance of strong political leadership for setting a reform agenda and providing consistent support for that agenda cannot be overstated.

Nevertheless, it's important to recognize that political leaders change and priorities can shift as can the resources at their disposal and so the political leadership was important to them, but it's critical to them -- but it did take more than that.

They came to feel that the rigorous generation of appropriate data can provide a unique non-partisan impetus for reform and can provide critical feedback. Several of their states develop an all-payer claims database, which is one of the things that we've talked about.

There was a note that before they had it in Colorado, that their Medicaid Director developed all-payer claims database envy, when she saw that other states had it and was able to go back and facilitate Colorado adopting that. So seven out of the eight participating states now have some form of all-payer claims database and of course, those are not the only states in the country that have that.

They talked about -- some about barriers to success,

fiscal environment, health information technology, unclear lines of responsibility and accountability, dangers of loss of momentum and so on. So there's nothing earth-shattering in here, but it helps put in context, I think, that what we're doing, we're doing in Alaska and hopefully, for Alaskans and Alaska and that there will clearly be some unique things.

We could probably all make an argument that there's more chance to have unique things for us than there are for, at least the Lower 48 states, but it's also very much a piece of what Americans are addressing and health care system leaders, government leaders from around the country. So I thought that was interesting to look at there. So it won't take long. It's not very profound, but I think it provides a good perspective on what you have.

So why don't we go ahead -- we don't know how long this will take today. We'll have to see. We have all day scheduled, but if we need far less than all day, that's okay too. So we'll see what we need, but I think we do have plenty of time to get into the thoughtful comments that we've received.

As Deb will mention, we do have some additional comments from Mark Foster dealing with the work that he has done for us, being responsive to some of the observations related to that work. So Deb, do you want to go ahead now?

COMMISSIONER ERICKSON: Sure. Okay, I have -- for folks

on the phone, I have the meeting discussion guide Powerpoint up right now, but I'm going to take a couple of minutes first to talk about just some -- a couple of business items and then we can get started with this discussion.

I am still missing a 2011 financial disclosure form from a couple of you. I will grab on the break and I have extra copies here. They're really pretty relatively easy to fill out, I think, since we made them as simple as we could with our attorney's assistance, but it's getting close to the new calendar year.

When we restart in 2012, we -- I prepared new 2012 financial disclosure statement forms. So I will share those with you at some point before we go at the end of the day today for you to take with you and I will also email it in PDF so you have it handy over email and we should probably acknowledge right now, but then maybe we can talk about it a little bit more at the end of the meeting or -- that we do have four seats that are rotating with our staggered start of the Commission.

All of the Commission seats are three-year terms. However, with these first couple of years, a number of folks were allocated to one-year and two-year seats. So folks weren't all rotating off at the same time and the four one-year seats are the primary care physician, the hospital administrator, the VA, Veteran's Administration Health

Services representative and the consumer representative and so some of our existing members are reapplying for their seats. Other's aren't and so some -- a couple of the folks who are with us today might not be joining us in the future. We'll make sure that we acknowledge their service at the end of the meeting, but I just wanted to mention that.

A number of the other folks around the table are in two-year seats and so their term will expire this January, a year and a month from now and then we'll be on the regular three-year cycle. Does anybody have any questions about our terms and things opening and closing that way? I think that's it for business items.

I wanted to point out to the Commission members that you all had an extra two documents at your place when you came in and sat down today, and these are the documents I referenced earlier for the audience, that we don't have copies available and are not on the web, but Pat Branco, since he couldn't be here, had emailed the document that he said he would have shared with you all if he had been able to be here and so I made copies yesterday afternoon for you all and you all should have those. It has a note from Pat that he asked me to share with you on the cover.

This is -- I wanted to mention that it might be hairsplitting, but just to be fair, this is -- don't consider this public comment. It came in after the public comment

period. This is information that one of your members wanted to share with you.

The other document, I had called and asked Mark Foster a question about methodology specific to one of the metrics that he and Scott Goldsmith of ISER had used in the cost report because it was one of the public comments we had received and he prepared a memo to explain that to all of you. I just got it last night and so you have a copy of this memo from Mark Foster, as well, in front of you all.

So those are the two extra documents, and for folks on the phone and in the room, as soon as I could get through the IT technician's queue again, we'll have those two documents posted on the web as a handout the Commission received during this meeting.

So we will make sure that we take some time this morning when we get to the point of discussing that to allow you to read through and make sure that you understand to the extent we're able without folks available to explain that additional information that's been provided and I think that's it. Why don't we get started?

One other thing on process, I took the liberty of where there were public comments that really seemed to warrant some clarification in our wording, but wasn't necessarily about a substantive change, I took the liberty of drafting some suggested, just to get us started, and so you'll see that. I

don't want you to feel as though I'm suggesting or pushing and I try to limit my proposed preliminary drafts to clarification issues and corrections. So I just want to make sure you're taking that in which the spirit it's offered.

What I thought we would do today, I'm going to click through a couple of these initial slides. I thought I would just -- this is not in your handout, but I thought it is worth reminding ourselves in the group, I pulled this in from our last meeting's discussion in working to make sure that our role and our charge is clarified, we've revisited periodically and again at this last meeting, that it's beyond our charge to be getting down into some of the details and providing oversight and guidance of state agency activities, that we're not providing operational recommendations for state agency programs, that we're not advising state government on implementation of federal laws and regulations, pursuit of specific federal grants and we do not, as a body, take positions on specific legislation, either state or federal, but what we are doing, we have envisioned the future for a transformed health care delivery system for our state and we've kind of laid out a pathway for getting there.

We're trying to identify innovative approaches for -- that state policy leaders can adopt for helping folks stay well and ensuring when they get sick, they have affordable, available, safe, efficient, effective, high quality health

care and at the same time, we're continuing to try to understand better the condition of our current system, current health care system and one more reminder, that we are not in the business of blaming any particular part of the industry, providers, patients, anybody else. We're just trying to understand the system better and we're trying to come up with some solutions, make it work better for everybody.

So with those reminders, I -- in terms of process, I kind of grouped -- I'm suggesting kind of grouping our -- based on how our report is structured, our discussion for today and I have -- and what I'd like to do is if there are any changes to our existing draft that you all would like to make, when we get to that point, we'll work through the language and vote on that particular change at the time, but then, as we get to each of those major sections, then go back and vote on the whole section to adopt it with any changes that we adopted earlier, just in terms of process. What else did I want to mention about process?

The one thing -- if we have any areas that we might be making significant changes, and there's only one area that I'm thinking of particularly, and that's around our cost findings, and that's one of the documents I gave you a starting redraft. We'll talk about it when we get to it and that's the one area where we just got this additional material, what we might do is spend some -- and since it will fall pretty early in the

morning, what we might do, I'll suggest this to you, especially, Mr. Chair, I didn't have a chance to talk to you beforehand, but what we might do is see how far we can get with everybody feeling comfortable with revisions and if you're not comfortable without having a little more time to sit with it for a while, we could not vote at that point, but then come back at the end of the meeting and finalize that conversation and any changes and give you a chance to have a break and that sort of thing, so you can make sure that you've had an opportunity to read the new materials and fully think through any changes we work out together.

Does that make sense? Does that sound fair? Does anybody have any questions just in terms of process right now, yet? Seeing no confused looks on anybody's faces, and what I did -- we ended up having comments across every single -- at least one person or organization comment on every single area of our report. So again, I just basically kind of laid out our plan for this morning following the structure of the report.

On these slides then, what I attempted to do was grab the -- for each of the major categories, a point about each of the areas that somebody might have commented about and I've included page numbers on this slide. The page numbers refer to the public comment packet that I provided to all of you. I hadn't, before I emailed a week or so ago this packet to you,

I hadn't written page numbers on -- and so folks who are on the phone, if you don't -- this is posted on the web if you don't have it handy and there's a copy in the back of the room for folks who are in the room.

I put together a table and tried to fairly capture a summary of the main points made by each commenter and it's in chronological order of the date and time that I received it in that table and then laid out, I included the actual comments that we received. So the Commission members all had full copies of everything.

So that being said, I hand wrote on this packet that I had scanned, the page number at the upper right-hand corner of each page. So that's what the page number on our slides refer to, so you can quickly find, if you need to, the actual comments made by the commenter and we can take a little time for you to review it, if you feel as though you need to. I've heard from most of you that you felt as though you already had time to read through these comments.

So -- so let's go ahead and get started. We had a few comments related to our goals, values and definitions and one commenter specifically on -- and you can find all of these on page 23, a suggestion that we include wellness in addition to prevention as one of our four goals, a suggestion about personal engagement, needing to make sure it involves financial commitment and a suggestion that health care

continuum definition address in some way the increasing public support, government support for -- I'm trying to paraphrase very briefly, for health care.

So why don't we start, since those are all related to our goals and values and kind of was following a theme from one particular commenter and it's on page 23 again, does anybody have any thoughts, comments? Page 23 of your packet, and again, if you want to have the public comment draft report, it's -- you have a copy of that in your packet. I also have copies for folks in the room at the back of the room and it's on the web, but you should be able to page through that at the same if you want to see the section that they're referencing.

COMMISSIONER HIPPLER: Since there was a request for comment, I did review this letter and I actually, strongly agreed with almost all of his points and specifically, he brings up personal responsibility and I think the Commission does acknowledge that the patient is the most important part of the equation. I think we do.

Nevertheless, we could iterate more that the patient's investment in his own health is the -- one of the driving factors. Thank you.

CHAIRMAN HURLBURT: Yes, Jeff.

COMMISSIONER DAVIS: Jeff Davis, just I'd like to concur with what Allen has said and I think the data actually supports that quite strongly. CDC reported that 75% of cost

of care is due to chronic disease and that about 1/3 of that is due to lifestyle related choices. So I think that's pretty clear evidence that we all have a role and that's one of the role that we -- each person has as an individual. Thank you.

CHAIRMAN HURLBURT: Keith, did you have anything?

COMMISSIONER CAMPBELL: I'm fine. I'm totally fine with this, as long as we can come up with a -- I mean, somebody -- and maybe I'm not catching it, but we need a common well-identified definition of wellness. It means different things to you than it means to me and it certainly -- I don't meet my wife's definition of wellness. So that's what -- that might be my only caution here.

COMMISSIONER DAVIS: Yeah (affirmative), I agree that there is no common definition of wellness, but I think the point that I heard Allen make and I'm getting from this comment and that I'm trying to reiterate is that we all have a role to play in our wellness and that's what needs to be encouraged and how people define that, we may be different and certainly, different people take different actions and have a different definition, Keith, although you should pay more attention to your wife's definition, I'm guessing, but that's my point, not to define one to say that we all have a role to play. This is not a passive system we're dealing with.

COMMISSIONER ERICKSON: If Commission members don't have any additional comments at this point, then I have a question.

What I think I'm hearing is a suggestion that we strengthen or change in some way our personal engagement value. Right now it states, "A redesigned health care system for Alaska encourages and empowers Alaskans to exercise personal responsibility for healthy living and for obtaining and participating in their health care," and we had this conversation when we developed this value and thought we were capturing the point that we thought the patient's engagement and participation, both financially and in decision-making was covered here, but if there is specific suggestions for clarifying that, I'll entertain those, and I'm on -- for those of you -- don't be confused if you see page numbers on the screen on a document, because I've added an introduction and some other stuff in the document that's on the screen.

On the public comment draft, we're on page three. That's where our value statements appear. So if you want to look at -- if you can't see it very easily on the screen and for folks who are on the phone, we're looking at the value statement for personal engagement on page three of the Commission's 2011 public comment draft on the website.

COMMISSIONER HALL: It seems to come to memory, but I don't remember what it was, that at a prior meeting a while ago, we spent a substantial amount of time defining wellness. I'm not sure what we decided wellness was, but if there's some piece of that, that we feel should be included here, I think

we have spent time defining it and came to at least something that was acceptable to all of us.

COMMISSIONER ERICKSON: Yeah (affirmative), on page of the public comment draft, or page five and six include the approved definitions and it includes a definition of health and healing, which is, I think, probably in there and there are three bullet points about that.

It states that optimal health is a dynamic balance of physical, emotional, social, spiritual and intellectual health, that an individual's health status is largely self-defined, encompassing a broader state of well-being beyond physical health and lack of disease or infirmity and that healing is restoration of wholeness and unity of body, mind and spirit.

It involves curing when possible, but embraces more than cure when illness is limited to disease and health care is limited to cure the deeper dimensions of healing are missed. So that's, I think, what you're remembering, Linda, is the conversation that we had around those definitions.

So we're kind of bouncing back and forth between a couple of different issues here; the wellness comment and the personal responsibility comment. Yes, Allen.

COMMISSIONER HIPPLER: Yes, I was going to bounce back to the personal responsibility. You had asked the question, so given this comment, do we want to modify the personal

engagement clause?

COMMISSIONER ERICKSON: Yes.

COMMISSIONER HIPPLER: And I was thinking about that. I'll throw out an additional sentence to add on for discussion purposes. Here's what I came up with; the Commission acknowledges that individual investment is a vital part of a robust health care system.

UNIDENTIFIED SPEAKER: Can you read that (indiscernible - too far from microphone)?

COMMISSIONER HIPPLER: The Commission acknowledges that individual investment is a vital part of a robust health care system.

CHAIRMAN HURLBURT: Allen, and it sounds to me like by design, that's probably big enough to drive a Mack truck through. That's a good thing. Individual investment means lifestyle choices, but individual investment can also mean some financial commitment. Is that your intent?

COMMISSIONER HIPPLER: It is my intent that both of those, what you just referenced, both of those are required to drive a good health care system.

COMMISSIONER ERICKSON: Can you read it one more time?

COMMISSIONER HIPPLER: Again, this is a draft. I'm not married to this, as an order. The Commission acknowledges that individual investment is a vital part of a robust health care system. Wow, our -- it's already typed up there. Good

job.

COMMISSIONER ERICKSON: Can you -- for the folks farthest away at the table, can you read what's on the screen okay? Is it clear enough?

COMMISSIONER DAVIDSON: So I had a question.

COMMISSIONER ERICKSON: So did -- I'm sorry, Val.

COMMISSIONER DAVIDSON: So I had a question. So where, as a part of our research, did we validate that kind of statement? So have we received information, presentations from some body that shows that there is a tangible connection?

COMMISSIONER DAVIS: Yes, we did, not this year, but last year, Dr. Dave Johnson testified to the Commission and had, I don't remember -- recall exactly the statistics he gave us, but they were in line with the ones I quoted to Allen earlier, but yeah (affirmative), we had a whole session on that, so -- and I believe we're continuing to build on all of the work, correct? It's not a one-year cycle, so.....

COMMISSIONER DAVIDSON: So maybe in the -- on the break, we can maybe refresh our memories with that information?

COMMISSIONER ERICKSON: I would say we have a couple of choices. We're going to get into this issue deeper, I believe over the next year. We could wait until we've had a chance to study it more or we could entertain a motion and then decide if folks are comfortable voting on it now or want to vote to table it until later in the meeting.

COMMISSIONER ENNIS: I think we're all familiar with the general notion if a person pays for something, they value it more and I'm wondering if the report that I admit I did not remember that Jeff brought up does address that relative to both medical care and personal well-being.

COMMISSIONER KELLER: Dr. Hurlburt. You identified two areas where investment might include and the broadness of it, you -- I wonder if there's a value in being a little bit more explicit in addressing investment, including choice and.....

COMMISSIONER HIPPLER: Lifestyle choice?

COMMISSIONER KELLER: Lifestyle choice, yeah (affirmative). I mean, I would prefer that, you know, unless it's, you know, hugely offensive to somebody, but I would like to, you know, it's okay to keep it broad, but specify that what we're thinking about here is that we're dealing -- we realize we're dealing with autonomous human beings that have choices, lifestyle choices to make and a new health care system in Alaska should encourage and enhance the individual lifestyle choices.

COMMISSIONER HIPPLER: So two things, so you're saying investment, including lifestyle choice and as a second comment, I don't mind waiting until the end of the day. We don't need to make a motion on this. We can let it slide for a little while.

COMMISSIONER ERICKSON: Well, I think we should have a

motion now and then decide if we're going to -- and then table it for later in the day, so we -- so it's clear that we're going to come back and visit it.

COMMISSIONER DAVIDSON: I think I'm more comfortable with statement as written and I guess I'm prepared to vote on the matter and it's interesting that if we're talking about tying it to individual investment, then we could actually go so far as to -- somebody could read this as go so far as to say, "Okay, then none of us really needs private health insurance." Really, we should be paying for those as a modified program so that we're not insulated from that value that our employer has. We don't really need private health insurance. We can just do another system that pays for that cost. So that we all equally feel what that investment is, because right now, those who are employed who don't have access to that information, are equally insulated. So I guess.....

COMMISSIONER MORGAN: I have to.....

COMMISSIONER DAVIDSON: I am prepared to vote on the motion.

CHAIRMAN HURLBURT: Yeah (affirmative), but Dave, did you.....

COMMISSIONER ERICKSON: And we don't have -- just to clarify, we don't have a motion yet.

CHAIRMAN HURLBURT: Yeah (affirmative).

COMMISSIONER ERICKSON: We really need a motion if we're

going to continue discussing it.

COMMISSIONER HIPPLER: I'll move the amendment as drafted.

COMMISSIONER ERICKSON: Thank you. Second?

UNIDENTIFIED SPEAKER: I second. I can't. I'm sorry.

COMMISSIONER ERICKSON: You can't. Wes can't second.

COMMISSIONER MORGAN: I'll -- hey, I'm up for debating anything today. I second.

COMMISSIONER ERICKSON: Okay.

CHAIRMAN HURLBURT: Now, it's been moved and seconded. Is there a discussion? Dave, did you have something you wanted to say?

COMMISSIONER MORGAN: I -- it's -- but it's -- I think you can take -- you can extrapolate anything to the -- stretch it to the far end either way. I don't think anybody in this room would say that if you weigh 500 pounds or you drink continuously or if you do those types of things that are choices sometimes, but a lot of times, that those don't affect your health and any system should try to help people not do that, either through incentives or through education or whatever, but -- which we've described in here, but on the other -- you know, I don't think all of us are keen to make a whole lot of changes in the document, mainly because poor old Deb's got to type them and print them and get them, but it is a reasonable common sense thing that our choices do affect our

health. I don't think anyone disagrees with that and some people abuse that.

CHAIRMAN HURLBURT: Any other comments? Noah, yeah (affirmative).

COMMISSIONER LAUFER: I think the difficulty here is this is actually the crux of the whole problem, the separation between a person's decisions or their doctor's decisions about their health and the actual cost, the lack of transparency, you know, this is why we're in the fix we're in. I think Allen's right, but it's complex and it isn't just -- your choices don't just affect you.

For example, your choices as to whether or not to immunize your children, particularly if you've got to pay a couple of thousand bucks out of pocket. Right now, you can get away with cheating, but you do affect the health of the population and that's -- those are places where there needs to be no barrier and in my mind, it needs to be free, but there are areas where a person should be at least aware of the cost of the choices that are made and we don't even have that transparency now. So that would be a state, awareness.

CHAIRMAN HURLBURT: Okay, Val.

COMMISSIONER DAVIDSON: I'm going to call for the question.

CHAIRMAN HURLBURT: Okay.

COMMISSIONER HIPPLER: Second.

CHAIRMAN HURLBURT: Can we read the amendment to the document then?

COMMISSIONER ERICKSON: Okay, so we're voting to add as a second sentence to our explanation of the personal engagement value; the Commission acknowledges that individual investment is a vital part of a robust health care system.

CHAIRMAN HURLBURT: Okay, all those in favor, signify by raising your right hand. Okay.

COMMISSIONER ERICKSON: For the record, all of the present voting members -- is your hand up?

CHAIRMAN HURLBURT: Yes.

COMMISSIONER ERICKSON: All of the voting members present vote to approve the motion.

CHAIRMAN HURLBURT: Okay, so the motion (indiscernible - interference with recording). Thank you, Allen, for that. Okay.

COMMISSIONER ERICKSON: Okay, so on these next point, again related to -- we're in definitions, and so definitions on pages five and six of the public comment draft, we received a comment from a couple of different individuals that you would find in your public comment package on page six and on page 43, suggestions that we need to make sure that we're clear in acknowledging public health as a part of the health care system and including a definition of that.

I would suggest you have three choices right now. This

is one where I took a stab at drafting a definition for you and it's on the next slide in your packet on slide five, if you wanted to consider adding a definition today.

If you want to spend a little more time thinking and talking about public health as a system and population based prevention, we could table this discussion and include it for 2012 or you could just dismiss it entirely. Those are your three choices. Do you want to -- so if you want to consider the proposed draft, it's on page five of the slides.

COMMISSIONER HIPPLER: I'm sorry, for clarification, when you say slide five, is this the slide you're referring to?

COMMISSIONER ERICKSON: That is correct. It's slide -- in the -- slide five in the December meeting discussion guide Powerpoint and if you wanted to adopt a new definition, it would go in our definition section on page six of the draft report.

CHAIRMAN HURLBURT: So those are two draft definitions that Deb developed as a straw horse to facilitate the discussion, if we wanted to be responsive to the comments on pages five and -- or six and 43 of your packet there. So then she outlined the three options. Val, yeah (affirmative).

COMMISSIONER DAVIDSON: So are those two going together?

COMMISSIONER ERICKSON: Yes.

COMMISSIONER DAVIDSON: Okay.

COMMISSIONER ERICKSON: Yes. It would be two bullets

under.....

COMMISSIONER DAVIDSON: Somewhere.

COMMISSIONER ERICKSON: Under -- well, it would be under the heading Public Health.

COMMISSIONER DAVIDSON: Okay.

COMMISSIONER ERICKSON: For folks.....

COMMISSIONER DAVIDSON: I would move to approve these -- this language to be included in the report.

COMMISSIONER ERICKSON: Is there a second?

COMMISSIONER CAMPBELL: Second.

COMMISSIONER ERICKSON: Keith -- Val motioned, Keith seconded.

CHAIRMAN HURLBURT: Is there discussion? Keith.

COMMISSIONER CAMPBELL: Yeah (affirmative), I think it's relatively important because it is mentioned in the Constitution that the state does have a public health mandate and so we ought to at least take a stab at acknowledging that at the very least and it can be refined in later years, but this is a start.

COMMISSIONER ERICKSON: One other thing I had meant to point to you all too, I had included in your packet -- I did not -- this is maybe the one thing I didn't make a copy of for the web or the back of the room, but it's one page from the Commission's 2009 report that describes the state's public health system. So just as a reference document for folks on

the phone, if you wanted to see it, it's page 58 of the Commission's 2009 report that's posted on our web, but it's a one-page description of public health and population based health promotion, disease and injury prevention and maybe -- should I take a minute while you're looking at that to read what -- in case folks on the phone don't have it up? I'll read what Val has moved and Keith seconded be adopted as a definition of the Commission.

It's two bullets. The first, public health is what society does collectively to assure the conditions for people to be healthy. That's actually an adaptation from an institute of medicine report that was published in 1988.

The two main characteristics of public health are its focus on 1) prevention rather than cure, and 2) population level rather than individual level health concerns, and then a little bit of a discussion about what public health does, the public health system does.

The public health system protects and improves communities by preventing epidemics and the spread of disease, promoting healthy lifestyles for children and families, protecting against hazards in homes, work sites, communities and the environment and preparing for and responding to emergencies, and as Keith mentioned, and it's referenced in the one-pager from our 2009 report, it actually is a provision in our state's Constitution, Article Seven, Section Four, that

the Legislature is charged to provide for the promotion and protection of public health.

CHAIRMAN HURLBURT: Allen, yeah (affirmative).

COMMISSIONER HIPPLER: I like the first bullet quite a bit. I think that's well put. The second bullet, I like the first and the last part of the second bullet. What's inside it, I'm concerned with, specifically. In the first bullet point, we talk about population level rather individual level health concerns and then in the second bullet point, we talk about protecting against hazards in the home.

I -- we may be getting a little bit too much in the weeds there and we may be giving the state government a little bit too much responsibility with respect to individuals and homes. So I would be concerned with a couple of those statements.

CHAIRMAN HURLBURT: Val, yeah (affirmative).

COMMISSIONER DAVIDSON: An example of the kind of work that the state already does, as well as the Alaska Native Tribal Health Consortium of protecting against hazards in the homes are ensuring adequate sanitation facilities, eliminating honey buckets in homes. It has a huge impact on public health in rural communities and any time somebody from one of those communities, a baby gets RSV or something like that, they jump on a plane and guess what, it is throughout the state, like that. So when I read that, protecting against hazards in homes, those are the kinds of programs that I'm thinking of.

CHAIRMAN HURLBURT: Yeah (affirmative), if you look at our state at what public health does, and that would be probably both the Division of Public Health and the Division of Environmental Health, which in a lot of states are together, but both, I think clearly public health functions, my bias is most of the things they do, I don't see in our state that the role of assuring high quality health care services is there and in our state that's partly Medical Board's function. It's partly Health Services' function here, rather than public health.

COMMISSIONER ERICKSON: That's not in our current draft.

CHAIRMAN HURLBURT: It's what?

COMMISSIONER ERICKSON: That's not in our current draft.

CHAIRMAN HURLBURT: Not in yours. Okay, I've got the old one.

COMMISSIONER ERICKSON: (Indiscernible - speaking simultaneously).

CHAIRMAN HURLBURT: Okay, thank you. Sorry. Sorry.

COMMISSIONER ERICKSON: I took it out based on your comments.

CHAIRMAN HURLBURT: Thank you. Okay, any other comments?

UNIDENTIFIED COMMISSIONER: Call for the question.

CHAIRMAN HURLBURT: Call for the question. Keith and Val, so for the definitions of public health, as you have in front of you and as Deb read, everybody in favor of adopting

that and incorporating that as a part of our 2011 recommendations, raise your right hand. All those opposed, raise your right hand.

COMMISSIONER ERICKSON: Okay, can -- I need.....

CHAIRMAN HURLBURT: Any abstainers?

UNIDENTIFIED COMMISSIONER: (Indiscernible - too far from microphone).

COMMISSIONER ERICKSON: So okay, we need -- I need hands raised high. For the record, it has passed unanimously.

COMMISSIONER DAVIDSON: Mr. Chairman, I'm going to suggest, I keep looking over at Noah's heavy arm and I'm wondering if we can raise our left hands, maybe. It's going to be a long day for him.

UNIDENTIFIED COMMISSIONER: He's going to (indiscernible - too far from microphone).

COMMISSIONER DAVIDSON: I know.

COMMISSIONER ERICKSON: He's going to have to really want it to pass. For folks on the phone, Dr. Laufer has a cast on his right arm.

CHAIRMAN HURLBURT: It takes a female to make that kind of an observation. Thank you, Val. Right, that's nice.

COMMISSIONER ERICKSON: Actually, a mother, I think.

CHAIRMAN HURLBURT: A mother, right, there you go.

COMMISSIONER ERICKSON: Okay, moving along then, let us go back -- go back to our -- we're on slide seven again of our

meeting discussion guide and the next category for discussion -- let -- should we -- or maybe it's not necessary. I was wondering if we could vote again to adopt all of those things. I don't think it's necessary -- slow things down.

For health care cost findings category, the comments that we received -- there's a comment on page 24 from the same gentlemen who had shared the issues around wellness and personal engagement, financial responsibilities, making the same point again on the second page of his letter, which is page 24 of your public comment packet, that patients, not providers are the driver of health care costs. I think he's trying to make the point again that he was making earlier.

I don't know that I agree with that complete statement and I don't know that he was really suggesting a change, but just continuing his theme that we don't disagree with, I don't believe. So does anybody want to talk about that particular comment and make any suggestions related to it?

CHAIRMAN HURLBURT: Allen.

COMMISSIONER HIPPLER: I'll make a quick comment. I don't have any proposed changes, but I think it was, in fact, Ms. Davidson who mentioned a couple of meetings ago that it's not so much the cost of health care that's bothering people. It's the value that we're getting out of it and this comment really reminded me of that because he's talking about the -- there's a huge demand or a growing demand for health care,

which in and of itself isn't a bad thing and the problem is, are we getting the value in return? So that was my only comment.

CHAIRMAN HURLBURT: Jeff, yeah (affirmative).

COMMISSIONER DAVIS: And I would just respond to that, I think the statement is partially true, that we all have a role and that, I think the evidence is pretty clear that choices we make are -- do have an impact, but there are also things that, you know, are completely out of your control, you know, hit by the bus, et cetera, et cetera. So it is certainly a -- the patients are certainly a part of the equation and a driver, but not the sole driver.

The providers can do things better, and you know, be better informed if we give them the information, that also are drivers and be more efficient, I mean, we all have a role to play, every single one of us and that's get the -- so maybe I'm splitting hairs, but it's just you can't -- to Val's point earlier, you can't take it all the way to the end of spectrum. It is not just about the patients. Thank you.

COMMISSIONER LAUFER: Could I just make a quick plug for transparency again? I was just in the ER. I don't know how much it cost. I still don't know. I didn't ask because they wouldn't be able to tell me. It wasn't a consideration, you know, it's just -- I know a bill is going to come and I'll probably gasp when I see it. That's all I know.

CHAIRMAN HURLBURT: Not probably, so right.

COMMISSIONER LAUFER: (Indiscernible - too far from microphone).

CHAIRMAN HURLBURT: Yeah (affirmative), yeah (affirmative). Val.

COMMISSIONER DAVIDSON: So I guess going to the notion of value, I mean, value really is -- and we make findings or make recommendations later in terms of value, but the two parts of value are not only the cost, but the benefit and our report did certainly capture the cost information, but nowhere in our findings did we look at the value -- did we look at the benefit piece and.....

COMMISSIONER ERICKSON: This was actually something that I don't know if you caught the very end of Milliman's cost driver's report, the third report. It was the very last statement they made. They said this was an analysis of -- related to costs, specifically reimbursement levels to answer one part of the question.

The -- one of the next things the Commission may want to study is the value, the outcomes that you're getting for these costs. So to your point, Val, Milliman had acknowledged that and it is something we've talked about and would -- I mean, we could put this on a parking lot. I didn't bring my flip charts, put it in a parking lot for consideration later when we're talking about what we might study in 2012.

CHAIRMAN HURLBURT: Other comments, and so we feel the point is well made. We take it into consideration for our future planning, but no suggested wording changes, okay. Deb.

COMMISSIONER ERICKSON: I was just making a note to -- regardless of whether we vote to add benefit outcomes from -- I'm typing this on a slide right now for folks on the phone, benefit outcomes from health care value equation. I know there's a much better way to word that, but I just added that to a list for us to talk about when we get to the point of talking about what we want to study next year and I also just made a note to myself to do a little better job of describing in the introduction -- it's a section that I'm not asking you all to vote on, in the 2011 cost of health care in Alaska discussion where we get to the point of the findings, in the introduction there, I will make an effort to do a better job of discussing this is part of the value equation that we're trying to understand better. This is just one part and the other part is just as important and we will get to that. Okay, so if -- yes, Keith.

COMMISSIONER CAMPBELL: Clarification, value, you are also including the word quality and things of this nature?

COMMISSIONER ERICKSON: Cost and quality and I'm remembering, you all have it right in front of you, I have it beside me, and it's on the website, the -- Milliman suggested two aspects of that side of the value equation. It would be

both the quality of health care services and outcomes from health care services would be the other side of the value equation from cost. Thanks for that clarification.

So moving on, I included in your handout packet on the left-hand side, I think it was the last document, it has yellow highlighting on it. The top of the page is Part Two, Understanding Alaska's Health Care System Challenges. It's posted on the web for folks who are on the web. It's something suggested -- about the proposed new draft for cost of health care in Alaska and there are also copies of it in the back of the room for folks in the room.

What -- so this is the point that we're to right now. The next five or six bullets that we have, the rest of the bullets under health care cost findings are related to this section and it's the additional material that Pat Branco provided for all of you, as well as the new memo from Mark Foster and so all of these pieces are interrelated.

We'll go through them one at a time, but before we had received any of those, I had already done this and made this copy and put it in your packets before I got Pat's email yesterday. I had taken a stab based on the earlier comments that we received and all of these comments are from the state, the Alaska State Hospital and Nursing Home Association, starting on page 25 of your public comment packet and going for several pages after that.

I took a stab at trying to clarify some of the language to, at least partly, address some of their concerns to the extent where I thought clarification was fair and helpful. The other thing I did here was go through -- we had initially drafted this for the public comment draft based on the preliminary draft reports we had received from Milliman and quite a few of the data points changed.

Nothing substantive changed in the final report, but almost all of them by just one or two percentage points. The only one that was significant didn't change the findings in any way, but was a more significant change, was the operating costs for rural hospitals. Their preliminary analysis showed about 70% higher and in the end with the completion of the work, they determined that it was 86% higher.

So that was the only point that changed significantly, but any of these places in this draft that -- and I highlighted all of the -- any change that I made, including leaving in the wording that I took out and I did strike-through on those words, letters, paragraphs. So those numbers that you see changed were all changed to reflect Milliman's final report, the statistics provided there.

One of the things I wanted to point out, probably should wait to go through each of the individual ASHNA comments to talk about the more specific changes here, but I thought it was helpful and so suggested adding a couple of primary

conclusion statements and this was something that Pat had asked of Milliman a couple of times and that they did in the end, was pull some conclusion, you know, main points into their executive summary and into the end and based on Milliman's final conclusions, I added two bullet points in the middle of page -- it shows as page 14 on this document and so I wanted to explain where those came from.

So I think what we might do is go through and just discuss each of the individual comments made on each of these sections and then give you all some time to look through the materials from Pat and from Mark and look at this draft from me. Does that sound like -- does that sound like a plan? Does that work for you, Mr. Chair? Folks are nodding.

So the first comment, page 25 and 26 of your public comment draft packet, is related to concerns over using the comparison of the value of oil produced at the wellhead annually to annual health care expenditures.

ASHNA actually contracted with a private consultant economist to review the methodology that ISER and Mark Foster had used. So that's -- there are actually two documents in your packet from Pat and that's the first one and is what -- and this is the comment that generated Mark's response as well.

So I don't know if you want to discuss that right now or if you want to wait and read -- yes, Val.

COMMISSIONER DAVIDSON: Can you just quickly summarize each of their comments?

COMMISSIONER ERICKSON: Okay. ASHNA was concerned that the comparison of health care spending against the oil industry production didn't have context. They were concerned that wellhead value was a term that was not well understood by the public.

They wondered why wellhead value was used to calculate oil value rather than some other measure of oil production and offered some suggestions of other ways to calculate the value of oil and they were concerned that it was not an apples to apples comparison and that it would be confusing to people and -- at best and inflammatory at worst. So that's a summary of their main points.

COMMISSIONER DAVIDSON: I'm sorry, I meant the other two -- the other two pieces of information. So the Erickson memo and then there was another memo you said that was done by Foster?

COMMISSIONER ERICKSON: Do you want to take a stab (indiscernible - voice lowered) or do you want to do it?

CHAIRMAN HURLBURT: Well, let me start and you can be thinking and gathering your thoughts because I think you probably need to do that in response to Val's question. On the Erickson analysis that we had, it was actually pretty gratifying in that I think he validated most of the concepts

and the work and the conclusions and said clearly, a lot of the conclusions are things that folks agree to.

The singular point of disagreement was on the appropriateness of the use of the comparison to the wellhead price of oil, the value in Alaska and points out that a number of things can impact that. That if we have whatever it is today, 106-dollar oil, the value is going to be a lot different than if we have 60-dollar oil and that whatever the throughput is today, it's 600,000 barrels, it's going to be a lot different than when we had two million barrels a day at one time and hopefully, not 100,000 barrels a day another time and so he made that point.

The -- Mark Foster's response addressed that in terms of how big a factor the energy is, and oil specifically, to the state's economy. He makes the comparison between Alaska and Wyoming where energy is also a dominant factor in their economy, notes the differences in the relative changes of health care compared to the value of that asset between the two states, how ours has been going up a lot more, health care costs related to Wyoming's. He goes on to make some other comparisons of health care costs related to the total payroll in Alaska, again, showing the increase in costs there.

I think that to some extent, we have an intellectual discussion between two economists, two respected, able economists here. I think they're probably both making good

points. I think that Mr. Erickson's points were appropriate and as I say, overall, the document to me was reinforcing that the product that we have is a quality product and is appropriate and was questioning the same area there.

He, Mr. Erickson, actually also points out that in the Milliman document that -- not in the Milliman document, but in Mark's document that really is just contained in one section and doesn't keep coming back to that, but it was an effort on the part of Mark Foster to help the Commission and to help the Legislature and the Governor and the public to understand, related to our overall economy, what's happening with health care and what the potential impact, the devastating impact can be on the overall economy. Deb, do you want to expand on that?

COMMISSIONER ERICKSON: Well, I think the only thing I would add -- but we definitely will allow time for the Commission members to read this themselves here shortly. The only thing I would add is on page two of Mr. Erickson's memo, under technical issues, he doesn't take exception in any way with Mark Foster's economic analysis at all. He just finds fault with my very poor wording in the draft report, potentially poor wording, confusing in his opinion, wealth and income, and production and output.

COMMISSIONER KELLER: Excuse me.

COMMISSIONER ERICKSON: So not being an economist or an

accountant, there's probably room for at least some clarification there. Yes, Wes.

COMMISSIONER KELLER: I have a question, if I could? If you would, point out in the draft document where that wording is that is in question. I just can't get my hands on it.

UNIDENTIFIED SPEAKER: (Indiscernible - too far from microphone).

COMMISSIONER KELLER: Okay, I was looking at the wrong one. Thank you.

COMMISSIONER DAVIDSON: It's page 11 of the new version and page 11 -- sorry, page eight of the old draft. Mr. Chairman, if I may?

CHAIRMAN HURLBURT: Please, Val.

COMMISSIONER DAVIDSON: I would like to move that this language in the first bullet of the finding and the sub-bullets be amended to read, and it's actually on page three of the Erickson memo, to read as recommended; health care spending in Alaska continues to increase faster than the rate of inflation. Total spending for health care in Alaska reached 7.5 billion in 2010, a 40% increase from 2005. At current trends, it is projected to double to more than 14 billion by 2020.

I think that's the point that we really want to make and I think introducing wellhead value and other kinds of things just complicates the issue.

CHAIRMAN HURLBURT: Comments.

COMMISSIONER ERICKSON: Is there a second for that motion?

COMMISSIONER KELLER: Before there is, could I -- you want to get the discussion.

COMMISSIONER ERICKSON: We need a second so we can discuss.

COMMISSIONER DAVIS: Second.

COMMISSIONER ERICKSON: So Jeff seconded. Now we can discuss.

CHAIRMAN HURLBURT: Yes, please.

COMMISSIONER KELLER: I -- for me, personally, this is just my own perspective, this is one of the most valuable parts of the report and I don't argue that there needs to be some work done maybe on the actual language in it. We obviously in Alaska do not spend half of our wellhead revenue on health care, but nothing is -- there are very few things that are as illustrative of the problem that we have, you know.

Health care -- we're talking about the amount of expenditure and we're actually talking about how much we spend. The other comparison that Mark made was with our salaries and what I was thinking about subsequent to that coming out, and that caused me to think about it, is that if we took this room and we took our salaries and we thought

about how much of our salaries are going to health care, obviously, my thinking -- I'm just guessing, none of us spend 50% of our wages on health care, and you know, the -- that illustrates the significant problem that we have, because the money that is being spent for health care is not from the initiative of volition of Alaska as a state or as individuals.

There is some being spent here that is in the debt category. So it illustrates our overall debt and spending problem and I would argue as strongly as I can that we keep that comparison in there, grant it, that there may have to be some working on the language.

COMMISSIONER DAVIS: Yeah (affirmative), thank you. Jeff Davis here. I agree with what you said. I seconded the motion because I -- we need to move this along. I like the wording that is here, but perhaps then you add to that, you know, as a point of reference, because when Commissioner Streur and Commissioner (indiscernible - voice lowered) were here and presenting to us, you know, they actually -- they made the point that here's health care going from a billion to two billion to four billion in the face of declining oil revenues and as Alaskans, you know, we kind of relate to that. We know that it's the life blood of our state economy.

So even though this -- Mr. Erickson's comments are also accurate, you know, it's not that we're going to spend 72% of all of that, it is an important point of reference that kind

of signals, whoa, you need to pay attention to this and be serious about addressing it.

CHAIRMAN HURLBURT: Val, do you have any -- David, yeah (affirmative).

COMMISSIONER MORGAN: As an economist, I would -- yeah (affirmative), now you're in trouble. You put three economists in a room and you'll have five opinions, you know, at least. The issues of some linguistics of the difference between income and wealth, you know, you just get your dictionary out and get the right word.

As someone who's been here since 1982 like most of the -- maybe probably some of the people around the room have been here since before they were born almost, I don't think there's anything more dramatic than to get a frame of reference and I don't think the intent of the report was to do what Mr. Erickson was implying we were trying to do, that you know, I once saw a study or a frame or reference of taking in the '90's -- where I went to school, everybody had to become an officer when you graduated and you extended the projection out and eventually, by 2050, we would only enough money in the defense budget to buy one bomber, at the growth of the cost of bombers and airplanes in the Army.

I don't think anybody -- and I don't think the intent was to say that eventually all of the oil revenue would go to health care, but I think, especially with the Legislature and

the Senate, State Senate and with the general public, that's something that they all understand. They all understand that most of our income for all of this stuff is from oil and I think we need to leave that in.

We could tweak some of the wording, but like what Jeff was saying -- but I think when you look at the -- what's our relationship with what drives 90% of the income of the state government and probably produces a lot of transfer of income to a lot of groups and individuals in the state and those that are employed, I do think we need to keep that in.

Now, tweaking the language around it, you know, I think -- I mean, technically, income, wealth, some adjectives, some connecting language, but I agree that we should leave in the frame of reference and we really need to do that. The band can't play on forever and we're going to have to deal with this. There's -- and I think everybody here would agree there's too much kicking the can down the road, so that's my two cents in all this.

CHAIRMAN HURLBURT: Val.

COMMISSIONER DAVIDSON: I call for the question.

CHAIRMAN HURLBURT: Is there a second on that? So we have a motion to revise the wording in the draft recommendations to be the wording that Mr. Erickson suggested, taking out the reference to the wellhead value of oil, to leave that out, but to otherwise leave the wording the same.

The motion is to revise the wording. Yes, Allen.

COMMISSIONER HIPPLER: Point of order, could you -- are we voting on the motion to call the question or are we voting on the original motion at this time?

COMMISSIONER DAVIDSON: Mr. Chairman, you don't need a motion to call for the question. Someone calls for the question and the motion is then acted upon.

COMMISSIONER ERICKSON: Right. Right.

CHAIRMAN HURLBURT: Thank you, Val. We're voting on the motion to revise the wording. If the vote is favorable, it will be favorable to revise the wording. If the voting is negative, it will be a vote to leave the wording as it is in the draft document. All those in favor of the motion to revise the wording, please raise your left hand. Okay, one. All those opposed to -- thank you, Val. All those opposed to the motion to change the wording, please raise your left hand. Okay, abstentions.

COMMISSIONER ENNIS: I meant to raise my hand, left hand at the first vote, please.

CHAIRMAN HURLBURT: Okay, on the first, okay, thank you.

COMMISSIONER ERICKSON: So for the record, voting for the motion was Val and Emily. Voting against the motion was Keith, Allen, Dave, Noah, Jeff and Ward. The motion fails.

COMMISSIONER DAVIS: Mr. Chair, I would like to move that we adopt revised wording that includes the suggested language

from Mr. Erickson and then a reference to the value -- within -- and add to it a reference to the spending on health care relative to the value of -- projected value of oil production.

COMMISSIONER ERICKSON: I didn't understand, Jeff, I'm sorry.

COMMISSIONER DAVIS: Okay, so that's -- there's the motion and I'll try to explain what I meant and then see if it makes sense.

COMMISSIONER HIPPLER: I will second the motion.

COMMISSIONER DAVIS: Thank you. Discussion? All right, so I like Mr. Erickson's wording as the first part of a statement, but what it lacks is those references to a relationship to, okay, so what, you know, relative to what and so we need to craft a statement, and I'm not suggesting language, but I could do that, but craft a statement that says if we're going to spend 14 billion by 2020, as a point of reference, 14 billion is projected to be X-percent of the value of oil produced in 2020 or whatever number we have. That's what I'm suggesting.

So it's an expansion of what Mr. Erickson said that I hope will meet the concerns expressed that as Alaskans, we are tuned into that and we know that's the golden goose and that we've got to -- that there is a day of reckoning and I would just also add that I've been in a couple of other meetings, large meetings where Mr. Foster made that reference and people

in the room were like, "Whoa," you know, they didn't make the extrapolation that Mr. Erickson made, but they understood that was significant and was a call to action. Thank you.

COMMISSIONER ERICKSON: Yes, Allen.

COMMISSIONER HIPPLER: Are you suggesting that we take -- that we leave the existing second bullet point referencing health care spending in 2010 was roughly 50%, dot, dot, dot -- you're suggesting we keep that bullet point?

COMMISSIONER ERICKSON: No, I think he's suggesting that we take that bullet point out, as Mr. Erickson had suggested and also take the last half of the general finding statement, just as Mr. Erickson suggested taking out and consumes a growing share of Alaska's wealth, so and -- but then adding a new bullet, still providing a frame of reference against the value of oil produced in the future against projected spending for health care as a relative sense of comparison with another important feature of the state's economy. Yes, Val.

COMMISSIONER HIPPLER: We should probably.....

COMMISSIONER DAVIDSON: Can you type up that bullet on the screen before we vote it?

COMMISSIONER ERICKSON: Yeah (affirmative), I -- yes, I -- absolutely. Absolutely.

CHAIRMAN HURLBURT: Jeff, what you're recommending is that on page eight of the draft report, that Mr. Erickson's referring to, that first bullet right under findings on that

page be revised as you suggest?

COMMISSIONER DAVIS: That's correct, Mr. Chair.

CHAIRMAN HURLBURT: Have you got something you can read, Jeff, on that or when Deb gets to it?

COMMISSIONER DAVIS: No, I am relying on the very capable Deb Erickson to understand my twisted thinking and get it on paper.

CHAIRMAN HURLBURT: While Deb's pulling this up, any other discussion on the motion while Deb's pulling this up? Val, yeah (affirmative).

COMMISSIONER DAVIDSON: I was going to say there might be after we see what we're actually proposing.

CHAIRMAN HURLBURT: Okay.

COMMISSIONER CAMPBELL: Mr. Chair.

CHAIRMAN HURLBURT: Yes.

COMMISSIONER CAMPBELL: I'm sitting here thinking that all this documentation from Milliman and all of the comments doesn't change the fact that it is what it is and our health care costs are unsustainable and were I sitting in Mr. Blanco's chair, as Chair of the Association, which I did three times in 20 years, I would be making the very same narrow argument, but the fact is that institutional costs are a pretty high driver in these costs, as is personal responsibility and all the things we've talked about it and I'd be -- if I were sitting on the State Chamber Board as I

did a couple of times, I'd be making those same kinds of comments.

Chairing Jeff Davis' Board, which I did, I'd be making those kinds of comments, but wearing the hat I'm wearing today, and with a couple of years and some gray hair, I just would urge us all to get a little bit -- a quarter of your -- the hat that you wear with your fiduciary responsibilities around the table, to think about this thing, and this is not a criticism, we just have got to get our consumer hat on here and everyone be cognizant of the fact that the facts are that this isn't sustainable and if the fields involved in this -- in health care don't do something about this, then someone else, whoever that someone else will be, will make these choices for society and I subscribe to the fact that I'd rather make these choices myself then have something imposed upon me and so that's enough said about this whole thing.

CHAIRMAN HURLBURT: Thank you, Keith, yeah (affirmative).

COMMISSIONER CAMPBELL: You can argue about the words.

COMMISSIONER ERICKSON: Can you read that, Jeff?

COMMISSIONER DAVIS: Yeah (affirmative), that's simple and it's straight forward (indiscernible - too far from microphone) -- sorry, Mr. Chair. That statement, I think does it, Deb, I mean, anyone who wants to read and see what the comparison is can see it from that. It's a fact. I mean, it would presented as a fact and people can draw their own value

-- their own judgments from that fact, so that would be fine with me.

CHAIRMAN HURLBURT: David.

COMMISSIONER MORGAN: Would you entertain a friendly amendment?

COMMISSIONER DAVIS: I would.

COMMISSIONER MORGAN: The statement in blue that's been struck out, what if we left that in, but changed the word -- take out the word, "Wealth" to "Income?"

COMMISSIONER DAVIS: That would be acceptable, thanks.

COMMISSIONER DAVIDSON: So since we're now focusing on income, then I would suggest another amendment that instead of comparing it to the value of oil produced, the value of Alaska's income or the income of Alaskans, which would be a more appropriate comparison.

I guess I'm thinking of, and if I can explain myself a little further, the way that much of the health care system is designed right now is really dependent upon oil. However, with the Affordable Care Act implementation and exchanges and people having opportunity to be able to purchase health insurance on an exchange, we may be shifting from dependence on oil and being able to shift into people's ability to be able to purchase health insurance and so therefore, does it make sense to continue to compare it to the value of oil in Alaska or does it make sense to compare it to an industry that

applies to everybody, regardless of where they are?

Shouldn't we compare that -- if we really want to capture everything and the full continuum of what our state encapsulates, shouldn't we want to compare that with the total income of the citizens of Alaska, rather than one particular industry?

COMMISSIONER MORGAN: I withdraw my friendly amendment.

COMMISSIONER DAVIS: Okay, and so let me take a crack at responding, if I may, Mr. Chair, to your question, Val. I am not suggesting including this reference because there's an inference that oil revenue is paying for health care. So therefore, I don't care if people are buying on an exchange or buying on their own money or whatever, I mean, that's not the point.

I think the point as an Alaskan to me, the important point is we're all kind of tuned into the fact that oil has been our life blood for a long time and will continue to be and so a comparison of what we're spending on health care to our economic life blood, I think is important, because you know, you can just say, "Oh," you know, if -- this is a big deal compared to what we know keeps us running and that's -- that is -- can then create a call to action for some people. That's the point of having that reference in there.

If you -- if there's a further reference too, and oh, by the way, you know, it's this much of income, I don't really

have any objection to that, but I think a reference to oil resonates with a lot of Alaskans, so.....

CHAIRMAN HURLBURT: In terms of the immediate targeted audience and recipients of the report, being the Governor and the Legislature, certainly there's a commitment on the part of Governor Parnell and the previous Governor to have more of our energy come from other sources, a target of what, 25% over the next 10, 15 years or so. That's a reality.

There's certainly interest, I agree, Val, in expanding our economy, but almost unique among the states, we really are tied to energy now on our economy. Probably the closest comparison would be Washington D.C. and government, that if the government died, Washington would die and in terms of the audience, and Wes, you might have an observation on this, as I see what the Governor gives priority to and feels he needs to be engaged in for the future of our state and the citizens of the state and as I see what consumes the discussion, the time and the interest of both houses of the Legislature, it's so much related to oil.

So I think the comparison to oil is helpful to bring it down to this is really real for the economy of our state and I don't know if that's overdrawn or not. Wes.

COMMISSIONER KELLER: I -- because I was affected so much by that comparison being made, you know, I mean, I can't help but see it any other way. In other words, I wholeheartedly

agree. The -- when you have to deal with the fact, that you know, I mean, and the wage comparison is also made in Mark Foster's income -- I mean, income comparisons are already -- also made in Mark Foster's presentation there and well, you just ask yourself if it's supposed to double and it's equivalent to half of the income, that forces a situation where the Legislature says either the Commission is crazy or we've got to figure out what's going on here, you know, and based on, you know, what it really does, is it really calls attention to the projections of the increase in health care spending and we have to deal with that and nothing that I have seen, you know, I mean, that's one of the highlights for me, you know, is why I'm defending leaving it in there.

COMMISSIONER DAVIDSON: I have no doubt that the Legislature can extrapolate that information on their own. I have no doubt that the Governor should be able to do that also on his own. I think it's unnecessary to the report, but if it is in there, if that's where we're headed, I can live with it, as long as we have another real life comparison. It's not all about oil, regardless of what we think about in the table.

It truly is not all about oil. If it was, we would have this one bullet in our report and we would all go home and so I would recommend that in addition to that, add another comparison that's more relevant to the entire population. By comparison.....

COMMISSIONER ERICKSON: I have.....

COMMISSIONER DAVIDSON: .....this is a percent of the average income or the total income for the state or of all natural resources, et cetera.

COMMISSIONER ERICKSON: What we're trying to do is give -- convey a sense of how unsustainable continued growth at this rate is and what it means for the economy and one of the points that Mr. Foster made, I thought I'd refer you to, and then we'll let you go, Noah, on page two of Mr. Foster's memo, that last paragraph, he gets at maybe what you're suggesting, Val, is a comparison of per capita personal health care expenditures as a percentage of per capital personal income and he points out that in 1990, in Alaska, and in this section, he's comparing Alaska to Wyoming and Milliman, if you looked carefully at the comparison, we were probably more aligned with Wyoming than any of the other states that were compared to in terms of cost spending.

It said in 1990, Alaska and Wyoming were both at roughly 10% and that's per capita of personal health care expenditures as a percentage of per capita personal income. By 2010, Alaska's per capita personal health care expenditures had grown to 21.5% of per capita personal income, an increase of 11 percentage points of health care market share of income in 20 years, while Wyoming saw an increase of only four percentage points of health care market share of income over

the same period.

The rapid increase in the proportion of per capita personal health care expenditures as a percentage of per capita personal income for Alaska, especially when compared to Wyoming, raises questions of whether the Alaska economy can sustain that level of spending growth and be competitive, and I think that's the point we're initially trying to make.

We had just borrowed from ISER's report, this comparison to give a sense of scale and scope and economic impact of continued growth of health care spending at this rate and I mean, this -- for me, it marries together in my mind with one of our other indicators of affordability, the fact that over just the past few years, five percent of Alaska small businesses have dropped providing health insurance coverage for their employees because they can't afford it anymore.

So not only are people spending -- individuals spending more and more of their personal income on health care in some way, shape or form, more and more businesses are unable to provide insurance.

I don't know if I shared this story with you all at an earlier meeting, but I have shared with you in the past, I get phone calls periodically from members of the public who just don't know who to call, who need -- are in some desperate situation in need of health care and earlier this summer, this past summer, I received a phone call from a young woman and

she was very upset.

She was very angry. She -- but she started her story -- it was obvious she was very angry, but she started her story with my husband and I just discovered that we're pregnant with our first child a month ago and the reason she was so angry was her husband had just been informed by his employer, who's an -- he's an employee of a small aviation firm here in town, that they were discontinuing insurance for all of their employees that following month because they could no longer afford to pay for it. The rates were increasing too much.

So I think that what we're -- we are not -- one of the things that -- the only thing I took exception with in Mr. Erickson's memo, was he suggested that we were trying to demonize the industry, which we are not trying to do. We say over and over again, this isn't about -- we have valued and valuable health care providers, both hospitals and physicians and everybody else involved in the industry.

We're trying to understand the problem better. We're trying -- the system's broken. It's not that providers are misbehaving and we're trying to figure out how to fix the system, because we can't -- I mean, the people like this woman who called me, have no voice in -- I mean, Keith's their voice, I guess, around the table here, but we need to be that voice for them and make sure that there's clear understanding of the sustainability of these increases and what we can do

about it. Noah.

UNIDENTIFIED COMMISSIONER: (Indiscernible - too far from microphone).

COMMISSIONER ERICKSON: Okay, go ahead.

COMMISSIONER DAVIS: Is that a friendly amendment, Val?

COMMISSIONER DAVIDSON: Yes.

COMMISSIONER DAVIS: Accepted.

COMMISSIONER ERICKSON: So what was the amendment?

CHAIRMAN HURLBURT: So maybe let me try to summarize.

COMMISSIONER DAVIS: (Indiscernible - too far from microphone) what you just read in some form (indiscernible - too far from microphone).

COMMISSIONER DAVIDSON: No, that wasn't (indiscernible - too far from microphone).

CHAIRMAN HURLBURT: No. Yeah (affirmative), Val, let me.....

UNIDENTIFIED COMMISSIONER: (Indiscernible - too far from microphone).

CHAIRMAN HURLBURT: Your amendment, Val, if I understand it, we have -- one is changing the word, "Wealth," to "Income," and leaving in -- got that, okay. So it's having a third bullet there relating the projected cost of health care to Alaska's payroll?

COMMISSIONER DAVIDSON: Yes.

CHAIRMAN HURLBURT: Yeah (affirmative).

COMMISSIONER ERICKSON: To Alaska's payroll?

CHAIRMAN HURLBURT: That was my word. The economists have a better word, gross income, okay.

COMMISSIONER ERICKSON: Is that more or less? So we're adding two bullets. One is comparing the projected health care spending in 2020 to the projected oil production value in 2020, and also comparing the value of gross income for all Alaskans in 2020.

UNIDENTIFIED COMMISSIONER: (Indiscernible - too far from microphone).

COMMISSIONER ERICKSON: What's that?

UNIDENTIFIED COMMISSIONER: You say by comparison gross income (indiscernible - too far from microphone).

COMMISSIONER DAVIDSON: Like gross income is projected to be -- just take the language at the end of that second bullet.

COMMISSIONER KELLER: (Indiscernible - too far from microphone) question.

CHAIRMAN HURLBURT: Yes.

COMMISSIONER KELLER: Did the -- the information we have, I don't think gets into the projected oil production value. It's 20 -- the reference is of 2010 levels. The same thing with the income and it seems like it would be more consistent if we stuck with that, but you know, because still the comparison is valid. You don't have to get into projections on wellhead value or income increases between now and 2020.

If 7.5 billion is the number and 7.5 in 2010 was half of the income value of Alaskans, 21% actual wages, but anyway, I would -- if it was -- for what it's worth, you know, it seems like the 2010 comparison is a lot safer for us.

CHAIRMAN HURLBURT: Noah.

COMMISSIONER LAUFER: Along those same lines, I'm thinking we're not putting ourselves at risk pretending to be economists or knowing more than they do if we just say anticipated declines in oil revenues and an uncertain economic future, that's -- they -- you guys know.....

UNIDENTIFIED COMMISSIONER: Yeah (affirmative).

COMMISSIONER LAUFER: Yeah (affirmative). Does that make it too wimpy or take wind out of the.....

UNIDENTIFIED COMMISSIONER: I don't think so.

COMMISSIONER DAVIDSON: I think at the rate we're headed, we could say that about everything. I don't think it's necessary.

COMMISSIONER HIPPLER: What is the motion on the floor currently?

EXECUTIVE DIRECTOR ERICKSON: I don't know that I captured the suggestion that Wes was just making.

CHAIRMAN HURLBURT: I think the motion on the floor is Jeff's motion as captured by Deb as amended by Val.

COMMISSIONER HIPPLER: So we're going to vote on an amendment -- the amendment is the second two bullets, "By

comparison," and "Also by comparison," is that correct, and are those amendments done or are we still working on them?

EXECUTIVE DIRECTOR ERICKSON: So is there a -- right now we -- the two new bullets read, "By comparison, the value of oil output is projected to be X in 2020. Also by comparison, gross income is projected to be X in 2020."

CHAIRMAN HURLBURT: I'd like to go back and maybe ask Val, because I thought we -- I thought we were there and then I was wrong on that, but the part that's highlighted in blue, as far as leaving that in, but changing "Wealth," to "Income." What is the reason to not want to do that?

COMMISSIONER DAVIDSON: That wasn't my amendment. That was Jeff's original amendment, which was to take the first part of the Erickson report.

UNIDENTIFIED COMMISSIONER: (Indiscernible - too far from microphone).

COMMISSIONER DAVIDSON: Whomever.

COMMISSIONER DAVIS: May I? I like Wes' suggestion too. So I don't know. Do we vote on this and then try to amend what we just voted on or can we amend it now to the -- what Wes suggested was that instead of bringing projections, we say, "Output was in 2010. Income was in 2010," and then people can do the math. Is that okay? It's okay. That's what we want to do.

COMMISSIONER HALL: That makes the comparisons all equal.

We're not comparing 2010 to 2020 and I think it makes much more sense.

COMMISSIONER KELLER: If I could though, I -- it wouldn't hurt to say the end is projected to double. I mean, the economists have -- our reports have done that -- I mean, to say that, but there's no reason why we can't, you know, reference that too, you know, I mean, but use the 2010 numbers, yeah (affirmative), I have it right here, thanks, Dave, you know, and it's projected to double.

UNIDENTIFIED COMMISSIONER: Okay.

UNIDENTIFIED COMMISSIONER: Yeah (affirmative), that's a fair comparison for both of them. It's consistent.

EXECUTIVE DIRECTOR ERICKSON: Okay, so this is -- I'm going to read this as a proposed friendly amendment to what was.....

COMMISSIONER DAVIDSON: Deb, can I interrupt you?

EXECUTIVE DIRECTOR ERICKSON: Yes.

COMMISSIONER DAVIDSON: And just for clarification, I think.....

EXECUTIVE DIRECTOR ERICKSON: Yes.

COMMISSIONER DAVIDSON: .....if you read the language as proposed, then I think it will be easier, rather than trying to track all of the amendments.

EXECUTIVE DIRECTOR ERICKSON: Okay, that sounds good. So this was the motion initially made my Jeff and seconded by

Allen, as adapted during the conversation. The main bullet for the finding will -- would read, "Health care spending in Alaska continues to increase faster than the rate of inflation," period, and there are now three sub-bullets under it.

The first would be, "Total spending for health care in Alaska reached 7.5 billion in 2010, a 40% increase from 2005. At current trends, it is projected to double to more than 14 billion by 2020."

The second bullet, "By comparison, the value of oil output was X in 2010, and is projected to be X by 2020," and the third bullet, "Also by comparison, gross income was X in 2010, and is projected to be X by 2020."

UNIDENTIFIED COMMISSIONER: Call for the question.

EXECUTIVE DIRECTOR ERICKSON: You have a call for the question.

CHAIRMAN HURLBURT: Okay, the question has been called. The amended wording for this section on page eight -- is it five -- and Deb just read it, all those in favor of adopting the amended wording, raise your left hand.

EXECUTIVE DIRECTOR ERICKSON: And is your hand up?

CHAIRMAN HURLBURT: No. All those opposed and those abstaining, okay.

EXECUTIVE DIRECTOR ERICKSON: For the record, the motion passed on a vote of seven for, none against and one

abstaining, and for the record also -- we also -- I need to make sure we're keeping a record of how each person votes and so for the record, Dr. Hurlburt abstained.

CHAIRMAN HURLBURT: Okay.

EXECUTIVE DIRECTOR ERICKSON: Mr. Chair, why don't -- it's about 10:00.

CHAIRMAN HURLBURT: Okay.

EXECUTIVE DIRECTOR ERICKSON: Why don't we take a break right now of 15 minutes and then come back? Does that sound good?

CHAIRMAN HURLBURT: Okay.

EXECUTIVE DIRECTOR ERICKSON: So it's actually about five until 10:00.

CHAIRMAN HURLBURT: Yeah (affirmative).

EXECUTIVE DIRECTOR ERICKSON: So let's try to be back by ten after 10:00.

CHAIRMAN HURLBURT: Ten after 10:00, good.

(Off record)

9:56:57

10:11:09

(On record)

CHAIRMAN HURLBURT: Why don't we go ahead and get started again? We've got a couple of folks out of the room on a phone call, but I think we can go ahead and pick up our conversation. Emily's here. Jeff and David, I think are the

only two and David just said he had a very quick call on his I-Phone he had to get. So we want to pick up on health care findings, then?

EXECUTIVE DIRECTOR ERICKSON: Okay, so the next bullet it related to the finding on cost shifting. The comment is on page 26 of the public comment packet and the comment is that they understand the spirit of the comment, but urge caution in making this conclusion, since the investments cited above are likely to be diminutive compared to the total gap between payer sources related to cost shifting.

I assume they mean we tried to make the point that recognizing that cost shifting occurs between commercial and public payers, that there are other ways besides just paying medical claims that the public payers participate in financing the health care system. Do any of you have any questions or thoughts, concerns, suggested revisions related to this comment? Hearing none, should we move on?

COMMISSIONER HIPPLER: I have a comment. So their concern, just to clarify, I didn't quite understand it. Is their concern that in the second bullet point under cost shifting, we begin, "While the major public payers appear to under-reimburse," then we provide examples of additional things that they do -- all right, is their concern that the structure of that bullet point implies that it all balances out? Is that what their concern is?

EXECUTIVE DIRECTOR ERICKSON: Well, the way I read this is that the investments that we cited as examples, which are probably true when it comes to disproportionate share and graduate medical education training, they're saying that those are diminutive, that they're small compared to the total gap between the payer source, between what Medicare, for example, pays and a commercial payer.

So they're citing that's small. I don't agree -- the last part of our statement and the Alaska Tribal Health System and the Indian Health Service on their behalf has made very substantial investments in the development of our rural health infrastructure. So that certainly is not diminutive, but I think they're just pointing out that doesn't make up for -- maybe they thought that we were suggesting that those other investments make up for the difference between what Medicare reimburses and what commercial payers would reimburse and we didn't mean to suggest that.

COMMISSIONER HIPPLER: So if we change that first sentence, the "While the major public payers," sentence, if we struck that whole first clause and changed that to say, "Some of the under-reimbursement is offset by providing additional financial support," and then pick that up, would that take care of the problem?

EXECUTIVE DIRECTOR ERICKSON: Keith.

COMMISSIONER CAMPBELL: Well, I don't know that there's a

problem, quite frankly, because cost shifting is a fact of life. Jeff feels it every day. Every physician feels it every day. Every institution feels it. Intuitively, that's a fact and where there's blame to go around, that's just the nature of our beast at this point in time.

As long as everybody acknowledges that it happens and institutions, doctors, all health care providers, as long as they can make it one way or the other, understand the system and what's going on, then you do have still a functioning system, even though it is flawed in the payment mechanisms and you will never cure that problem, unless you had a single payer system of some sort and then everybody would be screaming like a mashed cat because it wouldn't be enough to go around. So I don't know that there's a problem, in a short word. I move we accept the words as they're written.

CHAIRMAN HURLBURT: As it is, okay. Any other -- there's a second on that, on Keith's motion, motion to accept the wording as is.

COMMISSIONER DAVIDSON: Do we need to make motions on language that is remaining the same?

CHAIRMAN HURLBURT: No, probably not.

EXECUTIVE DIRECTOR ERICKSON: I don't -- yeah (affirmative), I don't think so.

COMMISSIONER CAMPBELL: That's fine with me.

EXECUTIVE DIRECTOR ERICKSON: I think what I would

actually do is see if Allen felt strongly enough about his wording change that he wants to make a motion to change it.

COMMISSIONER HIPPLER: No, I don't.

CHAIRMAN HURLBURT: Okay.

EXECUTIVE DIRECTOR ERICKSON: Shall we move on?

CHAIRMAN HURLBURT: Let's move on, yeah (affirmative).

EXECUTIVE DIRECTOR ERICKSON: The next comment, if I could find my place with all of these different documents is related to utilization. It's on page 27 of the public comment packet and ASHNA notes that they made extensive comments and we gave them the opportunity to provide comments to Milliman on their draft report and they had made comments that they felt that looking at the data that Milliman was using, that they didn't agree with the conclusion that Milliman was drawing and Milliman reviewed their comments very carefully and did not agree with them. So they did not accept that comment and I guess I would point out that there is a data point here or a point that's being made in these comments that's not correct, that the information is based on Medicare data and that Medicaid patients may have different utilization.

A significant portion of the utilization data that Milliman looked at was actually commercial claims data. It wasn't just Medicare data and in their approach to this work -- I mean, but what they were saying is that not that

utilization isn't high or low, but that as -- generally, but that as a driver of the higher premiums, it's not a factor in comparison. Any questions or comments related to this comment? Linda.

CHAIRMAN HURLBURT: Linda, yeah (affirmative).

COMMISSIONER HALL: As a general rule, utilization is part of the rate making process. It's one of the elements that we look at that we see when we review rate filings. So I'm -- we're -- I'm -- and so I'm obviously talking about premium here, which this bullet talks about and we do see historically, utilization being a key piece of some increases in premiums at times.

I think at this particular time, and so maybe -- and I'm not suggesting a change in wording, but I'm just -- for clarification, there's a point in time where any of this is valid and when we look at it, because we get a rate filing, it's -- when Milliman looked at it there at a particular point in time and right now, we're seeing utilization lower than we've seen historically and so I guess I would just caution not to take this and project it, because probably historically, this hasn't been true, although it may be true right now. Does that make sense?

EXECUTIVE DIRECTOR ERICKSON: It does and I think maybe -- I wonder if I should -- could make a suggestion to clarify this point, because perhaps at least in part to ASHNA's point,

we're not making a general statement about utilization. This was specific to whether it was a major driver between -- behind our premiums being higher than the comparison states.

I already had made a suggestion, clarification change that I was going to ask you to vote on in this statement. So I have it up on the screen right now. I'm on page -- if you take out the yellow highlighted document that's this whole health care costs section, page 13 of that document. I'm sorry, page -- not 13, page 12, at the bottom is the utilization bullet that ASHNA's referring to in this comment and just for clarification that it was related to -- based on financial analysis of the health care system, I wonder if I -- also add to this, behind higher premium -- let's see, did not appear to be a major driver behind premium rates being higher than in the comparison states. That's not -- that's kind of awkward.

I guess -- first, I'd ask the question; do you think we could add clarification to this statement so it's clearer that we're comparing Alaska in this particular case to the states that we were looking at? Yeah (affirmative).

COMMISSIONER DAVIS: I like the qualification that it's based on analysis of the private health care system. I think we agreed that we would do that in light of some concerns raised earlier. I think the statement is very clear the way it's written, that we're -- it is not a value statement. It

is an elimination statement.

It is saying this is not the cause and they're, you know, sometimes they're higher. Sometimes they're lower. They're roughly in line with -- that's not.....

CHAIRMAN HURLBURT: Yeah (affirmative).

COMMISSIONER DAVIS: It's not what's causing the higher premiums, so it.....

CHAIRMAN HURLBURT: Compared to other states?

COMMISSIONER DAVIS: Right, as it says here and so I think it's quite clear the way it's written and we should leave it alone.

CHAIRMAN HURLBURT: Yeah (affirmative), I agree with Jeff and -- but I think the context that I have in my mind, and hopefully, we all do, is as we talk more about evidence-based decision making, that it's not a driver for higher cost in Alaska, but it's not that our utilization is optimal, but that's another issue and that's not being addressed in this report.

EXECUTIVE DIRECTOR ERICKSON: Well, it's -- but we say it in another finding further on. We make your point in another finding further on.

CHAIRMAN HURLBURT: Yeah (affirmative), okay, yeah (affirmative).

COMMISSIONER LAUFER: It is potentially important and it should say from 50,000 feet, it doesn't appear that

utilization is a factor because this.....

CHAIRMAN HURLBURT: Compared to other states, yeah (affirmative).

COMMISSIONER LAUFER: The whole nature of this study is that it's incredibly superficial and based on a limited amount of data, you know. Yeah (affirmative), compared to other states, Alaska's different. It is. I mean, we've gone over that again and again.

COMMISSIONER DAVIS: If I may again, I agree with Dr. Hurlburt and Dr. Laufer that utilization is important, an important matter and we do comment on it later. The -- my understanding of the point of this bullet point is the whole Milliman study was a search for why do we have a 35% delta for Alaska and what they're saying here is this, although important, is not one of the things that explains that 35% delta.

CHAIRMAN HURLBURT: Okay, are we ready to move onto the next one? I think we're accepting that.

EXECUTIVE DIRECTOR ERICKSON: Well, so Jeff suggested we leave it alone, but we -- I did have a suggestion that we add at least what was highlighted here in yellow is based on financial analysis of the -- where did the rest of my sentence go -- of the private health care system, and then I didn't know if you still wanted to add to clarify again that we're higher than comparison states or not. So I was hearing

Jeff.....

CHAIRMAN HURLBURT: So do you want a motion to approve that modification, Deb, then?

EXECUTIVE DIRECTOR ERICKSON: Well, Jeff was suggesting that we leave it completely alone, but I think with the yellow highlight, is that correct?

COMMISSIONER DAVIS: I move we.....

EXECUTIVE DIRECTOR ERICKSON: We need a motion.

COMMISSIONER DAVIS: I move we accept this statement as amended on that screen at the moment with the blue and the yellow.

EXECUTIVE DIRECTOR ERICKSON: And I will.....

CHAIRMAN HURLBURT: Is there a second?

EXECUTIVE DIRECTOR ERICKSON: Let me -- okay, yes, a second and then I'll read it.

COMMISSIONER CAMPBELL: Second.

EXECUTIVE DIRECTOR ERICKSON: Keith seconds.

CHAIRMAN HURLBURT: Okay.

EXECUTIVE DIRECTOR ERICKSON: So I'll read that first sentence as amended. "Alaska's health care utilization rates do not appear to be a major driver behind premium rates being higher than in comparison states based on financial analysis of the private health care system." Any discussion?

CHAIRMAN HURLBURT: Call for the question? Okay, all those in favor of the amendment highlighted in yellow that Deb

just read, raise your left hand.

EXECUTIVE DIRECTOR ERICKSON: And blue.

CHAIRMAN HURLBURT: All those opposed. Allen. Anybody abstaining? Dr. Laufer.

EXECUTIVE DIRECTOR ERICKSON: So for the record, Keith, Dave, Ward, Val, Emily and Jeff voted for the motion. Allen voted against. Noah abstained.

CHAIRMAN HURLBURT: Correct, yeah (affirmative). Okay, so the motion is passed. Did we give you a chance to express your reasons for voting no or did we run over that?

COMMISSIONER HIPPLER: Yeah (affirmative), the question -- it was just called before I had a chance to say anything.

CHAIRMAN HURLBURT: Okay.

COMMISSIONER HIPPLER: But yeah (affirmative), it's.....

CHAIRMAN HURLBURT: We're informal enough that.....

COMMISSIONER HIPPLER: The blue highlight is grammatically puzzling and also doesn't appear to be necessary. So I voted against it.

EXECUTIVE DIRECTOR ERICKSON: Unless folks want to move to revise it again, we can move on. Unless folks want to make a motion to improve it, we can move on.

CHAIRMAN HURLBURT: Okay, I'll think we'll -- consensus is to move on. Thank you, Allen.

EXECUTIVE DIRECTOR ERICKSON: Okay, the next comment is related to hospital operating costs and in the public comment

packet, we're on page 27. Using the yellow highlighted section -- I'm going to move past that and take that out. We're on page 13. So the comments from ASHNA are that they had concerns about Milliman's methodology for calculating hospital operating costs. They had shared those in a document that we provided to Milliman on the draft report and again, Milliman reviewed their comments carefully and did not agree that there was any flaw in their methodology.

COMMISSIONER CAMPBELL: Meaning Milliman's methodology?

EXECUTIVE DIRECTOR ERICKSON: Correct, correct, there was no flaw in -- Milliman found that there was no flaw in their own methodology. Emily.

COMMISSIONER ENNIS: Deb, may I clarify that the allegation or the reason to believe there is a possible flaw is because of the Erickson analysis?

EXECUTIVE DIRECTOR ERICKSON: No, no, no.

COMMISSIONER ENNIS: Not at all, so.....

EXECUTIVE DIRECTOR ERICKSON: I'm -- it had -- not related to that in any way, shape or form.

COMMISSIONER ENNIS: Okay.

EXECUTIVE DIRECTOR ERICKSON: The Erickson analysis was very specific to the ISER report data point that we had pulled into our.....

COMMISSIONER ENNIS: Okay, not to Milliman, okay.

EXECUTIVE DIRECTOR ERICKSON: .....report on the

comparison to wellhead.

COMMISSIONER ENNIS: Just wanted to clarify that, thank you.

COMMISSIONER DAVIDSON: I just want to make sure I'm in the right section. Are we in the section that says, "Medical prices are driven by two components?"

EXECUTIVE DIRECTOR ERICKSON: Yes, we are.

COMMISSIONER DAVIDSON: Okay, thanks.

COMMISSIONER HIPPLER: Mr. Chairman.

CHAIRMAN HURLBURT: Yes, please, Allen.

COMMISSIONER HIPPLER: Is it -- I see there's a highlighted not to change from "Profit" to "Operating margin," and I see that repeated throughout the findings. Is this adopted from ASHNA's recommendation?

CHAIRMAN HURLBURT: Yeah (affirmative), it was an attempt to be responsive to theirs, because they felt there could be confusion between pretax and after tax.....

EXECUTIVE DIRECTOR ERICKSON: We're actually -- I'm sorry, we're actually going to get to that next.

CHAIRMAN HURLBURT: Yeah (affirmative).

EXECUTIVE DIRECTOR ERICKSON: Can we -- can we hold off on answering your question, Allen, until we're done with hospital operating costs because the next one's the hospital operating margin comment? Does.....

COMMISSIONER HIPPLER: So really the only thing we're

talking about is whether or not to change these percentages, is that correct?

EXECUTIVE DIRECTOR ERICKSON: You know, no, no, no, that's not what we're talking about at all. I'm sorry. We're talking about ASHNA's comment on page 27 of the public comment packet that they had expressed concerns before about Milliman's methodology in determining hospital operating costs. So I guess I would just say that they don't ask for a specific change here. They're noting that they expressed concerns before to Milliman and that their concerns weren't addressed. Their concerns were addressed, but not in the way they would have liked.

So unless anyone wants to -- unless you want to discuss that point further, we can move onto their next point and then I'll clarify our process on these other number change highlights. We need to vote on that too. Anything more -- does anybody want to discuss hospital operating costs, Milliman's findings and our incorporation of that to these -- our findings statements?

CHAIRMAN HURLBURT: Keith, yeah (affirmative).

COMMISSIONER CAMPBELL: I just would note that -- and we're going to talk about it later on when we get to our manpower section, but this is it on 10 higher operating costs driven by practices and medical salaries, et cetera, et cetera, and I think that just would reinforce later on when we

talk about our health manpower that one of the ways to put downward pressure on that differential of wages, because of the itinerant workers that are called in and things of that nature, that this does drive the cost of labor up and that is a factor, so that we should hit in this section later on and flag that is imperative that we do highlight that the more homegrown people you have in state, either -- for all of your health manpower needs -- that we should really stress because that will be the first thing that would put downward pressure on wages and costs, which is a big driver.

CHAIRMAN HURLBURT: Any other comments?

EXECUTIVE DIRECTOR ERICKSON: So next is the comment related to hospital operating margins, but let me go to Allen's question about the various percentages and numbers that are changed and highlighted in yellow and to my explanation at the beginning of our meeting that I went through to update those numbers based on Milliman's final report from the preliminary draft.

I -- what I would like to do is get through this last public comment and then go back and revisit any of the other changes that are suggested here and you can vote to accept or not, those other changes and any other changes you want. Does that make sense?

UNIDENTIFIED COMMISSIONER: (Indiscernible - too far from microphone).

EXECUTIVE DIRECTOR ERICKSON: Okay. So then the point to hospital operating margins, page 28 of -- I want to make sure I didn't leave something out. There's an additional comment related to operating costs. I'm sorry. I don't want to leave that out. So at the very bottom of page 27 and the top of page 28 in the public comment packet, ASHNA expressed concerns that the labor cost difference that Milliman noted and that we brought in as background for our findings statement, that their experiences -- they don't agree based on their experience, but Milliman had cited two different surveys that they used to back up their -- both -- one survey and BLS data that they used to arrive at their data points about this, but ASHNA said it doesn't reflect their experience.

They also noted that it doesn't -- the salary surveys don't capture benefit costs, although we did note that these are salaries, not complete compensation packets and we did include a bullet further on about the high cost of health benefits for hospital and physician practices' employees is another cost driver behind higher operating costs. So any discussion related to concerns raised about medical salary differences?

Hearing none, we'll move on then, to the comments related to the operating margins. So on page 28 of the public comment packet, ASHNA notes that they're disappointed with the finding in the narrative in the Milliman report. They didn't like the

methodology used. This was another point that had been raised on the earlier draft of Milliman's report and again, Milliman did not agree that there were any problems. They were -- they weren't doing a statistical study of this. They were actually doing a financial analysis and using the cost report data actually reported by the hospitals.

I think part of the concern, and that's why I went through and tried to be as clear and as precise as possible that this is an analysis of a system -- there were a few things that I did. So let me point that out for you. So if you go back to the yellow highlighted document and I -- one of the things I did was I clarified that this wasn't actually an actuarial analysis. It was conducted by actuarial experts, but earlier, just in the introduction to this section where I introduced it as an actuarial study, I changed it to a financial analysis and I added a sentence down under -- towards the very bottom of the introduction on page 11 of this document related to the Milliman reports and where they could be found.

I added a sentence that -- or a couple of sentences. Note that these reports, the Milliman reports, are system's level analyses and are not intended to be utilized as an evaluation of individual facilities or physician practices. Statistics for individual facilities vary widely within the system's level averages presented and conclusions should not

be drawn about specific facilities from these data without review of each facility's financial and cost reports.

So at least in part address concerns that assumptions will be made about individual facilities based on the system average presented -- thought it would be helpful to add that clarification. Also, raised in the earlier comments, not specifically in this report, there have been concerns raised that Milliman's analysis did not take into consideration that for-profit hospitals pay taxes, but -- and so to be as precise as possible, there are a number of different ways to measure profit and Milliman presents in one of their tables, total margin, gross margin and also operating margin and they use the operating margin figure as a component of what's driving price, but they didn't use a final net margin figure because it's not relevant to price.

So for example, I just bought a new car. Let's say it was $20,000. Ford paid 30 or made 30% profit. So their earnings were $6,000 off of that. They maybe gave $2,000 to the government in the form of taxes. It didn't reduce my price by $2,000. It's still a component of price and that's what Milliman was evaluating.

So non-profits use their earnings for community purposes and reinvestments. Non-profits or for profits, some of it goes to the government. Some of it goes to shareholders. None of those are -- points are relative to -- relevant to the

price calculations and so that's why Milliman, in part at least, hadn't agreed with ASHNA's comments and why I'm trying to be as clear as possible where profit is -- can be a more general statement that they really were looking at operating margins as the profit component in price and so that's why I changed the word "Profit" to "Operating" in that statement and as you noted, Allen, in a couple of other places, I made that change as well.

Another suggested change that I have relative to -- relative to this comment, if you look on page 14 of the yellow highlighted draft -- again, to be as clear as possible and to ASHNA's concern that the way that Milliman perhaps had worded some of their language in their narrative and the way we were wording it, it sounded as though where we're saying operating margins for Alaska's private sector hospitals are higher, if we could be specific that this was an average for the system, understanding again, that those averages vary widely.

So I suggested taking out part of the language from our draft and rewording the first part of that to a single stand-alone sentence that would now read, "The average operating margin," there's a line through that S. "The average operating margin for Alaska's private sector hospital system is 133% higher than the average operating margin for the comparison state's private sector hospital systems."

Another thing I wanted to point out, one of the ways that

Milliman thought they could help clarify to anybody reading their report that while they're looking at as an overall price driver, the operating margin, they still understand and didn't want folks to make the assumption that just because we say this about the system, you can apply it to an individual hospital, so I don't know if you caught, in their final version of the report, in one of their data tables, they actually listed the individual operating margins for every single one of the 16 private sector non-federal facilities that they included in as part of the analysis and so you can see that they vary widely from a negative nine percent margin in one of our smallest communities that have a hospital to nearly 30%.

So again, to not -- in an effort to try to not be misleading to somebody, a member of the public, who might be reading their report, that was one way in which they responded to that ASHNA comment.

COMMISSIONER DAVIDSON: So I'm looking at the next page of -- maybe on your screen, if you can scroll to the section that says, "The average operating margin for Alaska's private sector hospital system is 133%," and I'm trying to reconcile that with page 19 of the Milliman report and the three conclusions that I get from the Milliman report, I don't see the 133% statement anywhere.

The three things that I see from their report are

Alaska's margin for non-federal hospitals is 6.9 percentage points higher than the comparison state average.

EXECUTIVE DIRECTOR ERICKSON: I'm sorry, Val, what page are you on in the Milliman report?

COMMISSIONER DAVIDSON: I'm sorry, I'm on page 19, drivers of health care costs and Alaskan comparison states and it's the section on hospital margins and let's see.....

EXECUTIVE DIRECTOR ERICKSON: So their point -- they state their comparisons as a percentage of, not percentage higher. So if you look at -- what's the easiest way? Look at the very last short paragraph that's just a couple of sentences on that page, if you pull your eyes up three lines above that, that's where they state that the all-payer operating margins in Alaska are 233% of those in the comparison states. Two hundred thirty-three-percent of the comparison states is the same as saying 133% higher.

COMMISSIONER DAVIDSON: I guess the three things that stuck out to me based upon the Milliman's report -- are three things, if I can finish? One is that the Alaska margin for non-federal hospitals is 6.9 percentage points higher than the comparison state average. That's one.

The second is when restricting to operating margins for all payers, the average margin in Alaska is approximately 7.7 percentage higher than the average comparison -- in the comparison state and the third point that I saw is that for

Medicare patients, the operating margin is more negative by 2.6 percentage points than the comparison state average and then I guess, a fourth point is at the bottom that such markedly negative Medicare margins in Alaska caused upward pressure on commercial premiums in order to offset hospital losses from Medicare business or Medicare cost shifting and I think that -- I mean, we hired these folks. We spent a lot of money for them to produce this report. I think we ought to use their language.

EXECUTIVE DIRECTOR ERICKSON: So what I -- I would -- could -- well, one of the things we might do is -- unless you disagree, is this last point was to the cost shifting finding earlier, but we could include it here. The -- one of the things that you might note in their introduction, if I could refer you to page two of their report, one of the things that they were concerned that they were picking up from these comments was that there was a confusion on this particular data point because an operating margin is a percentage and they were also using percentages as comparison to the other states, that was going to confuse folks.

So you'll note that with every other bullet point, and I'm looking at the key conclusions there that Milliman drew, every other bullet point, they only state the one percentage point as the average of the comparison of the other states, but in the operating -- hospital operating margins, they

wanted to include both, because again, they thought it would confuse people to use the percentage of the operating margin and/or one or the other, the difference.

We asked them to provide a comparison stating what the actual margin is, doesn't give a sense of scale of the difference and so if you want to change it to the actual operating margin and the percentage point difference, then we might want to also include the dollar amount difference of those margins and we could do a calculation of that. I think it's about -- with total margins, it's close to a quarter of a billion dollars, but we can calculate that quickly from their table. Jeff.

COMMISSIONER DAVIS: So just weighing in here, I'm quite sympathetic to ASHNA's comments around this one. Few people are going to read the entire report, but sound bites will come out of it. Percentages confuse people. When 233% of a number is 2.3 times that number, you know, but the actuaries then state is as 1.3 times that number. So it's confusing and it also doesn't give you a relative to what, you know.

I could -- hospital margins could be .01 in the comparison states and .03 in Alaska and be three times what they were in the comparison states. So it doesn't tell you -- give you any scale. So I think that it is important that we -- if we give a scale, that we -- and I liked what Val proposed. I think put -- stating the actual percentages.

What was it? You know, 6.9, whatever, 13.7, stating those, leave it alone, let people do their own judgments on that is the most accurate way we could put it and I think it's also very important that we emphasize the fact that they vary significantly by facility and that to make any individual facility judgment, you have to look at that. Even that seems a little light to me.

I mean, since we're talking about a report done by actuaries, I think I've, you know, told this joke before, but two actuaries playing golf. One hits the ball 100 yards right and one hits the ball 100 yards left. On average, they both had a hole in one and averages are really misleading. So what I don't want is this to get used, ever used to say to a hospital administrator who is, you know, actually got a low margin, "Hey, you're, you know, you're making triple what the hospitals are in the Lower 48," and have that become urban legend.

I really think we need to be cautious of that, particularly in this and so as I said in the beginning, I'm quite sensitive to ASHNA's comments. So I believe in this one, more detail is better. We use -- I think using operating margin is the appropriate measure to pull out if we want to, because that's the most apples to apples, state the percentages, you know, it's 7.7% higher, 13.4 in Alaska, 5.7 in the comparison states, whatever that might be, I think

putting the Medicare number out there with the -- as was stated is also important and again, maybe a strong -- a very, very, strong caveat about comparison across facilities and I think somewhere with the statement regarding the cost shift needs to be included.

So I think I've repeated myself. Thank you. Perhaps I might just add, I'm probably a little sensitive to this from personal experience in our industry. Thank you.

COMMISSIONER DAVIDSON: So I would move what I meant, but what he said, and while we're thinking about this, the other interesting note, which is found on page 21 of the report, I think will be relevant when it comes time for the long-term care discussion, which revealed based upon Milliman's information that the losses were being incurred on swing bed skilled nursing services in hospitals, which has huge implications for our long-term care need.

EXECUTIVE DIRECTOR ERICKSON: Which caveat, that the margins vary widely?

CHAIRMAN HURLBURT: To me, it would clarify it if we had the word, "Total," in that first sentence, the average total operating margin, because that includes Medicare.

COMMISSIONER DAVIS: If I may, as much as possible, I think we should take Val's suggestion, which was to use Milliman's wording, which I think they tried to be as precise as possible.

EXECUTIVE DIRECTOR ERICKSON: And I think my concern -- I understand your point, Ward. My concern would be if you look at their table for gross margin, they use the word total margin and so if we put "Total" here with operating, that could be confusing. We could say for all payers.

CHAIRMAN HURLBURT: Yeah (affirmative), yeah (affirmative).

UNIDENTIFIED COMMISSIONER: (Indiscernible - too far from microphone).

EXECUTIVE DIRECTOR ERICKSON: Do you have a preference where it goes?

COMMISSIONER DAVIS: How do they say it?

EXECUTIVE DIRECTOR ERICKSON: I need your mic.

COMMISSIONER DAVIS: Sorry, I'm just reading from page 19 of Milliman's report exactly how they said it there and they said, "Operating margin for all payers."

CHAIRMAN HURLBURT: Yeah (affirmative).

COMMISSIONER LAUFER: Is it useful to include after operating margins for individual facilities vary widely within these averages, the statement that says, you know, and there are several hospitals that operate at a loss or to acknowledge that there are hospitals operating in the negative?

COMMISSIONER DAVIS: You could say, you know, between there (indiscernible - too far from microphone).

EXECUTIVE DIRECTOR ERICKSON: Provide the variation and

the range.

COMMISSIONER DAVIS: In fact, they range from minus da-da to plus da-da, and that would go right -- yeah (affirmative), that's (indiscernible - too far from microphone).

EXECUTIVE DIRECTOR ERICKSON: Make sure -- look at the table in Milliman's report on page 20 and make sure I'm grabbing the highest and the lowest, and we're using -- since Milliman was using 2010 data and this table, they actually provide 2008, 2009 and 2010, to show if there were any blips in a particular year, so we're using 2010.

So I'm seeing here that the most negative margin was for Cordova at negative 9.2% in that year and that the highest in margin in that year was 29.4%. So if you all want to confirm that I'm tracking correctly?

CHAIRMAN HURLBURT: Yes. Yes.

EXECUTIVE DIRECTOR ERICKSON: So I'm going to read what -- how I've reworded this and then somebody can make a motion if you like it and second it and you can vote on it. What I've done now is replaced the bullet. So what we're proposing to do is to replace the entire bullet that read, "The operating margins, especially are" -- well, I'm not going to read that, but the operating margins for hospitals bullet, we're replacing with a new bullet now that will read, "The average all-payer operating margin for Alaska's private sector hospital system in 13.4% compared with the average of

comparison state's hospital systems of 5.7%. Operating margins for individual facilities vary widely within these averages, ranging from negative 9.2% to 29.4%."

Should we specify that we mean for Alaska? Operating margins for individual Alaska facilities?

CHAIRMAN HURLBURT: Yeah (affirmative).

EXECUTIVE DIRECTOR ERICKSON: Okay, operating margins for individual Alaska facilities vary widely within these averages, ranging from negative 9.2% to 29.4%.

UNIDENTIFIED COMMISSIONER: Can we say what year?

EXECUTIVE DIRECTOR ERICKSON: In 2010, maybe we should put that up front. How about -- because it's for all -- it's all -- it captures all of this data. In 2010, average all-payer operating -- the average all-payer operating margin for Alaska's private sector hospital system was 13.4% compared with the average of comparison state's hospital systems of 5.7%. Operating margins for individual Alaska facilities vary widely within these averages, ranging from negative 9.2% to 29.4%.

For Medicare patients, the operating margin is 2.6 percentage points less than the comparison state average at negative 11.5% in Alaska, compared to negative 8.9% in the comparison states, causing upward pressure on commercial premiums in order to offset hospital losses. Any questions or comments on that revision and if not, does somebody want to

make a motion.

UNIDENTIFIED COMMISSIONER: Val did make a motion.

CHAIRMAN HURLBURT: Yeah (affirmative).

EXECUTIVE DIRECTOR ERICKSON: You moved it? I'm sorry, I didn't hear.

UNIDENTIFIED COMMISSIONER: (Indiscernible - too far from microphone).

EXECUTIVE DIRECTOR ERICKSON: Sorry. Moved and seconded.

CHAIRMAN HURLBURT: Any discussion? Keith, no?

COMMISSIONER CAMPBELL: Is the higher rate of charity care included somewhere else or is this the place where that should be included?

EXECUTIVE DIRECTOR ERICKSON: The high rate of charity care is captured in.....

COMMISSIONER CAMPBELL: Non-reimbursable.

EXECUTIVE DIRECTOR ERICKSON: .....or the charity care provided is captured in operating costs.

COMMISSIONER CAMPBELL: Okay.

EXECUTIVE DIRECTOR ERICKSON: I mean, it.....

COMMISSIONER CAMPBELL: (Indiscernible - too far from microphone).

EXECUTIVE DIRECTOR ERICKSON: Different hospitals, I think, you know, it gets calculated in different ways. It's covered in their costs.

CHAIRMAN HURLBURT: Yes.

COMMISSIONER MORGAN: This is David. If they're not doing it, then boy, are they doing their accounting wrong. They have to capture that cost in there.

CHAIRMAN HURLBURT: Any other discussion?

COMMISSIONER CAMPBELL: Call for the question.

CHAIRMAN HURLBURT: Okay, all those in favor of adopting the amendment stated, amendment as Deb read, left hand. All those opposed, the same. Anybody abstaining? It's unanimous.

EXECUTIVE DIRECTOR ERICKSON: That's it for the comments on this section. So what I'd like to do is go back and revisit section by section, if we need to, some of these other changes. We already voted on -- I'm going to go back up to -- so on the yellow highlighted draft again, make sure we do this right and capture it all, page 11, and you actually don't have this on here, that first finding, we already voted on the changes. So there's nothing there.

On the bottom of page 12, we already voted on that change, even though it might be a little bit awkwardly worded now. So then, the top of page 13, I'm going to suggest we strike this additional data addition and just skip over that. So if you go to the middle of page 13, health care prices paid in Alaska, note that the 70% figure changed to 69% on reimbursement, commercial reimbursement in the final report and then commercial reimbursement for hospitals changed from

35% higher to 37% higher in the final report.

So I would -- well, let's look at the rest of this page and then moving on down, the next bullet was related to the two components driving medical prices, operating costs and operating margins. We have a change to -- from profit to operating. We've changed 40% to 38% for the higher operating costs for hospitals, nearly 80% to 86% higher operating costs for private sector rural hospitals in Alaska.

I suggested just to -- for -- to simplify the language a little bit, taking out the word "Both" there. Cost of living in the final analysis, Milliman noted as 20 to 30% higher. Medical salaries in their final analysis, they showed ranged from zero percent to 10% higher and the top of page 14 then, continues that section up to the bullet we just changed, so more of the sub-bullets about why operating costs are higher.

It's just clarifying again, not generalizing to all hospitals, but referring to the hospital system. So drivers of higher operating costs in Alaska specific to -- adding the word "The" private sector hospital, taking out S, system, and their final number for the RN staffing ratio and to clarify, again, added that this RN staffing ratio, which -- average 29% higher than comparison states, it changed from 28% in the initial analysis, and occupancy rates, which on average are lower at 49.9% in Alaska relative to 58.1% in comparison states.

CHAIRMAN HURLBURT: I've got a question. Maybe with one other exception, all of your numbers are rounded to whole numbers.

EXECUTIVE DIRECTOR ERICKSON: You're not -- you need to use your.....

CHAIRMAN HURLBURT: Yeah (affirmative), I have a question. With one other exception in the changes, all of the numbers are rounded to whole numbers, except for this point. Is there a reason?

EXECUTIVE DIRECTOR ERICKSON: Well, I -- I grabbed -- I just grabbed what they actually had in the report.

CHAIRMAN HURLBURT: Yeah (affirmative).

EXECUTIVE DIRECTOR ERICKSON: And so I was just copying exactly what they put in the report. I think, you know, those two were so close before that my guess is in their earlier -- in their first draft, they had rounded slightly and decided to be more precise in the second go around and in this particular point, they're noting what the actual occupancy rates are, just like we just changed the margins too, instead of the difference.

CHAIRMAN HURLBURT: But all.....

EXECUTIVE DIRECTOR ERICKSON: In the others, they were stating the difference, so maybe that's why.....

CHAIRMAN HURLBURT: Yeah (affirmative), so -- but this is.....

EXECUTIVE DIRECTOR ERICKSON: .....they were being more precise.

CHAIRMAN HURLBURT: .....looking at the document going forward, the format that we have in here is all of the percentage numbers that we give, except for one other one, are in whole numbers and.....

EXECUTIVE DIRECTOR ERICKSON: Except for the margin numbers we just added, the actual margin figures.

CHAIRMAN HURLBURT: Okay.

EXECUTIVE DIRECTOR ERICKSON: So, see what I'm saying? It seems like we're being.....

CHAIRMAN HURLBURT: Yeah (affirmative).

EXECUTIVE DIRECTOR ERICKSON: .....more precise where they're stating the actual figure, rather than showing a comparison percentage.

CHAIRMAN HURLBURT: Okay.

EXECUTIVE DIRECTOR ERICKSON: I mean, I see your point, especially for a scientist, they don't like being inconsistent in how many decimal places you're carrying that out. Our other scientist is.....

CHAIRMAN HURLBURT: To quote Henry David Thoreau, "A foolish consistency is the hobgoblin of little minds."

EXECUTIVE DIRECTOR ERICKSON: So not to be too confusing, can we cut this off right at above the changes that I just read through, stopping right above the operating margin

paragraph we just rewrote and approved?

COMMISSIONER HIPPLER: I'll make a motion to approve all corrections to percentages and all other (indiscernible - voice lowered) changes.

COMMISSIONER MORGAN: I second that.

CHAIRMAN HURLBURT: Any discussion? Call for the question.

UNIDENTIFIED COMMISSIONER: Sure.

CHAIRMAN HURLBURT: Val. Everybody in favor, raise your left hand. Opposed, the same. Anybody abstained? It's unanimous, Deb.

EXECUTIVE DIRECTOR ERICKSON: I did add -- I'm not -- there are two additional points we need to talk about, three, sorry about that.

COMMISSIONER DAVIS: Where are you?

EXECUTIVE DIRECTOR ERICKSON: I am in the middle of page 14 and we can discard this entirely. These were the final conclusions that Milliman had shared with us and I thought that it potentially could bring some clarity to what we were -- the conclusions this body was drawing from their reports, so I suggested them here, but we can take them out entirely. It was just a thought that I thought might help provide some clarity.

So these are the two highlighted sections that you wouldn't have seen before today that say, "Private sector

hospital reimbursement in Alaska is high relative to comparison states driven by the first bullet. High operating costs in rural Alaska, the average of which is 86% higher than the comparison state average and two high operating margins in urban Alaska, the average of which is 184% higher than the comparison state average.

So Milliman had shared that in their final presentation. Our prices for hospital services are higher here and for rural Alaska, it's because their operating costs are higher and for urban Alaska, it's because their operating margins are higher and then too, the physician services, non-facility-based physician service reimbursement by commercial payers in Alaska is very high relative to comparison states driven by 1) high operating costs, and 2) significant negotiating leverage relative to payers.

So we can take these out all together. If you like having these more summary conclusion statements, we can leave them in and change them. What's your preference?

COMMISSIONER HIPPLER: Were these proposed -- I'm sorry.

CHAIRMAN HURLBURT: Val.

COMMISSIONER DAVIDSON: I was going to ask; can you show me where those comments are reflected in the Milliman report?

EXECUTIVE DIRECTOR ERICKSON: It might take me a minute.

COMMISSIONER DAVIDSON: Again, we paid.....

EXECUTIVE DIRECTOR ERICKSON: I have to do it after a

break and it might have been from their final presentation to us. That's what I was actually remembering was their summary at the end of their final presentation at the last meeting.

COMMISSIONER DAVIDSON: Okay, so I'm assuming it's going to be somewhere in their final report?

EXECUTIVE DIRECTOR ERICKSON: Right.

COMMISSIONER DAVIDSON: Okay.

COMMISSIONER CAMPBELL: Mr. Chair.

CHAIRMAN HURLBURT: Yes.

COMMISSIONER CAMPBELL: I think that I would recommend taking out those two bullets, as long as we're not trying to be inflammatory or anything like that and conciliatory and get the facts. People, these are facts, but the fact is that they will tend to be an irritant and these are people we're trying to bring to the table to solve this particular problem and we don't need to -- I think it's in the Milliman report. It will always be in the Milliman report and that we can concede that we don't need to highlight that at this point.

EXECUTIVE DIRECTOR ERICKSON: In answer to Val's question, on page four of the executive summary of the Milliman report, it's the conclusion of the executive summary. Overall, the higher commercial premiums in Alaska are being driven by higher unit costs, rather than higher utilization of health care resources. The higher physician reimbursement is caused, at least in part, by the relative scarcity of

providers and that was actually their conclusion of why they thought negotiating power was better -- was higher for physicians here than in other states and that's noted in another part of their report.

On the hospital side, higher reimbursement can be explained by higher facility costs in the rural areas, but is leading to higher profit margins in urban areas where the reimbursement in Alaska relative to the comparison states is greater than the relative cost.

CHAIRMAN HURLBURT: Jeff, yeah (affirmative).

COMMISSIONER DAVIS: Just kind of a meeting comment here, if we do decide to adopt these, I think we would need to struggle with the second sub-bullet under the hospital reimbursement because it has the same issues that we just dealt with in -- with the overall hospital bullet and trying to make sure we weren't tarring everyone with the same brush. So if we do keep them, I think we'll need to struggle with that.

CHAIRMAN HURLBURT: So Keith, was your comment in the form of a motion?

COMMISSIONER CAMPBELL: We'll make that -- yes, it is in the form of a motion.

CHAIRMAN HURLBURT: And was yours in the form of a second, Jeff?

COMMISSIONER DAVIS: No, sir, it was not.

CHAIRMAN HURLBURT: No, it was not, okay.

COMMISSIONER ENNIS: I would second.

CHAIRMAN HURLBURT: Okay, Emily, thank you. Is there -- go ahead.

EXECUTIVE DIRECTOR ERICKSON: I'm, you know, I'm sorry, I don't think you need a motion to take -- because this was just suggested clarification by me. We're not -- we don't need to move and vote on whether we include it or not. What we need is a motion from somebody who wants to add it to the report, if somebody wants to add it to the report. If not, we can move on.

CHAIRMAN HURLBURT: David, yeah (affirmative).

COMMISSIONER MORGAN: Can we have a couple of minutes recess, please?

UNIDENTIFIED COMMISSIONER: (Indiscernible - too far from microphone).

COMMISSIONER MORGAN: Yeah (affirmative), like five, three or four minutes, just for a few minutes to -- so we can discuss.

CHAIRMAN HURLBURT: Any objection?

COMMISSIONER MORGAN: I just want five minutes. That's all.

CHAIRMAN HURLBURT: Okay.

11:19:44

(Off record)

(On record)

11:23:31

CHAIRMAN HURLBURT: So is there some discussion on this section now, and Allen, you can go first.

COMMISSIONER HIPPLER: Yes, the second proposed addition, which begins "Non-facility-based physician service," I will make a motion to put that in.

CHAIRMAN HURLBURT: Is there a second on that? Not a second, okay. David.

COMMISSIONER MORGAN: I thank you for giving me a recess. We've had some staffing changes at the Primary Care Association and I had to go get some instructions. The feeling is the two sections that we sort of bypassed on the hospital part, I would like to make a motion -- I mean, I could second, but a motion to put those into the report. The two that -- where is it? We were discussing right before we took a break.....

EXECUTIVE DIRECTOR ERICKSON: Page 14.

COMMISSIONER MORGAN: Page 14.

CHAIRMAN HURLBURT: So is your motion, David, to put both the sections in, the physician services and the hospital or just the hospital?

COMMISSIONER MORGAN: The hospital part, right.

CHAIRMAN HURLBURT: Just the hospital part?

COMMISSIONER MORGAN: Yeah (affirmative).

COMMISSIONER DAVIDSON: Can you read which section you're talking about? I'm confused.

COMMISSIONER MORGAN: So -- well, I'm confused as to the page. I have the.....

EXECUTIVE DIRECTOR ERICKSON: I have the two up on the screen too, if that's helpful, yeah (affirmative).

UNIDENTIFIED COMMISSIONER: Yeah (affirmative), you're on the right page.

UNIDENTIFIED COMMISSIONER: No, I'm looking at that one. Is that right?

COMMISSIONER MORGAN: Yes. I make a motion to put those into the final report.

EXECUTIVE DIRECTOR ERICKSON: Both the private sector hospital and the non-facility-based physician service bullets?

COMMISSIONER MORGAN: Yes.

CHAIRMAN HURLBURT: Okay, I.....

EXECUTIVE DIRECTOR ERICKSON: So Dave has just motioned to include these two sections on private sector hospital reimbursement in Alaska is high relative to comparison states driven by high operating costs in rural Alaska and high operating margins in urban Alaska and the second bullet, non-facility-based physician service reimbursement by commercial payers in Alaska is very high relative to comparison states driven by high operating costs and significant negotiating leverage related to -- relative to payers. Is there a second?

COMMISSIONER HIPPLER: I will second.

CHAIRMAN HURLBURT: Okay, Allen seconds. Thank you. Is there discussion? Linda, yeah (affirmative).

COMMISSIONER HALL: Even though I can't vote, did you leave the averages in the two statements under the hospital one, the first one, the 86% and the 184%, did I hear you read those?

EXECUTIVE DIRECTOR ERICKSON: I skipped over them to be quick, because I figured we would go back and wordsmith if it even got adopted and before it was voted in final.

COMMISSIONER HALL: Okay. I just wanted to know if those percentages were left in.

EXECUTIVE DIRECTOR ERICKSON: Yeah (affirmative), as written, I -- it was just moved as written.

COMMISSIONER HALL: Okay, thank you.

CHAIRMAN HURLBURT: Jeff.

COMMISSIONER DAVIS: May I -- I was just going to ask our distinguished colleagues across the aisle here if they want to elaborate on why you're interested in having these included.

COMMISSIONER MORGAN: Well, we -- the information I'm getting is it is the Milliman study and correct, and that we think that it should be -- we know the Milliman study will probably -- is an addendum to the overall -- we just felt that it was significant enough and important enough that we would

propose that it be in the -- in our report to the Legislature and the Governor. It -- nothing personal here, it's just we felt the numbers were significant enough and important enough, they should be in.

Like I said, I thank the Commission for letting me talk to my -- to the mother ship, but we've had some changes and I -- some of the communications as -- when we review these documents, didn't get to me. So that's the reason why.

CHAIRMAN HURLBURT: Allen, did you have.....

COMMISSIONER HIPPLER: Okay, I -- if we take these one at a time, the first one, private sector hospital reimbursement, have these points not already been covered, both of them, in the -- directly proceeding section or am I missing something?

COMMISSIONER DAVIS: It appears to me that we did with our revised -- interested in your opinion, Deb.

EXECUTIVE DIRECTOR ERICKSON: Just from Milliman's final conclusion that based on their analysis that the higher reimbursement for hospitals in this state is driven by very high operating costs in rural areas and high operating margins in urban areas and that's not necessarily clear, while the specific data points are included, for operating, the difference between urban and -- or all Alaska and rural operating costs are noted.

The differences in operating margins between rural and urban Alaska is not noted in our findings and the fact that

for those two different areas of the state, that the prices -- the price differences are driven by different factors, where we were looking at the two factors as driving price, operating costs and operating margin, they were making the distinction and drawing different conclusions from different parts of our state. Val and then Allen.

COMMISSIONER DAVIDSON: I don't -- I'm still looking at the Milliman report and I don't see the comparison and the number of 86% and 184%.

EXECUTIVE DIRECTOR ERICKSON: It was the 86% -- I'm sorry.

COMMISSIONER DAVIDSON: So.....

EXECUTIVE DIRECTOR ERICKSON: Are you talking about the numbers specifically?

COMMISSIONER DAVIDSON: Yes.

EXECUTIVE DIRECTOR ERICKSON: So -- yeah (affirmative). Well, what I did in this draft was -- referring to their conclusion on page four, they don't use the numbers, but then pulling the numbers in to show what that difference was.

COMMISSIONER DAVIDSON: I guess I just keep coming back to the point of we paid them a lot of money and we should use the language that's contained in their report. Now, if we think that they didn't do their job and so therefore, we're having to reinterpret their information, then I think an adjustment needs to be made to their payment.

EXECUTIVE DIRECTOR ERICKSON: Yeah (affirmative). Well, and we can definitely do that. I don't believe that was a reinterpretation. That was the conclusion that they drew. I was just adding their substantiating data for it, because it's in two different places.

COMMISSIONER DAVIDSON: But I'm assuming.....

EXECUTIVE DIRECTOR ERICKSON: But go ahead -- I mean.....

COMMISSIONER DAVIDSON: I'm assuming that if they wanted to make that point, they certainly would have and certainly could have with the data set that was available to them and they chose not to for whatever reason.

EXECUTIVE DIRECTOR ERICKSON: Well, they did -- but they did. I mean, I don't mean to be argumentative.

COMMISSIONER DAVIDSON: Can you show me where?

EXECUTIVE DIRECTOR ERICKSON: On page four.

COMMISSIONER DAVIDSON: I see that. I'm looking for the 86% and I'm looking for the 184%.

EXECUTIVE DIRECTOR ERICKSON: It says the -- well, we could just put higher facility costs in rural areas and higher profit margins in urban areas. I mean, that's what they say here. They just didn't include data from the section of the report on operating costs and operating margins in their summary statement.

COMMISSIONER DAVIDSON: I guess I'm trying to find that page and find that -- that detail on page 19 and page 20,

which is the -- which is really the bulk of their information. It's what backs up their statement and I can't find it.

EXECUTIVE DIRECTOR ERICKSON: On the bottom of page 20, they say that margins in rural areas are similar to those in comparison states and nationwide. However, margins in the urban areas are significantly higher than elsewhere. Even within the urban areas, there is considerable variance in the margins by hospital, and then the data point is up above, they thought was significant enough that they pulled out the -- what they defined as the urban areas as Anchorage, Fairbanks and Mat-Su, and the non-MSA areas is how they referred to it. So you can see the total looking in 2010 operating margin of 13.4% for all Alaska, but then the difference is 16.2% for urban Alaska and 6.1% for the non-MSA. I think -- and it.....

COMMISSIONER HIPPLER: Mr. Chairman, I would like to split the question between the first bullet point, private sector hospital and the second bullet point, non-facility.

UNIDENTIFIED COMMISSIONER: I'll accept that change. Call for the question (indiscernible - too far from microphone) yeah (affirmative), call the question.

UNIDENTIFIED COMMISSIONER: Call for the question.

COMMISSIONER HIPPLER: There's two separate motions now.

CHAIRMAN HURLBURT: So we have a motion, which has been seconded to include both of the amended points as on the screen.

COMMISSIONER HIPPLER: With respect, Mr. Chairman, we have one motion to include private sector hospital and one motion to include non-facility, Mr. Chairman, I would submit.

CHAIRMAN HURLBURT: Okay.

EXECUTIVE DIRECTOR ERICKSON: So there will be two votes, one on the hospital piece and one of the (indiscernible - too far from microphone).

CHAIRMAN HURLBURT: Okay.

COMMISSIONER HIPPLER: And only the first one has been called at this time.

CHAIRMAN HURLBURT: Okay. So you're calling the question on the hospital issue, Allen, is that correct?

COMMISSIONER HIPPLER: I didn't call the question.

UNIDENTIFIED COMMISSIONER: I did.

COMMISSIONER HIPPLER: You did, okay.

EXECUTIVE DIRECTOR ERICKSON: So I -- let me read the motion then. The motion that we're voting on is to add a new finding bullet, "Private sector hospital reimbursement in Alaska is high relative to comparison states driven by," the first sub-bullet, "High operating costs in rural Alaska, the average of which is 86% higher than the comparison state average," and the second bullet, "High operating margins in urban Alaska, the average of which is 184% higher than the comparison state average."

CHAIRMAN HURLBURT: All those in favor of including the

amended language that Deb just read for the bullets addressing hospital reimbursement, all in favor, raise your left hand. All opposed, raise your left hand. All abstainers.....

EXECUTIVE DIRECTOR ERICKSON: So for the record, Ward and Allen voted for.....

CHAIRMAN HURLBURT: David.

EXECUTIVE DIRECTOR ERICKSON: I'm sorry, Ward and David, thank you. Ward and David voted for the motion and everyone else voted against.

CHAIRMAN HURLBURT: Against.

EXECUTIVE DIRECTOR ERICKSON: Okay, does somebody want to call the question on the second?

CHAIRMAN HURLBURT: Okay, Allen.

COMMISSIONER HIPPLER: I have a little discussion unless the question has been called.

CHAIRMAN HURLBURT: Go ahead, yeah (affirmative).

COMMISSIONER HIPPLER: Well, for the first point, I did think that was covered in the proceeding bullet point. For this, the second point, non-facility-based physician service, I'm not seeing that as elaborated elsewhere. I could be missing something, but I think that this is important and at least needs to be addressed, but if it is sufficiently addressed somewhere else, I will withdraw my idea.

EXECUTIVE DIRECTOR ERICKSON: I suppose you could see it captured in the same sets of -- set of bullets. So the

medical prices are driven by two components and most of those bullets that indicate the sub-bullets under the operating costs apply to both physician and hospital operating costs, so that's where -- documenting higher operating costs there and then for -- to the second point, the very last secondary bullet under the medical prices drivers is that physician discounts are low in Alaska relative to the comparison states, an indication that physicians in Alaska have more market power relative to pricing. So that's the -- I guess I would say that's those -- both of those points are covered, the same place that the hospital points are covered.

CHAIRMAN HURLBURT: Okay.

COMMISSIONER DAVIDSON: It's okay. So can you show me where in the Milliman report you're getting this conclusion or this finding?

EXECUTIVE DIRECTOR ERICKSON: Yes, I think. Sorry, under commercial discounts on page 33, we get into the laws. So the paragraph that starts, "The lower physician discounts in Alaska can be at least partly explained by the relative lack of competition among providers, particularly for specialty care. In many areas, including Anchorage, there are a limited number of providers in any given specialty, sometimes only one provider group. As a result, physicians can largely dictate the fees they are paid by commercial payers."

COMMISSIONER DAVIDSON: So is that information also --

I'm assuming it's examined more fully in this separate Milliman report on physician payment rates in Alaska and comparison states?

EXECUTIVE DIRECTOR ERICKSON: I don't believe so because that report was just documenting the differences and this report is regarding why there are differences. So this is the conclusion that they draw from analyzing the commercial discount data that they're describing in this section.

COMMISSIONER DAVIDSON: Thanks.

CHAIRMAN HURLBURT: David.

COMMISSIONER MORGAN: I call the question, if there's no more discussion.

CHAIRMAN HURLBURT: So the motion is to add the statement starting, "Non-facility-based physician services," that's in front of you to the report. All those in favor or adding that section to the report, raise your left hand, please. All those opposed, raise your left hand.

EXECUTIVE DIRECTOR ERICKSON: For the record, Dave voted for and the other seven voting members present voted against. Okay, a couple of more points on this section. In the first draft of the Milliman report, and we're in that same section that we were just reviewing -- was it page 33, commercial discounts?

In the first draft of the report and in their presentation to the group at the last meeting, Milliman had

pointed out that there were some state laws and regulations that were perhaps affecting pricing in our state and in the first draft, they had cited this one as an example. It's actually a state regulation that requires claims be paid at the 80th percentile. So that's why we had included that as an example in the draft. So I'm on our yellow highlighted document of our findings here, market forces affecting pricing for health care services are impacted by state laws and regulations in Alaska.

What I did hear, the last sentence that I added and highlighted in yellow was just pulled in a second example that they had included in their final report that wasn't included in their first report related to a state law that is regarding assignment of benefits, regarding payers to reimburse non-contracted providers directly instead of through the patient and they found that removes incentives that are typically used by payers to encourage providers to join their network and they note on page 34 that they -- that some of the approaches used, at least resulting from these laws and regulations are unique in Alaska and they haven't seen a similar approach in PPO products in the rest of the country. So I was just adding the second example under this finding that they included in their final report. Linda.

COMMISSIONER HALL: Does -- I would like to discuss this a little bit, but particularly the last part of the sentence

directly above the highlighted sentence that you added. You had asked me actually, Deb, to talk about this 80th percentile and why we have that in regulation, which I would be happy to do if anybody wants me to or even if you don't, probably.

EXECUTIVE DIRECTOR ERICKSON: Well, we're not really discussing the merits of why.....

COMMISSIONER HALL: I understand that and so I don't need to do that, but I'm going to say then, if you don't want me to talk about it, this section that starts, "Imposing a legal mandate to reimburse providers with more than 20% market share in a region for the full amount of billed charges, regardless of the rate," one, I do not think accurately states what Milliman says. I don't think it accurately states what our regulations says. So that's what I want to talk about or I'm -- I've already said what I have to say. I don't think that says what this report. I don't think it is actually what our regs says. So I have a major objection to that and it may be too late for me to make that. We're beyond the comment period, but.....

EXECUTIVE DIRECTOR ERICKSON: No. No, it's.....

COMMISSIONER HALL: I'm going to make it because I don't think it's accurate.

EXECUTIVE DIRECTOR ERICKSON: Well, if it's not accurate, we need to fix it, I think.

COMMISSIONER HALL: The 80% -- 80th percentile for

payment is accurate. That is in our regulation, but that -- and I'm not sure how that translates to this statement, but even Milliman doesn't say -- it says it implies that those providers can ensure blah, blah, blah. There's nothing in this report that says Milliman says it imposes a legal mandate to pay their full bill charges. So I think that needs to be revised.

EXECUTIVE DIRECTOR ERICKSON: Jeff.

COMMISSIONER DAVIS: Could you point me to the -- what they do say, please, specifically that you referred to?

COMMISSIONER HALL: Yeah (affirmative), the bottom of page 33.

COMMISSIONER DAVIS: The bottom of 33?

COMMISSIONER HALL: Yeah (affirmative).

EXECUTIVE DIRECTOR ERICKSON: I'll read that for folks who are actually in the room. Anybody on the phone would be able to access the Milliman report on our website, the health care cost driver report. "The relative provider leverage may be further exacerbated by Alaska's regulation requiring usual and customary charge payments to be at least equal to the 80th percentile of charges by geographic area. We are not aware of similar provisions in other states. Since many providers have over 20% of their market share, this implies that those providers can ensure that their charges are below the 80th percentile and therefore, receive payment for their full

billed charges." Jeff.

COMMISSIONER DAVIS: So Director Hall, if we just pulled this language out, would you be more comfortable with that or you just think that's.....

COMMISSIONER HALL: Yes.

COMMISSIONER DAVIS: Okay, well, I move that we do so.

EXECUTIVE DIRECTOR ERICKSON: Can you be more specific about which.....

COMMISSIONER DAVIS: Sure.

EXECUTIVE DIRECTOR ERICKSON: .....what exactly we're pulling out?

COMMISSIONER DAVIS: I think there's really -- there's two findings. There are two sides of the findings. It says that -- it makes the same point that you made in simplified language, but let's -- I think we're relying on the way Milliman said it, which probably makes good sense. So on page 33, second to the last paragraph would become a finding, just.....

EXECUTIVE DIRECTOR ERICKSON: So are you moving to replace.....

COMMISSIONER DAVIS: What you had proposed.

EXECUTIVE DIRECTOR ERICKSON: For example, Milliman notes, so we could leave that in -- a state regulation and then from there on, replace the language in our draft with their exact wording, is that what you're suggesting?

COMMISSIONER HALL: That wasn't what I was.....

COMMISSIONER DAVIS: No.

COMMISSIONER HALL: .....agreeing to.

COMMISSIONER DAVIS: No. What -- here's -- let me see if this is what you were nodding your head on. So I would start in the third line of what you drafted with "For example," and I would strike the rest of that with -- starting with "For example," strike all of the rest and I would replace it -- well, no, sorry. We.....

COMMISSIONER HALL: I don't think you need to replace the beginning of that. It's factual.

COMMISSIONER DAVIS: Yes. No, keep that.

COMMISSIONER HALL: Yeah (affirmative).

COMMISSIONER DAVIS: And then the -- after what's for the consumer, we would bring in the second to the last paragraph on page 33 and the last paragraph on page 33 that continues onto page 34, I believe.

EXECUTIVE DIRECTOR ERICKSON: So the paragraph that begins in the Milliman report on page 33, "The relative provider leverage?"

COMMISSIONER DAVIS: The first -- at first, we would pull in "The lower physician discounts in Alaska can be at least partly explained...", so the second to the last paragraph and then you would have to wordsmith this somewhat to put them together, but -- and then continue with.....

EXECUTIVE DIRECTOR ERICKSON: But -- okay.

COMMISSIONER DAVIS: They are two different points, which I believe make.....

EXECUTIVE DIRECTOR ERICKSON: But it supports the.....

COMMISSIONER DAVIS: .....the points that we were trying to make up here, but using Milliman's language instead of a revised language. So it's just reversing the order from the way you had it up there, but it's the way Milliman put them in. Director Hall, is that in line with what you believed you were nodding your head to?

COMMISSIONER HALL: What I believed I was nodding my head to was merely eliminating or changing to the Milliman language and imposing a legal mandate to reimburse providers, the last part of the sentence right before the highlighted part. I don't think that accurately.....

COMMISSIONER DAVIS: Okay, well.....

COMMISSIONER HALL: That's the part I'm concern with.

COMMISSIONER DAVIS: We'll let you off the hook and see if this language will work for the Commission.

COMMISSIONER HALL: Okay.

COMMISSIONER DAVIS: And if not, we'll go someplace else. Thank you.

CHAIRMAN HURLBURT: (Indiscernible - too far from microphone) the last sentence that Milliman has on page 33, starting "Since many providers have 20%," do you have -- I

thought I heard you say -- and do you have concern about the validity of that sentence in the Milliman report?

COMMISSIONER HALL: I (indiscernible - too far from microphone) I said that (indiscernible - too far from microphone) don't think this reflects what the Milliman report says (indiscernible - too far from microphone). Thank you, sorry. I don't think this reflects what the Milliman report says and I don't -- and the other thing I said may be my lack of understanding, but it's not my understanding that because you have 20% of the market, you're going to get paid at billed charges. They -- those -- that doesn't go together, but.....

CHAIRMAN HURLBURT: So did the Milliman statement with that -- starting at the bottom of page 33.....

COMMISSIONER HALL: "Since many providers," the Milliman statement could be -- replace this statement that it imposes a legal mandate.

CHAIRMAN HURLBURT: Okay, so it's.....

COMMISSIONER HALL: Because they're just saying that it implies.....

CHAIRMAN HURLBURT: Yeah (affirmative), I was unclear in my mind. So what Milliman states, you think is reasonable?

COMMISSIONER HALL: It's reasonable.

CHAIRMAN HURLBURT: Yeah (affirmative), okay. Allen.

COMMISSIONER HALL: I'm not sure how you get there, but it's not -- at least it's not a legal mandate.

CHAIRMAN HURLBURT: Yeah (affirmative). Allen.

COMMISSIONER HIPPLER: I was just going to ask while we were wordsmithing, to have someone explain to me the whole -- the implication of the 20% market share and how that affects how providers would be pricing their product.

COMMISSIONER DAVIS: Thank you, Dr. Hurlburt. I'll give it a try, Allen, and speaking to that point. The -- we'll just start from the beginning. The percentiles are the point at which, you know, if you're looking for the 80th percentile, that is -- if you graph the data for a particular charge, the 80th percentile is the point at which 80% of the charges are less than that charge and 20% are more. So that's the 80th percentile. That's how you determine it and it may be a normal graph or it may be a very skewed graph, and you know, the 80th percentile may be a long ways from the end. It may be close to the end.

So the way our actuaries apply this law is that every six months, they look at 12 months' worth of data and then for each CPT floor code, they go through and they determine what the 80th percentile for that code is in four different geographic regions of the state and that's our belief, that's consistent with the Alaska regulation.

So not being an actuary, but in discussions with them, what I understand in doing the math, is if I have, as a provider, have 20%, at least 20% market share, that means that

what I charge and assuming -- what I charge is at least 20% of the market. Therefore, when you do the graph, I am that last 20%.

I've got a CPA over here nodding his head. So that means my charges by definition become the 80th percentile. So therefore, my charges by definition under the regulation become the minimum payment that can be made for that service, unless my -- well, yeah (affirmative), become the minimum payment.

So just to -- in thinking about this, I'll go ahead and make the case that Director Hall declined to make earlier. The reason for this is it's consumer protection, in that you could have a carrier move in and say, "Well, we're going to pay the 80th percentile of Alabama, which is way lower than the 80th percentile of Alaska and therefore, the member is not protected in that. They're not receiving the full benefit they presumably bought.

The difficulty with it, and I think what Milliman is pointing out, is the difficulty is this creates a floor, but there is no ceiling. So I'll make an absurd example. Let's say there's a procedure that costs $1,000 that's the -- for 80% of the people charge, providers charge $1,000, but one provider, who has 21% market share decides to charge a million dollars for that. Well, in six -- in 12 months' time, that million-dollar charge would become the 80th percentile.

So I'm making an absurd case to make the point, but that's, I think, the difficulty in this and what Milliman's pointing to is if I, as a business person, can just set my charges and they become, you know, what's the minimum that's required then that, perhaps, has some unintended consequences. I hope that helps.

CHAIRMAN HURLBURT: Noah, yeah (affirmative).

COMMISSIONER LAUFER: These things are obviously endlessly complex, but it isn't all Machiavellian behavior on the part of the doctors. We're not allowed to go find out what somebody else's charge is. So we actually pay a subsidiary of an insurance company to tell us what the charges are in Genex, which was sued successfully in New York for bad behavior, because we don't feel we have the upper hand, but -- so not often enough, we look at what the fees are. We pay them and they tell us and then we say, "Well, gosh, we're only at the 50th percentile. We provide better than average care." So we'll raise the rates and so this is actually another area where there's no transparency.

Nobody knows what it costs. You're just looking at it and you say, "Well, gosh, you know, our competitors must be charging more and we're at least as good at they are." So it goes up and up, but it's another blind decision about finances.

COMMISSIONER DAVIS: If I may? I think if you --

building on your point, Dr. Laufer, it's -- the difficulty really lies where it's a high market -- a concentration of market share. So if you look at primary care, for example, it's 147% of all state average. If you look at some of the specialties where there are limited numbers, it's a higher number.

So it's -- this is not ubiquitous across the physician community and I believe that we need to continue to have consumer protection. So we need to have a floor, but I'm wondering if there's a way to deal with the unintended consequences by perhaps figuring out a fair way to also have a ceiling.

CHAIRMAN HURLBURT: Allen.

COMMISSIONER DAVIS: And oh, by the way, and it doesn't mean the physicians can't charge that, it just means that it's no longer the minimum that must be paid. Thank you.

COMMISSIONER HIPPLER: I'm just curious -- okay, so the difference between a highly competitive area, such as primary care, and a not so highly competitive area, such as very specialized care, there is a difference between, for example, you were saying primary care is more expensive here than in the rest of the country, but marginally so and specialized care is much more expensive than in the rest of the country.

How much of that difference would you anecdotally attribute to this regulation?

COMMISSIONER DAVIS: Okay, so I am answering the questions as factually as I can with no value judgment. I think people, you know, respond to the incentives that are given to them, but in my experience living with the data, there are three things that are driving, as been pointed out by Milliman, three things that drive the reimbursement rate for physicians and again, I am not throwing stones. I am not blaming. I'm just trying to report the facts. Supply and demand is an immutable law, so that's the first thing.

The second thing, I believe, is this regulation and the third thing, I believe, is the pay to statute, because with effect -- with those three things in place, we have, in my opinion, very little leverage over some provider groups and as evidence to that, I would point to the fact that there are a number of specialties that have not contracted with anyone, so let the data speak for itself.

COMMISSIONER HALL: I suppose I should say something. I actually agree with Jeff that those are -- they're cost drivers and as Noah said, there's certainly consumer protection. This regulation, the 80th percentile regulation was -- and we said we didn't want to get into a debate about it, but it was put in as a consumer protection.

We had insurance companies paying at the 50th percentile. You buy a policy. You don't know what you're getting. You don't know those kinds of things when you buy a policy. You

don't know them until you have a claim and so it was done for that reason.

I think as you're pointing out, and Jeff and I have had this discussion already, but is there a way we can find a way to put a ceiling that doesn't really harm consumers, but when we find, again, isolated instances of -- and I'm going to call them abuse. I'm a regulator. I look for abuse. I look for fraud. If you find someone charging ten times, 20 times, there's an example of 36 times what a procedure costs in Seattle, I'm having a difficult time not calling that abuse.

So I'm agreeing that there needs to be a way to find a ceiling, a way to describe a ceiling, but from my position, I don't want to harm consumers. I don't want to limit access to the medical treatment they need. So it's a really difficult dilemma. I don't think it means we need to throw out this consumer protection reg, but it does mean we need to find a way to make sure those things don't happen.

COMMISSIONER DAVIS: I just agree wholeheartedly with you, Director Hall.

COMMISSIONER HALL: That's really good.

CHAIRMAN HURLBURT: So that.....

COMMISSIONER HIPPLER: That was an amazing discussion. Thank you.

CHAIRMAN HURLBURT: That discussion, yeah (affirmative), from Jeff and Linda was very helpful to me, very enlightening

and I think we need to know that going forward because one of the issues that faces us, I think the immediate issue at hand now, for which this clarification has been really important is, how do we want to word that last paragraph on page 14 of the revised highlighted document and the suggestion, I believe, has been to take the last two paragraphs on page 33 of the driver's document from Milliman, including the ending of that last paragraph on the top of page 34. Is that correct? Val.

COMMISSIONER DAVIDSON: I'm confused about whether we have a live motion on the floor or not. So Jeff, were you moving those two bullets as drafted?

COMMISSIONER DAVIS: Give me (indiscernible - too far from microphone).

EXECUTIVE DIRECTOR ERICKSON: No, you can read it, but (indiscernible - too far from microphone) very well. What I did -- what I'd understood you to ask was to take out the whole sentence related to the 80th percentile by geographic area regulation, so I took that out. I'm not addressing the assignment of benefits law yet and typed in the two paragraphs from Milliman's report.

I did leave out one sentence, so starting with, "The lower physician discounts." The one sentence I left out was the one that said, at the very bottom of page 33, "We are not aware of similar provisions in other states." I took that

out, but other than that, I typed in those two full paragraphs, "The lower physician discounts in Alaska can be at least partly explained by the relative lack of competition among providers, particularly for specialty care. In many areas, including Anchorage, there are a limited number of providers in any given specialty. Sometimes only one provider group. As a result, physicians can largely dictate the fees they are paid by commercial payers.

The relative provider leverage may be further exacerbated by Alaska's regulation requiring usual and customary charge payments to be at least equal to the 80th percentile of charges by geographic area. Since many providers have over 20% of their market share, this implies that those providers can ensure that their charges are below the 80th percentile and therefore, receive payment for their full billed charges."

If I maybe turn this into a sub-bullet and take out "The," it would start to flow better.

COMMISSIONER DAVIS: And make the second part of that also a sub-bullet (indiscernible - too far from microphone) relative (indiscernible - too far from microphone).

EXECUTIVE DIRECTOR ERICKSON: So the suggestion Jeff is making off the mic, is to stick a return to make a second sub-bullet, "The relative provider leverage."

COMMISSIONER DAVIS: But it's two different (indiscernible - too far from microphone) supply and demand

(indiscernible - too far from microphone).

EXECUTIVE DIRECTOR ERICKSON: Physicians discounts.

COMMISSIONER DAVIS: And then if -- then the third thing -- then the third point could be the statute that requires direct payment, that could also -- that could be a third sub-bullet and then that would reflect the motion I was trying to inarticulately make.

COMMISSIONER HIPPLER: I -- that motion has not been seconded, I will second the motion. While we're waiting for typing, I would like to thank Jeff and Linda for enlightening me on regulations of which I was completely ignorant. Thank you.

COMMISSIONER KELLER: That was my thought precisely. We've got a whole bunch of those to go through.

CHAIRMAN HURLBURT: So the motion before us, which has been moved and seconded, is to use the paragraph with the dark bullet and the sub-bullets that Deb has typed in now to amend our recommendations. The next bullet down, that whole paragraph is gone and that replaces the language that's here. Is that okay? Now, is there any further discussion on that? Okay.

EXECUTIVE DIRECTOR ERICKSON: I'm sorry, I was typing too much. Who moved and seconded this one?

COMMISSIONER DAVIS: I moved and Allen seconded.

EXECUTIVE DIRECTOR ERICKSON: Thank you.

CHAIRMAN HURLBURT: And Allen seconded. All those in favor of the amended language, left hand.

COMMISSIONER DAVIS: I moved. Allen seconded.

CHAIRMAN HURLBURT: Okay. Opposed, the same. Anybody abstaining? None. It's unanimous, Deb.

EXECUTIVE DIRECTOR ERICKSON: So yeah (affirmative), for the record, the revision has moved and passed (indiscernible - interference with recording). Okay, let's get through this.

CHAIRMAN HURLBURT: It's 10 after (indiscernible - too far from microphone).

EXECUTIVE DIRECTOR ERICKSON: I know, but people aren't allowed to eat until we're done. We're almost done. This is going to be quick. One -- if -- turn to the page 15, the back. One of the things that we hardly talked about at all, the very first presentation that Milliman made to us over the phone when they presented the physician data -- we had asked them if they could include -- at the beginning of the contract, we had asked them if they could also include -- it wasn't part of the scope of work of the RFP, a comparison of DME, pharmacy and SNF for no extra money and they said it would be too much work to include SNF and pharmacy charges, but that it would be relatively simple for them to roll in DME and they agreed to throw that in for us and so it's actually -- all of this data is captured in the physician payment report, but in revisiting this, Ward and I thought we should

include it in our report as well, since it was something that was provided to us and it's separate from the physician reimbursement and so this just captures the data as stated in the physician report regarding the average payments and comparison of average payments for durable medical equipment.

So a main bullet for our finding, the average payment for durable medical equipment, DME, in Alaska is 21% higher for all payers relative to the average comparison state payment level. By payer, the average reimbursement for DME is 23% higher for commercial payers in Alaska relative to the average across commercial payers in the comparison states, the same in Alaska for Medicare and Tricare as the comparison states Medicare and Tricare average, 180% higher for the VA in Alaska relative to the average VA payment across the comparison states, 55% higher for the Alaska Medicaid program relative to the average Medicaid program payment across the comparison states.

They were not able to get North Dakota data for that, so it's excluding North Dakota and 98% higher for the Alaska Worker's Compensation program relative to the average of North Dakota and Washington state's Worker's Comp payment levels. They were not able to get Idaho, Oregon and Wyoming data for that one. So I wanted to be very specific there. So the suggestion is that we just pull this data on DME into this report, as well as a finding. Does anybody have any questions

or want to move to include this?

COMMISSIONER CAMPBELL: Move its adoption.

EXECUTIVE DIRECTOR ERICKSON: Keith moves that we include this bullet related -- these bullets related to DME. Second? Does anybody want to second including it or do we not want to include it?

COMMISSIONER MORGAN: I'll second it.

CHAIRMAN HURLBURT: Any discussion? Yes, Allen.

COMMISSIONER HIPPLER: I have discussion. So the payment for durable medical equipment is effectively amortizing the cost of medical investment equipment, fixed assets, over a period of time?

UNIDENTIFIED COMMISSIONER: Yes.

COMMISSIONER HIPPLER: Okay, I have no clue what this means.

CHAIRMAN HURLBURT: Go ahead, Jeff.

COMMISSIONER DAVIS: So wheelchairs, crutches, splints, things you would -- you could -- you would buy and use at home is largely what's in this category.

COMMISSIONER LAUFER: There is a history of the DME market being heavily corrupt in other parts of the country and so I think it's a little bit of an important thing to look at and to me, it raises all kinds of questions like the VA, which is theoretically a rational system. Why would they tolerate this? Is it that it's so much lower elsewhere or did they

just say we accept this as a cost of providing care in Alaska? I don't know. I mean, there's actually probably some very interesting stuff in here -- why?

COMMISSIONER HIPPLER: I would suggest that somehow we make this clear that we're not talking about amortizing the cost of an MRI machine over 20 years, because that's -- when I see this as a layman, that's what I think you're talking about.

CHAIRMAN HURLBURT: Yeah (affirmative), that's a really good point, because I never would have thought of it, yeah (affirmative), and I think, you know, thinking of our audience, those are things that we could really put our foot in our mouth on and not realize it, so.....

COMMISSIONER HALL: Could you just add a couple of examples, you know, such as, wheelchairs, crutches?

COMMISSIONER LAUFER: Two-hundred-dollar compression stockings, fancy socks.

CHAIRMAN HURLBURT: Yes, Keith.

COMMISSIONER CAMPBELL: I'll tell you a story. Lo, many years ago, oxygen generators for home administration of oxygen came in and they were hundreds and hundreds of dollars way back then and lo and behold, after the patient died, then they would end up in the hospital basement because they worked. They were fine, but lo and behold, somebody came from a specialist in Anchorage and they came home with a script and

they had a brand new oxygen generator when there were maybe three or four that I'd have given somebody, but Medicare paid for it or Medicaid paid for it or VA paid for it and pretty quick, you had a room full of oxygen generators and this is the fallacy of this whole kind of thing. Loan closets are full in every community in this state and the country, probably, of this kind of stuff that you could go and get for free or for very few dollars, but somebody writes a script for this thing and boom, it's off and it's a crime.

CHAIRMAN HURLBURT: And Jeff's going to pay for it.

COMMISSIONER LAUFER: Here's a plug, but if you have a broken leg and you come to medical park and you need crutches, there's a good chance we'll have a used pair with tape on it and stuff, but we'll give it to you. That's primary care.

CHAIRMAN HURLBURT: Yes, Val.

COMMISSIONER DAVIDSON: I guess, I'm sorry, I can't remember the durable medical equipment piece well enough from Milliman's original report and given the challenges we've had with wordsmithing proposed language in our report that I didn't feel was accurately captured or implied in the Milliman information, I'm uncomfortable accepting these recommendations for a report that I can't remember and we don't have in our packet.

EXECUTIVE DIRECTOR ERICKSON: It's actually in your packet right now. It's not a recommendation. It's just

capturing the findings from -- it's in the physician report that you have right in front of you.

COMMISSIONER DAVIDSON: Can you show me the page number?

EXECUTIVE DIRECTOR ERICKSON: Yes. Yes.

CHAIRMAN HURLBURT: While you're doing that and maybe asking particularly Jeff and Noah, related to Allen's comment, could we use durable medical equipment like a paren, non-pharmaceutical items ordered by a physician or by a provider? That doesn't tie it to a prescription because some things like crutches, you're not going to write a prescription for. Other things, you will, but is that wording clear to you, as a lay person, Allen, and as a payer and as a provider, is that reasonable to you guys?

COMMISSIONER HIPPLER: No. Coming from the financial industry, when somebody says fixed assets, for example, which is what I instinctively translate this to mean, fixed assets can include things like tables and chairs and Caterpillar machines and three-million-dollar boats.

CHAIRMAN HURLBURT: I'm sorry. I -- what I was trying to say, DME is items that are ordered by a provider for a patient, non-pharmaceutical items ordered by a provider for a patient.

EXECUTIVE DIRECTOR ERICKSON: So I just included a sentence in here. Sorry, Val, I'll get to you in a second. The average payment for durable medical equipment in Alaska is

21% higher for all payers relative to the average comparison state payment level. DME is non-pharmaceutical equipment ordered by a provider for a patient, such as wheelchairs, compression socks and crutches.

COMMISSIONER LAUFER: It might be useful, especially since we're moving into this, what do they call it, the quantified self is the new age, you know, there's all kinds of equipment that you can have. So if you have coagulopathy and you're on Coumadin for blood, you can, for around $2,000, get equipment so you can do your own testing at home or if you have asthma, you can get your own nebulizer to use it at home. Some of these are very expensive pieces of equipment, you know.

I write a script for them, but it's not clear, not to mention all the CPAP machines that people have for thousands of dollars. So it's a bigger and bigger chunk.

CHAIRMAN HURLBURT: Yeah (affirmative), I think that identifying just wheelchairs and crutches can be misleading because you might order, say, a glucose auto-analyzer, which they could get at a drug store or they could get at a DME, either place, but that's categorized as a DME expense often. So non-pharmaceutical isn't a perfect term, but I think just to pick on crutches and wheelchairs could again lead you down the wrong path a little bit. Emily.

COMMISSIONER ENNIS: May I ask Keith a question related

to the loan closet that you referred to in your hospital basement? We're encountering concerns now about loaning equipment relative to risk and liability. Did you encounter that at all? I mean, the items are sitting there and should be reused. They're perfectly good.

COMMISSIONER CAMPBELL: I'm too old for that. This was too long ago, before the ugly head of malpractice stuff.

COMMISSIONER ENNIS: Okay, well, that's -- yeah (affirmative), it's an issue now and again, looking at ways to save.....

COMMISSIONER CAMPBELL: But you have -- but I would submit that most institutions have a technician who goes around and certifies all of this stuff, the pumps and all of these sorts of things. So there's a way around that particular problem, I think.

EXECUTIVE DIRECTOR ERICKSON: Can I help Val now, please?

CHAIRMAN HURLBURT: I would say for non-pharmaceutical items. Equipment is again, a little misleading term.

EXECUTIVE DIRECTOR ERICKSON: Val, in the physician payment rate in Alaska and comparison states report on page -- and they don't really call it out in narrative, I don't think, but they're mostly just presenting data in comparison statistics here, but on page four, if you look at Table 2.2, the very last line of the data table that's offset a little bit, it shows that DME is.....

(Phone ringing)

UNIDENTIFIED COMMISSIONER: Is that you're phone?

EXECUTIVE DIRECTOR ERICKSON: Sorry. No, I turned it off. I knew I turned it off. Okay, it shows that Alaska DME is 121% of the average of the other five states and so that's the 21% higher and then for the comparison by payer, you have to go to Appendix A-1 of the very -- of the big long sheets, so the very, very first page of the big long sheets and Appendix A -- again, they offset it from the physician specialties, the very last line that reads "DME" and the first section on Medicare and then the next section after that is on Tricare. It actually shows that Alaska is a smidge lower, one percent lower, but in this bullet, it reads the same.

Then the VA, it shows that Alaska is 280% of the average of the other states and that's the 180% higher in our bullet and then if you turn that page over, it shows the Medicaid fee comparison, again, DME 155% of, which is 55% higher, Worker's Comp, 198% of, with NA's and those certain columns they didn't have and then commercial, 123% of, which translates into 23% higher.

CHAIRMAN HURLBURT: Did that sound okay, Val?

COMMISSIONER DAVIDSON: Thank you.

CHAIRMAN HURLBURT: Okay. Deb, let me go back.....

UNIDENTIFIED SPEAKER: (Indiscernible - too far from microphone).

CHAIRMAN HURLBURT: Sorry, thanks. Let me go back on the wording, thinking with the exception of the clinical members of the Legislature, I think, you know, Allen's pointed out "DME" is not a term that people know, I think that the end of the sentence starting with, "Such as," is better left out because there's a lot of DME items that aren't anything like those examples and if you read those examples, you wouldn't think well, it's a glucose auto-analyzer for the diabetic patient. Yeah (affirmative), that would be my suggestion.

COMMISSIONER DAVIDSON: This is just a tiny thing, but can you say, "DME includes non-pharmaceutical items," because "Is," is just weird with items.

CHAIRMAN HURLBURT: And so what would it be beyond that?

COMMISSIONER DAVIDSON: I just swapped "Includes" for "Is."

UNIDENTIFIED COMMISSIONER: Why?

COMMISSIONER DAVIDSON: Because otherwise it says, "DME is non-pharmaceutical items," just a grammatical change.

CHAIRMAN HURLBURT: Okay, but does it.....

EXECUTIVE DIRECTOR ERICKSON: How about, "DME are non-pharmaceutical equipment items?"

CHAIRMAN HURLBURT: DME is a singular term.

COMMISSIONER DAVIDSON: I thought we could avoid an awkward grammatical debate by saying, "Includes."

CHAIRMAN HURLBURT: Yeah (affirmative), but doesn't

"Includes" imply that there is more than that?

UNIDENTIFIED COMMISSIONER: (Indiscernible - too far from microphone) I like it.

CHAIRMAN HURLBURT: Hot dog.

EXECUTIVE DIRECTOR ERICKSON: Okay.

UNIDENTIFIED COMMISSIONER: Thank you.

EXECUTIVE DIRECTOR ERICKSON: We have a motion made by Keith, seconded by Dave. We've done a little wordsmithing. Shall I read it or is there more discussion needed? I don't need to read it. The members have it before them on the screen. Do you want to call for the question?

CHAIRMAN HURLBURT: Yeah (affirmative), any further discussion? Question, all those in favor of adopting the wording here, raise your left hand. Opposed, the same. Anybody abstaining? It's unanimous. So let's take a break for -- the lunch is on the table there. As usual, we would request that the folks sitting in the back allow the Commission members to get their sandwiches and items first and so we'll try to get back together in 20 minutes or so and bring your lunch with you if you're not done. There should be plenty for everybody in the room and you're more than welcome, but if the Commission members could go ahead and get their lunch? Thank you.

12:23:44

(Off record)

(On record)

12:47:51

EXECUTIVE DIRECTOR ERICKSON: Okay, we're going to get started and continue here, restarted. So let's see, let's go to our discussion guide, meeting discussion guide slides again. On slide seven, we are done with health care cost findings. The next section related to just our little one-page overview of the long-term care system, we just received one comment from ASHNA on page 28 and 29 related to that, that they appreciated that discussion. I don't think there's any need to make any changes there. There are no findings or recommendations there. It's just kind of a one-page description of the system.

Then moving on, then -- and sorry to keep you cross-referencing multiple documents, but in the public comment draft report on page 13 is a list of the items prioritized for study of our current system during 2012, just so you have that as a reference.

UNIDENTIFIED COMMISSIONER: Where are you?

EXECUTIVE DIRECTOR ERICKSON: The public comment draft report, our draft, 2011 findings and recommendations, so just so you can see.....

UNIDENTIFIED COMMISSIONER: What page is that?

EXECUTIVE DIRECTOR ERICKSON: Page 13. So related to that page, we have a series of comments now. The first, I

just noted that we did get a comment on page six of the public comment packet from Dr. Nakamura that he appreciated and agreed with our plans for continued study. I just thought I would note where we were getting thumbs up on some things.

The next point is related to the study of the cost of skilled nursing facility care and pharmaceuticals in Alaska. A comment on -- in our public comment draft, page 29 and 30, the -- ASHNA has suggested that we don't need to study the cost of skilled nursing facility care and so on page 29, there -- they say -- I don't want to leave anything important out. They point out that SNF care now represents three percent of spending. Sorry, Allen, SNF is skilled nursing facility, now represents three percent of spending in the health care system, 21% of long-term care expenditures and 2.1% of long-term care clients and they don't object to studying the cost of long-term care in Alaska, but object to studying the skilled nursing facility costs only.

They already know that Alaska has the most expensive long-term care among the comparison states and that a study of nursing facility care only is expensive and duplicative. In addition, the costs are almost entirely Medicaid and Medicare and that data's easily available and that a study of the cost of all major components of the long-term care system, including community based would be more useful and one other thing I wanted to point out to you all, just to get you to

pull another document out again, the document that Pat Branco provided for us, includes a data table that ASHNA provided, they thought had been included in one of the slide presentations we got from the long-term care group in April and then, I think in our last meeting that actually had not been included, but it's the very last page in the packet from Pat that has Pat's little one-paragraph note to you all.

It's from -- it's a table from a 2009 Met Life market survey of long-term care costs and it compares the Pacific Northwest states and a few other states, specifically average daily nursing home rates, average monthly cost in assisted living facility, home health aid average hourly rate and adult day services daily rate.

So they wanted to make that you were -- that you saw that data table as well. So any questions, comments, discussion on the question of whether to include skilled nursing facility cost analysis in the coming year or not?

COMMISSIONER ENNIS: Deb. Thank you, Mr. Chair. I would like to comment on a study of long-term care, a broad study, but I wanted to just call your attention to perhaps an omission in that table you just referred to that Pat sent on to us and that is the third column of home health aid average hourly rates and because we are talking here about assisted living facilities, that rate may be found in a Pioneer Home, but in most community-based care assisted living homes and

group homes and other residential options, that rate is significantly higher than what most nonprofit providers are paying and we're talking about, it's double.

Most mom and pop assisted living homes and many, if not most, of are nonprofit providers that offer these residential services are starting at $12 to $15 an hour for a direct service worker. So it's different and a very -- much lower and certainly too low to keep those people in a long-term career path and results in a lot of turnover and additional cost and it's one of the reasons we're having a great deal of difficulty maintaining an adequate health care workforce in this long-term care piece of service, but 25, I mean, we wish it would be $25 an hour. I think then we could have some retention and also recruit some folks who want to make this a career, so just a point, and then in regard to a more expanded long-term care cost survey, I do believe that would be useful.

I agree with that recommendation. We are hoping to have in our community-based service delivery system, the first survey for select providers based on FY12. We have not had cost surveys done in the community-based service system ever that I recall, 20, 30 years. It's been very piecemeal. It's been very, very individualized. So there's a wide range of cost.

Only recently, we've tried to bring those together and establish some aggregate rates, but they're based on some

very, very old averages. So again, looking at the cost differentials and really comparing what it costs to, not only sustain, but develop these community-based supports, which are so cost effective, I think is -- would be very valuable.

COMMISSIONER CAMPBELL: I, too, would want the circle as wide as you can get it around -- if we do subscribe to doing a study, because all the growth has been out of the institutions. We -- and I think they're valid. We know what the institutional costs are and they're all inclusive homes, you know, just like hotel services and I don't know what a true cost analysis would be, because we know what you're paid, but we do know -- do we know what other services that may be Medicaid services. Maybe it's some sort of food assistance. It's rent assistance and all these things that tend to be ignored as a true cost of providing these services by society.

So if we do it, I want it as wide and as inclusive of all the costs of daily living that is there, but I don't know if we have the budget for it.

EXECUTIVE DIRECTOR ERICKSON: You know, I think that's one question I would have, and I'm wondering if we should be considering just taking it out entirely or not, rather than adding everything else in, because I have no idea how much it would cost to do a comprehensive cost analysis and if it would be within our budget, that would be one of my concerns.

My other concern is, there's this whole other big

steering committee doing this planning effort and we're potentially duplicating some work that they're doing. So I just wanted to offer those two thoughts.

CHAIRMAN HURLBURT: Yeah (affirmative), I think the SNF care, the skilled level of care, anecdotally, just like the other kinds of care that we've talked about and we know is high, but I think that it probably is fairly straight-forward to get a comparable analysis on that and it should be for pharmaceutical costs to round out what we've done, but we've heard from Kim Poppy-Smart, for example, that the long-term care costs are, what is it, just going up so high and eating her alive, but we may need to look for a little -- a different contractor to do that.

I think the SNF care, the pharmaceutical care, you know, may not cost that much. I don't -- we need to, obviously, comply with all of the contracting requirement, but it could be a relatively small add-on, but I think that the other is, I agree, it's important to study, but we may need to look for a little different expertise to help us do that, but it's something we have to figure out.

EXECUTIVE DIRECTOR ERICKSON: Maybe -- and maybe I should just add too, that I did ask Milliman to give just a ballpark idea of what adding SNF and pharmaceutical costs would be and to be honest with you, the cost went up after they were done working with us. They said that they spent way more money

than we paid them, because they're not used to having their work scrutinized to the extent that it was with the -- all the comments that we provided and all the time they spent on the phone going over this stuff, all very good natured, but we paid a third of what the VA recently paid them to do a study in Alaska of spending here.

Anyway, I just wanted to let you know, probably about $50,000 for -- if we were to go back to them and ask them to do a similar study on skilled nursing facility and pharmaceutical care.

COMMISSIONER ENNIS: Thank you. I think it would be a good idea to ask our Steering Committee to comment on this, make recommendations. I'm not sure in their scope of work, they would be doing a cost analysis and even if they were, I don't know that the system is prepared at this time to present data in a way that we could really use. I think that's part of the problem.

We have large organizations that have fairly sophisticated data collection and accounting programs and then we have small, small ones that don't, and you know, we have to find a common ground and provide some technical assistance, but I would also like to address one other point and that is the rapidly rising cost of Medicaid for long-term care services and I think part of that, a big part of that explanation is what we just read as a comment from the

Hospital Nursing Home Association.

Care is not being provided in the skilled nursing facilities. It's being provided in the community and those dollars are coming from Medicaid to take care of that community care. We're not increasing nursing home beds and so that cost, while there's inflation there and rate adjustments, the cost has not increased relative to the other side and that's because the folks aren't going there.

They're living in their homes or with family members and receiving care in the community and so it's not surprising that those costs on that other side, the Medicaid costs, have gone up. We have, you know, the numbers have increased dramatically and are going to continue to increase because of our baby boomer and senior population.

Nevertheless, the cost of that care is much, much less than it would be or would have been had we added many more nursing home beds to accommodate many of these individuals that have critical care or some very complex medical and behavioral needs, but are being served in community-based services. It's an important point.

I would like to move that we remove this section and on the recommendation for a study of the nursing home costs and reserve this review again for next year after we have a comment from our Steering Committee so we can wordsmith it however you want it, but I would make a recommendation that we

table this recommendation this year.

EXECUTIVE DIRECTOR ERICKSON: So a motion's been made to remove the skilled nursing facility cost analysis for 2012. Is there a second?

COMMISSIONER CAMPBELL: Sure, I'll second it.

EXECUTIVE DIRECTOR ERICKSON: Keith seconded, so moved by Emily, seconded by Keith. Discussion?

COMMISSIONER MORGAN: Yeah (affirmative), I was just going to ask a question. Will you -- who will -- will you or will the Chair like go talk to the Steering Committee or how will that work, to find out what they're going to do and.....

EXECUTIVE DIRECTOR ERICKSON: Well, I think what we're voting on is taking it out of our 2011 report entirely.

COMMISSIONER MORGAN: Okay.

EXECUTIVE DIRECTOR ERICKSON: And tabling it for 2012 entirely.

COMMISSIONER MORGAN: Okay.

EXECUTIVE DIRECTOR ERICKSON: And we would just have to follow up over time.

COMMISSIONER MORGAN: Okay.

EXECUTIVE DIRECTOR ERICKSON: Unless you want to meet again next week?

CHAIRMAN HURLBURT: I'm not clear of the practical impact of this. So if we take it out of the report, it's not something we're going to be doing this calendar year anyway,

because we're at the end of that. It would come in the current state's fiscal year if we proceeded with the SNF and the pharmaceutical analysis and looked at how can we get a handle on some of these other things. So whether it's in the report or not, does that have an impact? That's just my question.

COMMISSIONER ENNIS: I think while we were reviewing and perhaps concluding that data is already available for the nursing facilities, that there's readily available data and we don't need to recommend an additional study for that service system and that's what I was recommending that -- or moving to recommend, that we remove the finding that we have that study completed.

CHAIRMAN HURLBURT: So the data is available comparable to what we have for the hospitals, for example?

COMMISSIONER ENNIS: I'm sorry, that -- for the nursing homes, as we -- in the ASHNA recommendation, they basically said they believed it would be expensive and duplicative to conduct another study on nursing homes.

CHAIRMAN HURLBURT: Okay, and.....

EXECUTIVE DIRECTOR ERICKSON: I think -- and we do have rates, but we probably don't have the level of detail analysis that Milliman would do in terms of the operating costs and cost drivers.

CHAIRMAN HURLBURT: Yeah (affirmative).

COMMISSIONER ENNIS: Right.

CHAIRMAN HURLBURT: And that's what I'm -- and that's what I'm challenging.

COMMISSIONER ENNIS: Well, correct, all right.

CHAIRMAN HURLBURT: I think -- yeah (affirmative).

COMMISSIONER ENNIS: But I suppose it -- well, I don't know then, I could retract my motion, but I do believe that we don't want to go forward without doing the broad study and if there's additional data we feel we can get from -- including the nursing homes that we do need, then that would be fine, but the most important element is to expand it to include community-based services and those residential and related supports that are offered in the community.

CHAIRMAN HURLBURT: Val.

COMMISSIONER DAVIDSON: No, I was just going to agree that if we are going to look at long-term care as a service level of what's needed in our state, then we ought to be looking at the full continuum of long-term care, not just skilled nursing.

CHAIRMAN HURLBURT: Okay, and I'm -- I don't disagree with that. I think we need to, but I think that SNF care and pharmaceuticals are also very much a part of the continuum of care that we have with physicians and with hospitals and if we don't have those, we're not looking at that part of the medical care system and at least, in my experience with

payers, your SNF care is paid within certain limits by commercial payers, by Medicare, a lot of it by Medicaid, but as you get, as Emily was pointing out, you get into the home setting, it's pretty much Medicaid or self-pay or the special policy, but no so much your regular health insurance policies.

So the SNF care is a part of that continuum, but it's also very much a part of the continuum of if you have a myocardial infarction, you go to the hospital and you go there and you get your rehab and you go home. Yeah (affirmative).

COMMISSIONER DAVIDSON: Well, taking your logic, we should also be looking at in-patient psychiatric services, but I guess my point is, if you're going to look at something, for example long-term care as a service line, you really do need to look at the full continuum of care. There are -- as people are beginning to integrate behavioral health services as a part of the primary care model and we've talked about that here, that it's a critical piece of being able to turn our health care system on its head to be able to give people what they need as early as possible, then we would be remiss if we didn't include that full spectrum of care.

CHAIRMAN HURLBURT: Yeah (affirmative).

COMMISSIONER ENNIS: I am concerned that if we don't have the budget for expanding the study, that we would perhaps miss the information we need to get from the community side of service delivery if we limited it just to the skilled nursing.

CHAIRMAN HURLBURT: Yeah (affirmative), and I'm not advocating against -- for not expanding it, but I believe it's going to be a very different kind of study than what we've done. Whereas, the SNF is very much like what we've done and it is part of long-term care, but it also is a part of the acute medical care, whether it's psychiatric care or orthopedic care of urologic care or whatever.

So that's why I think that to round out what we've done, there's an omission there and it's not at all to say we shouldn't look creatively and expansively at what is this fastest growing part of the budget that we have in Medicaid.

COMMISSIONER ENNIS: Just one last comment, while I don't understand what would be involved in the review that would be done to make it similar to what we already have from Milliman, I do know that both hospitals and nursing homes in statute have regular rate reviews, which examines the costs and provides justification for adjusting their rates and community-based services have not -- it has not had that opportunity.

There are no reviews, no cost studies, no rate adjustments. So you know, it's devoid of any of that information. I don't know if what's available, even thought it may -- might not be in the similar format, whether that would be adequate for our use or are we just really feeling it would be advantageous to have, you know, the similar Milliman

study provided for that one part of long-term care.

It's just a question for you. I'm not sure, but simply realizing we have nothing to go on in the community-based system, but we do have studies and rate reviews for skilled nursing available, just a comment. Thank you.

CHAIRMAN HURLBURT: It's -- we're probably saying different things. As a clinician, as a person who has worked with health plans, when I think of SNF care, I don't first think of long-term care. Clearly, it's a part of long-term care. Clearly, long-term care is critical, that we look at that, but I think that while SNF care is a part of it, it's also a part of the more acute and sub-acute care continuum and a big cost driver there. Yeah (affirmative), so I don't know, Jeff, if you have a perspective as a payer, Jeff, but.....

COMMISSIONER DAVIS: (Indiscernible - too far from microphone).

CHAIRMAN HURLBURT: Yeah (affirmative), okay. Let's see, did we have a motion to remove that?

EXECUTIVE DIRECTOR ERICKSON: Yes, we did. I'll -- yeah (affirmative), I'll repeat. The motion is to remove skilled nursing facility cost analysis for -- from our plans to study in 2012. Motion was made by Emily. It was seconded by Keith. So I don't know if there's more discussion or call for the question.

CHAIRMAN HURLBURT: Yeah (affirmative), any further

discussion? Keith.

EXECUTIVE DIRECTOR ERICKSON: Keith.

COMMISSIONER CAMPBELL: Just a question, you're talking about SNF costs and Medicaid is the payer of almost 100% of this, other than the Medicare portion for the short time that you're eligible for rehab services?

CHAIRMAN HURLBURT: In commercial -- if Jeff has a commercial patient with a MI and they're not really ready to go home. They're not -- there's -- either not a sub-acute rehab facility of something available, they may go to a SNF, get some of their rehab there and that's the next step in going to the lower level of care before they go home, plus self-pay, of course.

COMMISSIONER CAMPBELL: I guess I was just looking at the major payer type and that was my question.

CHAIRMAN HURLBURT: Yeah (affirmative), that would be probably Medicare and Medicaid. I used to be a treasurer for a nonprofit SNF and we had a fair amount of commercial business in there, but probably it was third with Medicare and Medicaid and commercial.

COMMISSIONER DAVIDSON: Mr. Chairman, if I may propose a friendly amendment to recommend the inclusion of long-term care, but to include the full continuum of long-term care services as a part of that study.

EXECUTIVE DIRECTOR ERICKSON: It's proposed as a friendly

amendment to Emily's motion.

COMMISSIONER ENNIS: I would accept that.

CHAIRMAN HURLBURT: Is that inconsistent, because I certainly absolutely agree, but I think what I was thinking is that might be two different kinds of expertise. We might not be able to roll that into all one contract. Whereas, I think the SNF is -- we can use the kind of expertise we have here.

I don't know. They may or may not, but my guess is that's not the expertise of the same kind of a firm that we dealt with, but I may be wrong. Yeah (affirmative).

COMMISSIONER DAVIDSON: So do you already have a vendor? Who's the "They" that you're referring to?

EXECUTIVE DIRECTOR ERICKSON: Well, we do not have a vendor. We would have to do a separate RFP. It's just when we had initially asked Milliman if they would do it for free, they said, "No," and I asked them if they could just give us a general idea how much we might expect to pay an actuarial firm like theirs for that.

So I would be concerned that we have enough money to do -- especially considering Emily's suggestion that the data collection part of this would be significant with all of the small providers that don't have good record keeping systems, but I just wanted to remind you all again that would be an issue. I don't know if we could actually afford a full long-term care cost analysis.

COMMISSIONER DAVIDSON: I -- Mr. Chairman, if I may, I guess I just think we need a complete picture and I think that, unfortunately, for this report, we emphasize pretty heavily at the beginning the importance of value, which really has two components, but the only thing we really did in our findings and our research and our recommendations was one part of that equation, the cost.

We didn't delve into the value and while we're going to do that next year, which is really nice, unfortunately, one-half of the equation is already going to be out there and it's going to be splashed across headlines everywhere and what I'm trying to do is to try to learn from that unfortunate lesson and apply it to this situation for next year, so we don't make the same mistake twice.

CHAIRMAN HURLBURT: I don't agree it was a mistake. I think we did what was doable, where the data is available. We don't have quality data. Some states do and we need to get it. Everybody here would think we need to, so I think what we did was what was doable. I don't think it was a mistake. You can only do what you can do and yes, we absolutely have to get the quality data.

If you go to New York, you can get data of what are the outcomes when people have cabbages in their hospitals. Now, our former President may go to one of the hospitals at the bottom of the list to have his cabbage done. So even

intelligent, educated people don't always act on that, but in terms of getting all-payer claims database information, getting quality data, we need it. We need to have it here, but we don't.

The data that we got, the study that we did, we did from data that was available from Medicare, from commercial payers, from other payers. So I don't this it's a tragic mistake to do what you can do.

COMMISSIONER DAVIDSON: But we do have other information out there about the benefits of what the Alaska health system has been able to accomplish. So for example, the huge decrease in -- or the huge increase in child immunizations. There's a whole host of areas that we're making considerable progress, but none of that is mentioned in our report and in report and in our recommendations and I think that we -- we're not painting a full picture and I'm just worried about that same kind of thing happening with long-term care for next year. The information is already there.

CHAIRMAN HURLBURT: The system that you represent does a very good job on childhood immunizations. The rest of the state is terrible. We've improved a little bit and we don't have good data. When I talk with our immunization people, we're working on a vac-track system. We're trying to get more data in, but I say, "How do we know what our rates are? How can I find out," because usually, you can drive what you do by

what you measure and by data and our folks say, "We don't have that in Alaska," and immunizations among the Alaska Native kids is absolutely commendable. If we could do that with the rest of the kids, we'd be in good shape, but we're doing a lousy job in the rest of the state.

COMMISSIONER ENNIS: I believe that expanding the study to include long-term care is important because the community-based services are one of the significant drivers of the increase in Medicaid and that's a big concern and we haven't had an ability to really adequately project that growth and cost increase and yet, we're already doing -- taking a good look at how we contain that.

I mean, we're very concerned about the significant increase in Medicaid costs in our state and yet, the -- a big reason is that we have directed all of this long-term care to our community-based services. So knowing more about it will help our Legislature and help all of us respond to the needed capacity and cost.

EXECUTIVE DIRECTOR ERICKSON: So if we study the cost of the long-term care continuum of services and we feel as though something's missing that we didn't study benefits added by the medical services study that we did, are we leaving something out here if we don't include the benefits of the long-term care system as well, and if we're going to add that, my concern is, as Dr. Hurlburt was saying, we can only do so

much, unless you all want to meet five days a month, every month.

We have a limited amount of time for discussion and for learning together and we need to be as focused as possible in addressing the issues. That's why we're prioritizing and planning ahead, but I'm trying to get a sense of what we have the resources for, in terms of both money to pay consultants and time for you all to spend learning and coming up with findings and recommendations. So it's just a caution.

COMMISSIONER LAUFER: Can I -- as a Commissioner or member who's going to only be shortly here, maybe a few more hours, sorry, I kind of see this as a process and I think that what we did this year in showing that it's, you know, way too expensive and on a logarithmic growth curve and not sustainable, that's really important, but I agree with Val and I think the next question is; okay, we're spending all of this money, you know, what are we getting, and that's a legitimate question. That's the next step in deciding as individuals and as a society, okay, you know, so 7.5 billion dollars, what do we want, is the next step and that's important and that's my big anxiety.

I'm -- I'll be 65 in 2030. The bank's going to be empty, I would imagine, and how are we going to get all the boomers, you know, through this difficult and expensive part of their lives?

EXECUTIVE DIRECTOR ERICKSON: It -- sorry, we have a motion on the floor to amend our plans for next year to study skilled nursing facility costs to include a study of costs for all long-term care services across the continuum of long-term care services and that would be in addition to our study of pharmaceutical costs, our study of state legal and regulatory barriers, our study -- our continuing tracking of federal reform and the study of all of the actual strategies for fixing the problems that we're discovering that we're going to talk about later today. So just to put in context, we're amending our plans for study SNF costs to include all long-term care costs. That's the motion that's on the floor. Does somebody want to call for the question?

CHAIRMAN HURLBURT: Okay.

COMMISSIONER CAMPBELL: I'll call. Let's see where it plops.

CHAIRMAN HURLBURT: So we have a list of tasks for 2012. Yes, Wes.

COMMISSIONER KELLER: Before you vote, I wonder if a list of what would be included in the whole picture of a study of long -- of the continuum. I think that includes hospice, right? It probably includes rehab.

EXECUTIVE DIRECTOR ERICKSON: We could look at our.....

COMMISSIONER KELLER: I mean, we -- this is a sizeable decision that we're making here, you know, I mean, I was just

reviewing the retiree evaluation of the continuum and actually, they list -- interesting -- SNF a little low in priority as far as cost increases and utilization and so if we expand, if you vote yes on this, I think we're really expanding and I wonder -- want to make sure we all understand how much the expansion is.

COMMISSIONER MORGAN: So what would be -- what would we be adding is assisted living, right, waivers, home health, hospice, what else?

EXECUTIVE DIRECTOR ERICKSON: PCA.

COMMISSIONER MORGAN: PCA and is there -- I'm trying to think of.....

EXECUTIVE DIRECTOR ERICKSON: General categories that we identified as part of the long-term care continuum.

COMMISSIONER MORGAN: PCA is the only one we don't do.

EXECUTIVE DIRECTOR ERICKSON: These are just general categories across the continuum for long-term care and this is our definition of home-based maintenance, home health skilled care, assisted living and nursing home.

CHAIRMAN HURLBURT: And the nursing home is the non-skilled long-term institutionalized care and the skill care in the SNF. They're two different programs.

COMMISSIONER MORGAN: Some of these that are a high percentage of Medicaid, probably we could get some numbers or some idea from the state, but some of these are very small

operators like care coordination under waivers and are multi-numbered. I know in our cost report, we have a waiver -- we do three of the four waivers and they are requesting to put in a survey for us to complete this year of cost information, but this would be -- because unlike hospitals where you've got 25 or 30, this is a lot of small mom and pop operations compared to what we've been talking to and I think Wes has a good point.

Maybe talking to the other commissions that overlook this might be a way of gathering up this type of data, but I'm -- I just -- I think we might be biting off more than we can chew on this one, guys.

COMMISSIONER DAVIDSON: I think the point about not duplicating efforts that are happening elsewhere is a valid one and so I would recommend that we take long-term care off of this, but maybe actually leave a reference that maybe the Health Care Commission will be looking at information or collaborating, whatever you want to say, with the other long-term care effort that's going to be undertaken over the next couple of years and we.....

EXECUTIVE DIRECTOR ERICKSON: We do have -- I just want to point out at the bottom of page 12 in our draft, at the end of the long-term care in Alaska, the Commission -- the very last sentence, "The Commission benefitted from presentations by the Coalition this year." We discuss the Coalition,

"Commends them on their rapid progress and looks forward to additional information and future recommendations from the Coalition." So I just wanted to remind you that we did point that out.

So it sounds like we have a friendly amendment to the friendly amendment and it's taken us back to the original motion to delete the study of SNF costs from our plans for 2012, understanding that we've already referenced that we'll continue hearing updates and considering future recommendations from the Long-term Care Coalition that's meeting.

CHAIRMAN HURLBURT: Any further discussion?

EXECUTIVE DIRECTOR ERICKSON: So the motion on the floor -- the motion on the floor is to delete cost of skilled nursing facility care from our plans for study in 2012.

CHAIRMAN HURLBURT: Okay, all in favor, raise your left hand.

COMMISSIONER HIPPLER: I'm sorry, repeat the motion.

EXECUTIVE DIRECTOR ERICKSON: So if it would help to look at our page 13 of our public comment draft, okay, so the second bullet down, at the top, we have three bullets of issues we're going to study in 2012, issues related to the current system. The issues that we're going to study for potential solutions and other strategies is in another section.

That second bullet reads that we'll study cost of skilled nursing facility care and pharmaceuticals in Alaska. The motion is to remove cost of skilled nursing facility care from our plans. Clear? Okay. So we started a vote, hands.....

CHAIRMAN HURLBURT: Okay, all in favor.

EXECUTIVE DIRECTOR ERICKSON: Is your hand.....

CHAIRMAN HURLBURT: Opposed?

EXECUTIVE DIRECTOR ERICKSON: For the record, seven voting members for the motion and Dr. Hurlburt opposed. So you could be looking up while I'm making the note before I forget of what we just did, there's suggestions and comments from two different folks. So if you pull out again, your public comment packet, and if you're looking at the slide up on the wall here, related to behavioral health, we have two letters.

One -- this issue is referenced on page 37 and 40 of your public comment packet and another letter with attachment, page 44 through 46, that are -- both are suggesting that we study behavioral health in the coming year.

The first letter is from the Mental Health and Substance Abuse Board. My take on their request or suggestion is that we study in some -- and at least have some presentation similar to what we had for long-term care and learn more about the behavioral health services in this state in the coming year. That last one is more specific to an issue of concern

over the use of psychiatric medicines and particularly, in children, but it's related to learning that the commenter thinks we should do as a Commission in the coming year. So if you want to take a look at that for a minute? Yes, Emily.

COMMISSIONER ENNIS: Well, I believe Noah's description prior to our beginning our meeting today speaks to this issue. Behavioral health needs can create havoc at worst and certainly, a lot of disruption at best in folks' lives. We've heard about the impact on primary care and the impact on ER visits by individuals who have unmet behavioral health and mental health issues.

I think it would be extremely beneficial for the Commission to have a better understanding, a broader understanding of what is happening in our state, the things that we're doing really well and the gaps that need to be addressed. So I would support presentations or additional information, just as we've heard from the long-term care steering group.

EXECUTIVE DIRECTOR ERICKSON: Is that a motion?

COMMISSIONER ENNIS: It could be. Yes, I would make a motion to include that as a recommendation for future study in this next year.

CHAIRMAN HURLBURT: We have a second.

EXECUTIVE DIRECTOR ERICKSON: And Noah seconded.

CHAIRMAN HURLBURT: Yeah (affirmative), and discussion on

that? Keith.

COMMISSIONER CAMPBELL: I found the psych rights law project pretty intriguing with not a -- not having read their four citations by Ms. Nelson. Does anyone have a feel or will we learn and get a feel for just how valid that point of view might be about the drugs and use of drugs and in children and et cetera, et cetera?

COMMISSIONER LAUFER: If -- yeah (affirmative), if you were to have Mr. Gottstein come and testify, you'd get a feel for it. He's, you know, a very, very heartfelt advocate and is frequently in court and often on the sidewalk trying to talk to people downtown.

COMMISSIONER CAMPBELL: That doesn't lead to my understanding of true validity just because you have a true believer in sandals walking on water.

COMMISSIONER LAUFER: Yes, I completely agree. I think he should speak for himself and then you'll get a feel for it.

CHAIRMAN HURLBURT: Emily, did you have a comment on that?

COMMISSIONER ENNIS: (No audible response).

CHAIRMAN HURLBURT: I believe that it's a valid issue. There's been a dramatic escalation in the use of psycholytic drugs in young kids, often hard to support. I also believe this is more of an operational issue that I don't think is the appropriate purview of the Health Care Commission. I think

it's a valid issue that we need to be taking on as a society, but I don't think the Health Care Commission can be all things to all people and I would say it's too operational for us to do, but it's absolutely, I believe, a valid issue.

COMMISSIONER CAMPBELL: I have, you know, I have no way of judging, you know, how valid it is. That's the reason I asked the question.

EXECUTIVE DIRECTOR ERICKSON: So we have a motion on the table to spend some time learning about behavioral health services in the state. Are we ready for the question?

CHAIRMAN HURLBURT: Okay, all those in favor, raise your left hand. Opposed, the same. Any abstentions? That's unanimous, then.

EXECUTIVE DIRECTOR ERICKSON: And unanimous, very good. Then moving along, malpractice reform, we just had a comment from Mr. Meddleton on page 24 of your public comment packet, just wondering if it isn't something we shouldn't study and not table.

COMMISSIONER CAMPBELL: Mr. Chair.

CHAIRMAN HURLBURT: Yes.

COMMISSIONER CAMPBELL: We've had some tort reform since, what, '05 or something like that? I guess maybe as a starting place, we ought to just have -- see if there's any stats on if it's made any difference in rates and behavior and et cetera, et cetera, if what we've learned in five or six years, at the

very least.

EXECUTIVE DIRECTOR ERICKSON: So is that a motion to add malpractice reform to our list of the things -- of things to study for the coming year?

COMMISSIONER CAMPBELL: Yes, but I wouldn't spend six months, every week on it or something like that. You bet, it's a motion.

EXECUTIVE DIRECTOR ERICKSON: Is there a second to add malpractice reform? Noah.

CHAIRMAN HURLBURT: Noah, yeah (affirmative). Any discussion on that?

COMMISSIONER HALL: Given that I'm the responsible party for tracking the impacts of that, I can assure you, it would be a very short topic. Our ability to get information on either really good evidence on malpractice and on rates or in the general liability world is very difficult and there is a potential of a bill being introduced this year that will not take away my responsibility of doing reports, but to impact the kinds of reports, because we don't have really good information or the ability to get it. So it's not likely to be -- I think it's worth doing, but it's not likely to be a huge project, I guess is all I'm saying to you.

CHAIRMAN HURLBURT: Noah.

COMMISSIONER LAUFER: From a doctor's point of view, the impact of tort reform is going to be very, very long. It's

cultural over decades and generations of medical students, and you know, what you learn from your guild, but I can tell you that for, I believe, the second or third year in a row, there is a refund going to doctors in Alaska who are insured through one of the major insurers and it is not as highly litigious as it once was and it's preventing frivolous cases and I think it's just kind of a question of, you know, how many times you're going to cast if the fish is small?

CHAIRMAN HURLBURT: Jeff, yeah (affirmative).

COMMISSIONER DAVIS: Just looking for clarity, is the motion to study the effect of the tort reforms that were already enacted in 2005 or is it broader than that? What was the motion? I'm not sure.

COMMISSIONER CAMPBELL: Well, I think we can look at it in its broadest form, because we may want to bring stats in from other places, but I think it would be valid to learn what has happened here as a focal point.

CHAIRMAN HURLBURT: Val, yeah (affirmative).

COMMISSIONER DAVIDSON: I wonder if that's something that the legislative research or legislative audit can do, so that we don't have to spend our limited resources on that? I mean, it's clearly within the Legislature's purview to look at what the impact of malpractice tort reform has had in Alaska and they've got the resources to do it.

CHAIRMAN HURLBURT: Yeah (affirmative), we could do some

things. It's so often cited as a cost driver, both in terms of the costs of settlements, where the average settlement has gone up and in the impact on how medicine is practiced, but in Alaska, I think as Noah was saying, it doesn't seem to be a big problem and it might be that we could incorporate it and look at it without incurring the added cost and get the kind of information that the Insurance Division has and maybe have somebody come from MICA to talk with us about their perspective just to educate us on what they see as the situation in Alaska without having to spend budget on -- funds and as Linda says, maybe not take a long time, but to kind of round out our picture. Noah.

COMMISSIONER LAUFER: Like all of these things are so, you know, complicated on the ground, if you call my clinic in off hours, there's a recording like there are in most clinics in town that we are not available. If this is an emergency, go to the ER. That is the direct result -- that was a decision made by us in response to what was seen as an unfair suit in Anchorage, and you know, we're risk adverse.

I don't want any of my decisions to be affected by concerns about being sued, but it does enter into the decision making and the impact of that echoes for, you know, the course of my career, for decades and so it really is important to be aware of it and maybe just a 20, 15, 20-minute review of where the state stands in comparison to other states. That would be

probably enough, right?

COMMISSIONER CAMPBELL: Yeah (affirmative). I would subscribe that NORCAL and maybe -- is it, Doctors, is still a major player here in the state from Seattle, they would be glad to toot their horn, I suspect.

EXECUTIVE DIRECTOR ERICKSON: Let's call for the question.

CHAIRMAN HURLBURT: Let's -- do we have a vote, then, and the vote is to include that in our 2012 plan as an educational item for the Commission. All those in favor, raise your left hand. Opposed, the same. Any abstentions?

EXECUTIVE DIRECTOR ERICKSON: Val, which of the three were you?

COMMISSIONER DAVIDSON: I don't know. I will abstain.

EXECUTIVE DIRECTOR ERICKSON: That would probably be a good decision.

CHAIRMAN HURLBURT: Okay.

EXECUTIVE DIRECTOR ERICKSON: Everybody voted for adding malpractice reform in 2012 as an educational item and Val -- except for Val, who abstained. Is that correct? Everybody's nodding their head, okay.

So moving along, if I can multi-task here, I'm just referring back again to Milliman's final statement at the end of their final report in the executive summary. "This report did not review the quality of care provided to Alaskans, nor

the relative health outcomes from treatment. These issues were beyond the scope of our report, but should be addressed when evaluating the relative value of health care in Alaska," and so the question of studying in 2012, at the beginning of the day today, just as a reminder, this is not from a public comment, but we agreed that when we got to this point in talking about what we're going to study about the current system in 2012, that we would consider adding to the list the relative health outcomes from treatment and quality of care provided to round out our study of the value equation for health care services. Does anybody want to make a motion to add this study to -- for 2012? Keith.

COMMISSIONER CAMPBELL: I'll move whatever you say.

COMMISSIONER MORGAN: I'll second.

EXECUTIVE DIRECTOR ERICKSON: Keith moved. Dave seconded.

CHAIRMAN HURLBURT: Any discussion?

COMMISSIONER LAUFER: How are you going to do that? So what I mean by that is, obviously, there are efforts all over the country to do this. There's huge debate about what's significant or not significant and what parameters to include or not include, so since I'm going to be gone, I would suggest to select a few that are clearly beneficial and leave it at that.

CHAIRMAN HURLBURT: Val, yes.

COMMISSIONER DAVIDSON: Can you repeat the motion? I'm sorry.

EXECUTIVE DIRECTOR ERICKSON: The motion was to include on our plans for study in 2012 of the current system, the relative quality of care provided to Alaskans and the relative health outcomes from treatment.

Is this -- I have a question for anybody. The way I read this statement from Milliman, they seem to be suggesting that it was the sort of thing that their firm does. Do you think that's true?

CHAIRMAN HURLBURT: Yes, they do, a different part of the firm. They do look at outcomes and give you comparative outcomes and they have norms and standards for that. You've got to have a good database and I think it's limited in what we have, but to some extent, it could be like long-term care. I think we probably agreed, we need to get into this, but it may not be a topic that we can accomplish all in 2012, but that doesn't mean we shouldn't start and maybe see what we need because it's -- that's a part of getting at, as Val was pointing out, we did half of it with the cost. The value part, we haven't gotten, but that's a part of getting there, isn't it, Val?

COMMISSIONER DAVIDSON: I guess, it's starting to feel like we're a Milliman ad and I think that one of the things we learned from the Milliman experiment -- experience is that if

they don't have the information readily available to them, then they're not going to include it and so our information on the hospital is, again, about 60% of the hospitals in Alaska and I just want to be very clear that if the data sets aren't there and aren't available, then we should be very careful about what we do with that lack or limited information.

COMMISSIONER HIPPLER: In addition to the lack of and limited information, which I also share the concern, we have to ask ourselves the value of this very study that would look at value. I don't know what our end game is here with the study. We know there's a problem. The cost of health care is going up and while the quality of health care may also be going up, it is not going up as quickly. Hence, we have a problem. We already know this. I don't see the point.

CHAIRMAN HURLBURT: Keith.

COMMISSIONER CAMPBELL: Maybe if we can just define the parameters of what we really want to get our arms around, that would be a huge start. I'm reminded of the book, "The Art of Motorcycle Maintenance," where everybody drove themselves crazy just trying to describe quality and it was -- it's a huge problem just defining the issue.

UNIDENTIFIED COMMISSIONER: Call for the question.

CHAIRMAN HURLBURT: I think that related to Allen's question, it is tough. What are we trying to find out, but we know. We knew before we started. We know that we spend more

than others and we don't live as long and more of our babies die. So that's a value kind of an issue.

I think what we're talking about is getting more specific. We've talked some about evidence-based practice. Don Berwick in his farewell talk said 30% of what we're spending in this country, we're not getting any benefit from and I think the first meeting of the Health Care Commission that Governor Palin established, anyway, heard a similar kind of figure. Others will say 30 to 40% of what you do -- so I think that's part of getting at value. We can't do it by getting down in the weeds.

I had an article here from Health Affairs that I showed to Noah and Jeff saying, you know, two-and-a-half years ago, there was two, double-blinded randomized trials of the percutaneous vertebroplasty, sticking a needle into the back and going in and putting some stuff into the space between your bones on your vertebrae there to help stabilize it for chronic low back pain.

It's something -- it's less invasive than, you know, slicing you open and that kind of thing, but these double-blinded studies where they were able to do a sham in half of the patients, just stick a needle in your back and the other half they did it and put this magic goop in between the vertebrae, the double-blinded study showed that there was no difference in outcomes by doing this multi-thousands of

dollars procedure that they do and saying that despite those publications of high grade evidence two-and-a-half years ago, there has been no difference in what payers are paying for and what's being done.

So we don't want to get into those kinds of weeds, but I think in terms of what we're paying and what value that we're getting, I think there is opportunity to look at the concepts of making sure that what we pay for and what clinicians understand should be their guiding DNA in their practice is really making clinical decisions based on high grade evidence, making payment decisions based on high grade evidence and I think that relates to quality.

We can do that generically and conceptually, but not specifically like this. So I -- that's what I would respond, Allen. Yeah (affirmative).

COMMISSIONER HIPPLER: I still -- I -- once we get this study back and it says something, right, it's difficult for me to imagine a something that it says that will affect us in any way at all. I just can't conceive of anything that the study would say that would guide the Commission.

EXECUTIVE DIRECTOR ERICKSON: Jeff, I can't -- I wasn't sure when you left. Do you know what we're -- what motion we were considering?

COMMISSIONER DAVIS: (Indiscernible - too far from microphone).

EXECUTIVE DIRECTOR ERICKSON: So this is the very last bullet on the slide in front of you and this -- we're discussing a motion that was made by Keith and seconded by Dave that we add for 2012, a study of the relative quality of care provided to Alaskans and the relative health outcomes from treatment for the benefit side of the cost/benefit/value equation.

COMMISSIONER DAVIS: First, I apologize for having to step out for a moment, but I think just from the limited part I've heard, Ward, you point a great -- that study is a great case in point and now, how -- the one you just referenced, the double-blinded study, you know, if we know something like that, we should be able to act on it.

I mean, what are we getting for our money is the question, right? Are people better off because we're spending all this. Should we put all of our money into, you know, somebody standing at the door of the school doing childhood immunizations as they go in instead, or you know, tracking down pregnant ladies in the mall and making sure they're getting -- should we put it into something else or are we getting value for what we're doing?

I don't -- that is the most -- that is a really difficult question in health care, unfortunately. Some of my colleagues just call it the quagmire because we're not really sure what to do about it, but it is a really important question, because

we may not -- I mean, you look at the advancements in length of longevity and those sorts of things, most of them are related to, you know, lifestyle and immunizations and nutrition and sanitation and washing your hands, you know, those sorts of things. They're not related to medical care, per se.

If you look at the determinants of health, about 10% is related to medical care and everything else -- and the other 90 is related to other things. So as difficult as it is to conceive of an actionable item that would come out of that or even how someone would even do that for us, I think we would at least have to ask the question and see what there is we can work with.

Otherwise, we're spending 4.5 billion dollars and we really don't know what we're getting for it and I sometimes think we're getting very little compared to what we could be getting with other things. So I think it's a really important question. I don't know how we're going to do it or what it's going to tell us, but we need to throw it against the wall and see what happens. Thank you.

CHAIRMAN HURLBURT: Wes, yeah (affirmative).

COMMISSIONER KELLER: I think a lot of the value lies in the -- just the credibility of the Commission. It's awfully difficult for a legislator, anyway, to identify between what is advocacy for the bottom line of the company, whatever that

company, you know, I'm just picking something and so I -- the recommendations, the weight of the recommendations is increased by qualified studies, so for what it's worth.....

CHAIRMAN HURLBURT: Noah, yeah (affirmative).

COMMISSIONER LAUFER: I don't know how to include this into the Commission and you've got to give me a little leeway, but ultimately, the -- or the value is judged by the patient and the patients are largely absent from this Commission and that's been my sort of professional conclusion is -- and that's why I mentioned that term, "Narrative medicine." You know, I don't have to say, "Hey, what you're doing is wrong." I can say, "Hey, how's life going" and is alcoholism part of your hero narrative or would you like to do something about it," or smoking or obesity or whatever and ultimately, the patients have to decide what they want from us and that message isn't clear.

What we have -- the message the providers are getting is from the payer, who's this abstract person, employer or insurer that it costs too much, but the message we get from patients is mixed and it really does come down to what Allen was saying to personal responsibility and what do you want? What do you want from health care, and that's the decision and no one is even going to go near it because you end up tiptoeing around things like, are you going to resuscitate a 23-week preemie? Are you going to, you know, go for the

second stem cell transplant for multiple myeloma?

These very difficult questions that no one even feels ethically capable of addressing, but that's the crux of all of this. What is wellness? Who defines wellness? How much are we willing to pay for it? So I'm glad I'm not going to be here for that discussion.

UNIDENTIFIED COMMISSIONER: We'll call you back as an expert witness.

COMMISSIONER LAUFER: Well, my hope is that there's going to be a long line of primary care people who come in and voice similar attitudes about it that I have. I'm not alone. I mean, I know -- we're not in agreement, but people have a similar perspective. My head is filled with the stories of individual people and they have different priorities.

CHAIRMAN HURLBURT: Okay. Are we ready to vote to add this bullet to our recommendations and to, at least, embark on this process in the next year?

COMMISSIONER LAUFER: (Indiscernible - too far from microphone) life expectancy, infant mortality, I don't know -- the things that.....

EXECUTIVE DIRECTOR ERICKSON: You need to -- you need to.....

COMMISSIONER LAUFER: The parameters, like I said, have to be simple and clear and tangible and meaningful and.....

CHAIRMAN HURLBURT: Doable.

COMMISSIONER LAUFER: That shouldn't cost that much because that's just epidemiologic data.

CHAIRMAN HURLBURT: No. Okay. All those in favor of adding that point, raise your left hand. Opposed, the same. Anybody abstained? Okay, seven to one.

EXECUTIVE DIRECTOR ERICKSON: It passed unanimously?

CHAIRMAN HURLBURT: No, Allen voted.....

EXECUTIVE DIRECTOR ERICKSON: Okay, so moving along in your slide packet, we are on slide six. I know it says 10 on your screen, but we had added some slides from your packet and from what's on the web. We had received a number of comments related to our patient-centered primary care recommendations. They were all supportive. I noted them here. They're in your public comment packet on page 24, page 30, page 35 and page 43, and there were no suggested changes or improvements.

Nobody commented negatively about it. All of these comments were essentially in support of the recommendations you made. I'm going to assume we can move on, unless any of you want to discuss any of those comments.

Okay, the next set of comments we have are related to our transparency recommendations. Only one commenter, it was from the State Hospital and Nursing Home Association again, page 30 of your packet. The reminder -- we have two recommendations here. One related to encouraging participation in the hospital discharge database and the other is on creation of an

all-payers claims database and the Hospital and Nursing Home Association notes that they're committed to a comprehensive data collection from the hospitals, however, resources to devote personnel to this task are extremely limited and not currently adequate. So there's not a request there, but a suggestion that they don't have enough money.

The next comment related to the all-payers claims database is that they agree with our comment that's actually in another section, that a feasibility study is -- should be conducted. Their suggestion is we should -- the Commission should not recommend an all-payers claims database for the state prior to conducting the feasibility study. So discussion on these two comments, again, page 30 of your public comment packet.

COMMISSIONER DAVIS: Thank you. I'm commenting on the recommendation of an all-payer claims database, I think the Hospital and Nursing Home Association may be onto something here. I know that I was one of the proponents in earlier or the earlier meeting. I've gone back and talked with others who are more in the know and the recommendation was, be careful to identify what you're trying to accomplish first and then work backwards into what data is required to accomplish those objectives.

Otherwise, and it has been the experience of -- in other places, that you build this big database and great and

wonderful and now what? What do we get out of this for a significant investment in time and money? So toward that in a feasibility study that would, first, identify what you're trying to accomplish, best practices, those sorts of things, scale and then come back and -- for the consideration of the Commission and potentially putting our weight behind it make a lot of sense to me, rather than endorsing something that is not very well defined.

COMMISSIONER DAVIDSON: I would second that motion.

COMMISSIONER DAVIS: So moved.

CHAIRMAN HURLBURT: So could an analogy be -- maybe to a somewhat more limited extent, but something like what we did with patient-centered medical homes where we looked at what has been done, how it's been done in other states and we haven't come down.

It's still an agenda item, but seeing what the advantages are and how people get there that we could do the same thing, because we are behind the eight ball on an all-payer claims database. So there should be people available to come and tell us what they did, how they did it, what mistakes they made, what the benefits are, kind of try to learn from others. Yeah (affirmative).

COMMISSIONER DAVIS: To clarify, I -- just a comment on the motion, I believe that having additional data is of value, but it's, you know, is it this big or is it this big, and so

yes, studying it further and understanding what exactly it is we're recommending and why makes sense, rather than what is currently a blanket recommendation, we just do one and I don't think, you know, we haven't defined it yet, but I do support the need to move ahead with some efforts to have a better view of the whole system.

COMMISSIONER MORGAN: At the affordability conference that was back in the fall that one day at Dena'ina Center, a lot of people echoed that, but also, the insurance -- Wes was there, but the insurance brokers and guys like you were just vibrating in that they could not get data. They couldn't figure out what we -- what you guys have been saying all along.

So when they did talk about it, having a database, many of them had ideas what they would -- what should be in it, but the whole insurance community at the conference wanted the database, wanted something they could look at so they could do planning.

There were several brokerages there that were just very upset and they started saying, but in -- I'm just pulling a state, you know, in Utah, we can find out how much it costs to do a gallbladder or something. You know what I mean, and so yeah (affirmative).

COMMISSIONER KELLER: Just a question for Jeff, what -- are you saying that you're not -- are you saying that this --

we shouldn't go so far as to make a recommendation in 2012 on whether it should happen or not or are you saying we should approach this very thoughtfully and kind of put that decision off until later in the year, because I -- to me, that's the way we'd go at it is look at other states and comparisons and whatever and I can -- I don't really have any problem with us putting off the decision, but you know, start with feasibility, but I mean, ultimately, I would like to just ensure that you're thinking that we could potentially include it as part of the 2012 recommendation.

COMMISSIONER DAVIS: Yes, I am thinking we could include it as part of 2012 recommendations. What I'm responding to is the current recommendation, unless I've got this wrong, that the current recommendation says, the Alaska Health Care Commission recommends the state of Alaska develop an all-payers claims database for Alaska. I don't think we're at -- I think that is our goal to get to that, but we need to define what that is and what we're trying to accomplish.

Case in point, David just described people who want to see information around transparency. Well, that's a whole different thing that if we're trying to look at some other. So we just need to know what it is. Otherwise, we could spend another 7.5 billion dollars just trying to develop a database that we don't know what the utility is.

So I think you're absolutely right, doing it the way

we've done it before, whether it's a feasibility study or it's studying the issue and learning from others and moving forward, we just need further recommendation before we come down with a firm, we should go ahead with this thing, since we don't know what "This thing" is. Thank you.

EXECUTIVE DIRECTOR ERICKSON: I think we need to be real clear on the motion that you're making and what I'm hearing is that the motion that you made, Jeff, that Val seconded, is that on our second recommendation under transparency that we change it from, "The Alaska Health Care Commission recommends the state of Alaska develop an all-payers claims database for Alaska," to "The Commission recommends the state of Alaska study the feasibility of an all-payers claims database for Alaska," the needs -- conduct a needs assessment and feasibility study, both and we do note in our plans for study in 2012, related to future strategies, that the Commission is committing resources to doing that because we want to make sure it happens and move it along, but we would then also make this change here. It would kind of marry up with it. I'm going to type that up while you all continue discussion it.

COMMISSIONER DAVIDSON: So I'm assuming that a part of that feasibility will be the cost of implementation, okay. So in that light, there's a similar parallel -- what we're basically recommending here is just as the state is taking the position on the -- developing an exchange, the state isn't

developing an exchange. The state is developing -- doing an RFP for a feasibility study of what an exchange might look like. So this is a similar parallel.

Before saying we need an all claims database for Alaska, we're also recommending a similar feasibility study of what that would look like, what it would cost to implement and what might be included.

CHAIRMAN HURLBURT: Okay, are we ready for the question? All those in favor of looking at the feasibility next year of an all-payers claims database, educating ourselves about it and so on, raise your left hand. All opposed, the same. Anybody abstaining? It's unanimous. Thank you.

EXECUTIVE DIRECTOR ERICKSON: The comments that we received related to payment reform, I noted, again referencing your public comment packet, there were a couple of comments that were just general discussion of support for payment reform as moved toward value and I just noted the pages that -- where we were -- where that support was noted and I'm assuming we don't need to discuss that.

Page 31 and 32 of your public comment packet, ASHNA had noted related to our data collection statement. Let me find that here. So our recommendation number three, the state develop health data collection analysis capacity as a tool for quality improvement and payment reform and that data collection analysis and use decision should involve

clinicians, payers, and patients.

ASHNA notes that they agree with the need to move toward value, rather than volume. As stated, new data collection efforts must include prior consultation. So I think this is just agreement, and then moving on from data -- the point about data collection, purchasing policy on this same page -- the remainder of ASHNA's comment is the "Likewise, common purchasing policies and efforts by state government should include up front consultation with providers." Emily.

COMMISSIONER ENNIS: Deb, are we considering adding additional language or do we feel we have all that?

EXECUTIVE DIRECTOR ERICKSON: No, I'm just referencing ASHNA's comments. You can.....

COMMISSIONER ENNIS: I understand.

EXECUTIVE DIRECTOR ERICKSON: You can review their comments and decide if you want to make a motion to make any changes based on them.

COMMISSIONER ENNIS: Correct. I wondered if anyone was going to suggest -- they're good comments. I think that from the home and community-based perspective, that's something we are certainly encouraging in terms of development of data collection or other activities that are proposed that we be at the table for discussion before studies or new ideas come up that sometimes that tends not to happen. So I think it's an important reminder.

So if it would help including it in the language, I'd certainly move to add that prior consultation with key health care stakeholders, including providers be an important element of the recommendation. It's not in there already. I'm not seeing it.

EXECUTIVE DIRECTOR ERICKSON: So if you want, I have the fourth of the four up on the screen. If you want to be looking at it in the report itself, our public comment draft, it's page 22. You can look at all four of our draft recommendations there related to payment reform.

COMMISSIONER ENNIS: I think, although, there's reference to collaboration, I would support that actually specifying key stakeholders and providers would be a helpful addition to make sure they're included.

EXECUTIVE DIRECTOR ERICKSON: Do you want to propose a specific motion?

COMMISSIONER ENNIS: You mean you want me to -- would you like me to wordsmith it or just -- let's see if I can find a place, perhaps somebody else could help me.

UNIDENTIFIED COMMISSIONER: How about that last paragraph (indiscernible - too far from microphone).

CHAIRMAN HURLBURT: The last paragraph, second sentence, "These collaborative efforts," including key stakeholders and providers.

COMMISSIONER ENNIS: I think that would be a good place.

Thank you.

CHAIRMAN HURLBURT: Okay.

COMMISSIONER ENNIS: I move too.

CHAIRMAN HURLBURT: Okay.

COMMISSIONER HIPPLER: Second. I would like to call the question.

EXECUTIVE DIRECTOR ERICKSON: Before we do that, can you tell me who seconded, please?

COMMISSIONER HIPPLER: I did, Allen Hippler.

CHAIRMAN HURLBURT: Okay. I think we have the language on page 22 of the circulated draft document with the modification that we just added underlined there in front of you. We have a motion and a second to approve this with that amendment. All in favor, raise your left hand, and opposed, the same. Any abstentions? That's unanimous, Deb.

EXECUTIVE DIRECTOR ERICKSON: Thank you. Okay, there is some discussion on page 39 and 40 of your handout packet.

UNIDENTIFIED COMMISSIONER: Which one?

EXECUTIVE DIRECTOR ERICKSON: I'm sorry, you're public.....

UNIDENTIFIED COMMISSIONER: (Indiscernible - too far from microphone).

EXECUTIVE DIRECTOR ERICKSON: I know, your public -- the public comment packet.

UNIDENTIFIED COMMISSIONER: Okay.

EXECUTIVE DIRECTOR ERICKSON: And I think we probably addressed this already. I'm trying to find the specific sentence, but it seems to me that there were similar suggestions related to payment methodology development that stakeholders be involved, but now, it's all turning into a blur. So if any of you are remember from your review -- okay, so I'm on page 40. The boards, these are the Mental Health and the Substance Abuse Boards. "The boards generally agree with the findings and recommendations provided in Section Three, Payment Reform.

We acknowledge that work needs to be done to develop payment methodologies to promote cost effective quality outcomes and integrated care setting. Sweeping payment reform has already been initiated through the development of the integrated behavioral health regs that were just implemented December 1. Commend the Division of Behavioral Health on its incredible efforts. We were included and look forward to achieving" -- well, maybe there's nothing more to do here. They just had noted this. Okay.

Yeah (affirmative), they do have a recommendation we're going to get to in behavioral health that's related to payment methodologies and that's above that paragraph I just read. So we'll get to that in a few minutes. Does anybody have any other suggested changes to payment reform? Any questions, comments, remembering anything I'm forgetting or leaving out

from public comments?

Okay, moving onto the trauma system, you have comments on page 24 and page 31 of your public comment packet and the first, I believe, are more of a series of questions related to the value of trauma centers and I don't know if these are more questions from an individual that isn't involved with trauma centers and trauma system that we could just follow up with privately, but if you want to look at that for a minute, page 24, and then there's a comment from the State Hospital and Nursing Home Association, page 31 of your packet. Yes, sir, Dave.

COMMISSIONER MORGAN: This is a question. I didn't get a chance to Google it, but what is the LFA -- what is LFACHE? Is that.....

EXECUTIVE DIRECTOR ERICKSON: I'm sorry, what are you -- where -- what page are you looking at?

COMMISSIONER MORGAN: Well, it's on 24 and the fellow that wrote the letter with all the questions. I don't know if that's a certification or an organization. What is that? Does anyone know?

CHAIRMAN HURLBURT: He's the Chair of the Alaska Mental Health Board.

COMMISSIONER MORGAN: So it's a certification then?

CHAIRMAN HURLBURT: Yeah (affirmative), and he used to be, Deb was telling me, Director of the Division of Public

Health.

EXECUTIVE DIRECTOR ERICKSON: Not of public health, not public health.

CHAIRMAN HURLBURT: Behavioral health.

COMMISSIONER MORGAN: Okay.

EXECUTIVE DIRECTOR ERICKSON: Mental Health.

CHAIRMAN HURLBURT: Mental Health, yeah (affirmative), so this guy's been around a long time, I think a well-respected person.

COMMISSIONER MORGAN: Well, I'm not -- I was just wondering.

CHAIRMAN HURLBURT: And I think that this question on the trauma system, to me, just suggested that's not something that he normally deals with and is asking for information and that's -- my suggestion was like Deb said that I would certainly be glad to talk with him, that there is the national data, the certification and designation and care in those facilities, both in the U.S. and Canada, shows that you have survivals and it is the system of care that's used throughout the country and Alaska's kind.....

COMMISSIONER MORGAN: I.....

CHAIRMAN HURLBURT: So it's just a matter that, Dan, I think it's not an area that he's real familiar with.

COMMISSIONER MORGAN: Okay, no, no, I'm not -- that wasn't my question. I understood all of that and I'm reading

his letter and I sort of recognize the name.

CHAIRMAN HURLBURT: I have no.....

COMMISSIONER MORGAN: I was just wondering what the letters after his name meant?

CHAIRMAN HURLBURT: Do you know (indiscernible - speaking simultaneously)?

COMMISSIONER MORGAN: Do you know what it is?

COMMISSIONER DAVIS: No, but I can make a wild guess.

COMMISSIONER LAUFER: It looks like Licensed Fellow of the American College of Health Care Executives. Is that right?

COMMISSIONER DAVIS: I was going to be all right, all but the first word.

CHAIRMAN HURLBURT: Okay.

COMMISSIONER LAUFER: Sorry, what does L stand for then?

COMMISSIONER DAVIS: I was going to say like Lifetime Fellow of the American College of Health Care Executives was going to be my guess.

CHAIRMAN HURLBURT: Yeah (affirmative).

COMMISSIONER DAVIS: But ACHE, that's normally what it is.

EXECUTIVE DIRECTOR ERICKSON: So our second -- the second comment related to the trauma system recommendation is on page 31 of your public comment packet from ASHNA at the top of the page and it's related to the second recommendation that we

made that the state continue to support implementation of the recommendations of the American College of Surgeon's Committee report and include achievement and maintenance of certification of trauma center status of Alaskan hospitals and ASHNA says, "We support the implementation of the legislation passed in 2010 and as the narrative reflects, hospitals have responded positively to this legislation, however, given cost considerations, some trauma designations may be unattainable in the future. Cost should be balanced with quality and efficiency." Discussion or are you ready to move on?

CHAIRMAN HURLBURT: Let's move on.

EXECUTIVE DIRECTOR ERICKSON: Moving on, obesity, on page six, since we were noting our former directors, I'll note page six's Dr. Nakamura was the Director of the State Division of Public Health for 10 years, from 2001 -- 1991 until 2001, was kind of tickled to get comments from him.

He supports -- just wants noted and we also have a letter on page 43 from the state, the Alaska Public Health Association, both supportive of this recommendation and then also on page 43, from the Public Health Association, they were just suggesting that we emphasize the importance of the community and the built environment and also partners in working on obesity control measures.

Let's see, all important points -- one question I have is; our recommendation is pretty general. We're not getting

into too much of the how and more of the what and we've recommended that evidence-based programs to address the growing rate of Alaskans who are overweight and obese should be implemented.

So I don't know if you all want to get more specific or not then, in response to that comment or if you think that it's already covered in your more general policy recommendation.

COMMISSIONER CAMPBELL: (Indiscernible - too far from microphone).

EXECUTIVE DIRECTOR ERICKSON: Keith mentions that he thinks it's covered.

CHAIRMAN HURLBURT: Anybody disagree?

EXECUTIVE DIRECTOR ERICKSON: Okay. Moving on to immunizations, we received 16 letters of support, mostly from primary care physicians and other providers in support of our immunization recommendation. The -- and so I've -- and I've listed all of the page numbers where we would find those in your public comment packet, page 6 through 18, 21, 35 to 36, and 43. I don't know if there was anything in particular you all felt a burning need to highlight from any of those letters of support.

I did note in the email when I transmitted this packet to you, that I didn't want you to be confused. A couple of the letters were actually addressed to legislators or To Whom it

May Concern and I clarified with those folks that they intended those to come to you when they came to me as part of this public comment period on our recommendation as well.

There is, on page 31 of your public comment packet, a comment from the State Hospital and Nursing Home Association and it just mentions that hospitals are engaged in immunization efforts, if I can paraphrase a little bit and then on page 35 and 36 of you public comment packet, the Primary Care Association, which had also voiced strong support for this recommendation, suggested that a statewide public awareness campaign should be implemented related to concerns over all of the misinformation and misunderstanding about immunizations and I have a similar question for you along the same lines as obesity. You have a more general policy recommendation that the state's immunization program be adequately funded and supported. Is that more -- a more specific recommendation related to the need for a statewide public awareness campaign necessary or is it already addressed here as far as you're concerned?

COMMISSIONER CAMPBELL: I'd ask Wes, from the standpoint of his vantage point in the Legislature if it's addressed or not.

COMMISSIONER KELLER: I think it is and it will get some attention this year anyway, because there's a hole left in the funding that's going to have to go to GF and so there's going

to be some folks on it and I'm sure you probably know more about it than I do with the recent gap in the funding that is left because we no longer -- it's no longer paid 100% by the feds and now, a GF item, so it'll -- just be prepared to talk about, but I think the report is fine as is.

CHAIRMAN HURLBURT: Going, going, gone? I think we're okay. Okay.

EXECUTIVE DIRECTOR ERICKSON: Okay.

CHAIRMAN HURLBURT: Thank you.

EXECUTIVE DIRECTOR ERICKSON: To the behavioral health recommendations -- I lost them. This was one that I actually made some -- as I was -- mentioned at the beginning of the day, there were a few areas where I thought clarification or suggested language might be helpful and so I did take a stab at drafting here, just for clarification purposes on this first one.

So first of all, related to our behavioral health recommendations, these are more about the population-based prevention related to behavioral health. There were a few mentions of support for the part of the recommendation related to integration of behavioral health in primary care and I've noted the pages where those are noted.

There was -- one of these comments suggested that it wasn't necessarily clear, I thought we were making it pretty clear, making it generic enough that integration could occur

in either setting, in a primary care facility or a behavioral health setting, if that was more appropriate, but based on the question about that, I thought that maybe it wasn't quite clear enough and so this was just one idea, if you're looking at the screen to that bullet, integrated behavioral health services -- "Integrate behavioral health services with primary physical health care services in common settings." That's the way it currently reads.

So do you think adding, "Appropriate to the patient population," would help make it clearer that it could be primary care services in a mental health clinic for those patients who are seriously mentally ill and are going to be getting most of their health care in a behavioral health setting and would be more comfortable receiving primary care and that's -- that's the issue and so I don't know if that clarifies this or is necessary or not. I thought it was covered enough in just "In common settings," without being specific to a particular setting, but -- yes, Val.

COMMISSIONER DAVIDSON: I'm looking at the comment that was submitted on page 33 and I think there's something else that's missing, which is "Assuring coordination with primary care and higher level behavioral health services," so that if somebody may have been, for example, released from an inpatient psychiatric facility, what kind of coordination happens between that facility and a primary care setting, and

back and forth, and I think that's not captured in the revision 1A.

EXECUTIVE DIRECTOR ERICKSON: I'm not seeing that in this comment, but.....

COMMISSIONER DAVIDSON: So if you look at -- on page 33 of the comments.....

EXECUTIVE DIRECTOR ERICKSON: Yep (affirmative).

COMMISSIONER DAVIDSON: Under one, "Integrate behavioral health services with primary care when appropriate or assure coordination between primary care and higher level behavioral health services," and we hear that often that there really is no, for example, or little or miscommunication or sort of challenges in, for example, people who are discharged from API, suddenly, they're in the primary care setting and the primary care physician or provider has no information and vice/versa.

COMMISSIONER LAUFER: Can I speak to that a little? I think Val's absolutely correct. I have -- I don't think I have ever received a summary of an admission to API from a psychiatrist. I've never had any communication, unless I specifically sought it out and then it was very difficult. That's sort of one direction.

The other issue is when -- most of the time when people need, you know, higher level behavioral health care, they're not able to get it. They're often not able to pay, which is

the biggest issue and then that's just enough of a barrier for them not to go. So it's really -- it's almost like there are two separate worlds and without getting anybody too pissed, when I first got here, we'd get these calls from the inpatient psychiatry, your patient is here and they need a physical and they've been here for 18 hours and it needs to be done within 24 hours, and I'd say, "Well, who admitted them?" "Oh, Dr. So and So." "Well, they're a doctor. Why don't they do a physical?" "Well, you know, they're not comfortable doing that, you know, you need to come over," and there is a false separation between mental and physical health and in my mind, they are totally the same thing. They're integrated and connected and that could be better on a lot of areas.

There's very little communication, except, you know, I have a few psychiatrists I know personally that I call and say, "Hey, can I get them in? They'll pay you later."

UNIDENTIFIED COMMISSIONER: (Indiscernible - too far from microphone).

COMMISSIONER LAUFER: Yes.

COMMISSIONER DAVIDSON: So can I -- maybe I can -- if I can just add -- after A -- between A and B, maybe another bullet or another section that reads, "Assure coordination between primary care and higher level behavioral health services," as was recommended in the comment. I mean, don't say, "As was recommended in the comment," but I'm taking it

from that language, that recommendation.

COMMISSIONER HIPPLER: Thank you, Mr. Chairman, perhaps you or Ms. Davidson can answer. My understanding from the outside of the industry looking in, is that the recent HIPPA regulations have just crippled the ability of physicians to talk to each other and would this fall under that?

Is this something that would -- so if a primary care physician refers someone to more advanced psychiatric care, is the relationship over or I mean, is the patient so protected by privacy that his doctors can't talk? No? Okay.

COMMISSIONER LAUFER: I think it's more cultural. They just don't talk. They don't talk to us, unless you call and ask. It really isn't that -- that is true, unfortunately, even with some psychologists and there are a lot of different levels of behavioral health and all of them, often very valuable, but you know, we just don't hear from them usually, unless you know, we seek them out.

COMMISSIONER HIPPLER: So -- I'm sorry.

COMMISSIONER ENNIS: Allen, often a release will be completed to facilitate that communication, but I think the point is that it doesn't necessarily happen any more than if you're referred to an ENT from your primary care doctor, you are left responsible to bring back the records, generally. Your primary care or the ENTs aren't going to necessarily, except in a small community, pick up the phone and talk to one

another. It's unusual. It'd be great if it happened, but it doesn't.

COMMISSIONER LAUFER: When they're more dependent on us for referrals, they call us back and they make sure that we get it and now with the EMRs, we are starting to get some integration so that it shows up right away. Some of my favorite referees, I guess you'd call them, I'll get a written summary back that day, you know, when they care about it and I even got a bottle of port yesterday from an ENT.

UNIDENTIFIED COMMISSIONER: Great.

COMMISSIONER MORGAN: Yeah (affirmative), I thought the one thing that the electronic health record and the E-network was supposed to help was once that's implemented, that with -- when a patient goes, gets referred or goes to a physician and then is referred or goes to another physician, they have to sign the necessary paperwork and that's the whole point of it. That's the point of the 3.5 million-dollar system that we're supposed to put in is to move those records around.

Now that -- hopefully, that'll help, but still, you have that problem tonight when somebody hits -- and even, I'm probably speaking out of turn here, luckily, I know that my wife is traveling, so she won't hear me. She works at Covenant House. The shelters receive a large number of mentally ill street people, especially young people that they treat or care for.

They don't treat. Shelters are -- but suddenly, they have a mentally ill youth in the shelter and trying to deal with that and this is a big, like you said, it's a big problem, but I'm hoping that the electronic health record process system should at least help in getting these records around, so at least everybody knows who's giving who Thorazine, at least, through the process.

COMMISSIONER HIPPLER: So is the point of this recommendation, assure coordination, are we -- we're envisioning the state of Alaska helping primary care physicians give records to high level behavioral health service physicians or what are we envisioning here?

COMMISSIONER KELLER: I'm not carrying that legislation (indiscernible - too far from microphone).

COMMISSIONER MORGAN: I think we're speaking to the industry or the system. I don't think we're speaking to Wes or Commissioner Streur in this. I think we're speaking to the industry and hopefully, electronic health record and what's going on will facilitate this thing kind of working better, but still, there's going to be holes and glitches in this and we'll just have to carry, right, carry on as best we can, but at least know we've got the problem.

EXECUTIVE DIRECTOR ERICKSON: Well -- and this recommendation is to the state of Alaska and it's under the broader heading that the Commission recommends the state

supports efforts to foster development of patient-centered primary care models in Alaska, which we have a whole other section on that, but this was specific to, what can we do related to, kind of a population-based approach to improving behavioral health and this was so that -- that's what this recommendation is about and we identified that, okay, if the state's going to be working toward patient-centered primary care models -- and so what we're saying here is that as the state does that, they should develop -- foster the development of models that integrate behavioral health services with primary care and now you're also adding, "Assure coordination between primary care and higher levels of behavioral health," along with those other screening recommendations. We didn't get any suggestions from the public about -- yes, Emily.

COMMISSIONER ENNIS: I'd like to just clarify -- the initial comment is one that I believe that we didn't -- that the Alaska Mental Health Trust was concerned that we didn't include a recommendation that implied that all primary care providers needed to begin to integrate behavioral health services, because for some individuals, that's not going to be appropriate.

They're going to need to get their primary care in the behavioral health center. So we want to make sure we support the development of primary care within a behavioral health center for those individuals that have higher behavioral

health needs, that we're not expecting every primary care physician or center to develop care of management and psychiatric supports in their practice. That's clearly not what we think is -- the Commission is recommending, that it's in both settings.

EXECUTIVE DIRECTOR ERICKSON: Yeah (affirmative), and we did, just as a reminder, if you want to go look at our public comment draft on page 28, the last finding bullet right before this recommendation, is that integration of primary care for both behavioral and physical conditions in a common clinical setting is an essential feature of patient-centered primary care.

So again, I think we were making the point that it wasn't necessarily in one or the other type of setting and that it was general. So what -- go ahead, Allen.

COMMISSIONER HIPPLER: I'm wondering if this should be a finding, a finding that if we create a proper patient-centered primary care model in Alaska, it will assure coordination between primary care and higher level behavioral health services. I'm wondering if this is a finding, rather than a recommendation.

EXECUTIVE DIRECTOR ERICKSON: If we're saying, "It should," it sounds like it would be more of a recommendation than a finding.

COMMISSIONER HIPPLER: We're implying some action on the

state's end.

EXECUTIVE DIRECTOR ERICKSON: Well, we are for those others, as well. We're -- and we're suggesting that as they develop models. So they will be -- the state, specifically, will be working through the Medicaid program is where they're focused on developing a plan for patient-centered medical homes. So I think what we're suggesting is that these are features or attributes or conditions that they should include as they develop those models.

That's how I would see them taking a recommendation like this and implementing it, anyway, and then as they move forward, if they start working on payment reform and working with multi-payers that -- if they develop in the future or even as part of this first effort, a multi-payer patient-centered medical home effort with Medicaid or with the Department of Administration state employees, we're recommending that this be a feature of that.

COMMISSIONER LAUFER: Just to make that sort of clear on a practical level, in family medicine training, almost every program in the country has integrated into the resident clinic a behavioral health person, a psychologist, at least one. I would imagine neighborhood health would like to have one or will have one. We would like to have one, but we -- and we have tried, actually, but the payment model doesn't allow for it, but it might in the future and if we are working in

collaboration with the hospitalists, who are the docs who do the admissions, and there's a behavioral health person who's integrated into this team that allows for transition to and from the hospital, that might -- might really help, but now we're jumping into value from cost, which I would applaud, but anyway, that's sort of the more practical viewpoint, you know, how do we get reimbursed to have a behavioral health person as part of our team?

EXECUTIVE DIRECTOR ERICKSON: Which is to our second recommendation, which is about the reimbursement model. Okay, so we have a suggestion here. Did we have a formal motion? I didn't catch it if we did. Val, you.....

COMMISSIONER DAVIDSON: I so move.

EXECUTIVE DIRECTOR ERICKSON: You made a motion. So for both of these suggested changes that are underlined under A and B, 1A and B, so that it would read, "Integrate behavioral health services with," I probably should read the first part. "The Alaska Health Care Commission recommends the state of Alaska supports efforts to foster development of patient-centered primary care models in Alaska that A) integrate behavioral health services with primary physical health care services in common settings appropriate to the patient population, B) assure coordination between primary care and higher level behavioral health services, and C)" we haven't addressed, but we had no comments about this, "Include

screening for the patient population using evidence-based tools to screen for a history of adverse childhood events, substance abuse and depression." So we had a motion. Val, you had made this motion, did you, and who seconded it?

COMMISSIONER ENNIS: I will. Emily seconded it.

CHAIRMAN HURLBURT: Maybe a question for Noah by way of discussion. I think the recommendation to talk about higher levels of behavioral health care is to make sure that there's the communication and collaboration between primary care physicians and psychiatric physicians, but you also want to have collaboration with the LCSWs, for example, they may be the appropriate provider for maybe even more of your patients than need to see a psychiatrist, right?

COMMISSIONER LAUFER: Yes, but in a plug for the complex systems view of this, in the current environment, if I do a really good job of taking care of very difficult, low reimbursed painful patients, I will be punished for that because they'll send them my way. So you know, you have to understand sort of this bigger picture of the whole thing and I think it needs to sort of be system-wide, you know, and well, it's -- the other thing is a recognition that this is one part of a person's life in the continuum of their life and they may be down for this year, but you help them now and they're up later and anyway, it's obviously more complex, but yeah (affirmative), that would be the idea. It would be

healthier for us all.

CHAIRMAN HURLBURT: Emily, yeah (affirmative).

UNIDENTIFIED COMMISSIONER: Call for the question.

COMMISSIONER ENNIS: Ward, are you concerned about the (indiscernible - voice lowered) "Higher level," meaning.....

CHAIRMAN HURLBURT: Right.

COMMISSIONER ENNIS: .....that it's a psychiatrist and.....

CHAIRMAN HURLBURT: If that's an exclusive term.

COMMISSIONER ENNIS: Right, and I wasn't sure whether "Higher level" meant, you know, something else. It could mean a number of things. It may -- I've read it as somewhat more generic. So I don't know if we need to clarify it or if it's okay. I think it's more generic.

CHAIRMAN HURLBURT: Okay. So we're ready for the question. All those in favor of the wording up there, say -- raise your left hand. Opposed, the same. Any abstentions. It's unanimous, Deb.

EXECUTIVE DIRECTOR ERICKSON: Thank you. Okay, moving onto the second recommendation here, again to page 39 and 40 of your public comment packet, the Mental Health and Substance Abuse Boards raised a concern about the wording of this recommendation, which currently reads, "The Alaska Health Care Commission recommends the state of Alaska develop, with input from health care providers, new payment methodologies for

state supported health services."

If you'll recall when we -- a few meetings ago when we very first drafted this, it was specific to Noah's point and it was related to our last finding bullet and also the recommendation above, that new payment methodologies needed to be developed to support the -- and facilitate the integration, but then at some point, and it was never clear to me why, but at some point, you voted to take that last part out.

Now, the Board's picked up on the fact that this recommendation wasn't linked to anything else in this section and my sense from their letter is it made them a little bit nervous that it was a little bit too open-ended. So I'm remembering from their comments that there were kind of two points.

One, that it wasn't linked. There isn't a finding statement about general payment reform related to behavioral health being needed and so they didn't think it quite fit when it was left that general and that they were concerned that if it was left too general that some mischief potentially could be made that wasn't following the intent of the Commission.

So I took a stab again at just drafting, especially since we initially had this in, and I didn't remember a conversation about taking it out. So I've suggested wording that would read now, "The Alaska Health Care Commission recommends the state of Alaska develop with input from health care providers

new payment methodologies for state supported behavioral health services," adding, "To facilitate integration of primary physical health care services with behavioral health care services." Does anybody want to make a motion that -- to amend the recommendation as suggested since a couple of heads are nodding yes, anyway, at least for discussion purposes?

COMMISSIONER ENNIS: So moved.

EXECUTIVE DIRECTOR ERICKSON: Emily moved.

COMMISSIONER DAVIS: Seconded.

EXECUTIVE DIRECTOR ERICKSON: Jeff seconded.

CHAIRMAN HURLBURT: Any discussion? Are you ready to vote?

COMMISSIONER HIPPLER: Can you clarify what the motion is, the verbiage?

CHAIRMAN HURLBURT: So I.....

EXECUTIVE DIRECTOR ERICKSON: Yeah (affirmative), as I just read and as written on this screen. It's to add to our recommendation. The added language is the underlined language. So is that clear? So we're adding, "To facilitate integration of primary care and behavioral health."

COMMISSIONER CAMPBELL: Call for the question.

CHAIRMAN HURLBURT: Okay, did you have a comment, David?

COMMISSIONER MORGAN: I was just going to basically state, just in case you hadn't heard it, one of the problems with behavioral health reimbursement is it's always sort of

stood off to the left, center stage left, you know, the dancing Hitlers go left, the dancing -- the singing Hitlers go right kind of thing and basically, the way they have -- between Medicaid and other reimbursable entities that reimburse or cover it, they tend to have a parallel, this is what a provider is.

This is what providers get paid and though we talk about integration a lot, the reimbursement, unless you're getting an encounter rate already for it, a lot of the fee for service and VA and other reimbursables kind of look at it as a parallel and they always limit it, instead of where we keep talking about integrating it.

That will engage a lot of parties from all the way from Medicaid to the insurance companies to how regulations are even written. So it's not -- it sounds like all simple things, it's going to be a real toughy to do. What's funny is, everybody says, "This is what we should do and we need to get it done quickly."

The problem is, is trying to get them to pay for doing it or at least keeping the reimbursement you're currently getting when you integrate. If you integrate, sometimes you lose the behavioral health reimbursement because there's no longer a primary diagnosis that's a behavioral or a mental health problem.

So there's some stuff to fix and I mean, a bunch of it,

but we're going to have to do it, especially, I mean, we have a medical home, patient home and we're taking hits because we do it, but we can't basically get reimbursed for some of the -- some of this behavioral health stuff we do. So that's what this is about in case you didn't know and if you did know, maybe we all need to hear it again, right?

CHAIRMAN HURLBURT: Okay. I think we're ready to vote. All those in favor of the wording on the screen in front of you, raise your left hand. Opposed, the same. Any abstentions? Okay, thank you.

EXECUTIVE DIRECTOR ERICKSON: Okay, the last point related to behavioral health again was from the Boards and on pages 38 and 39 of your public comment packet, there was a suggestion that we needed to distinguish between behavioral health and health behaviors. Just my initial reaction, I'll share with you that I agree it's a very important distinction, but on the other hand, I couldn't quite tell from the letter -- it wasn't clear to me exactly where they thought we were causing some confusion and I looked through our paper and I couldn't figure out where exactly and what exactly they were suggesting we needed to amend.

So if any of you read that and have a specific idea, that would be helpful. Otherwise, we can just make a point of making sure we're clear in the future.

CHAIRMAN HURLBURT: Any discussion on that? Shall we

move on? Okay. I think we're okay, Deb.

EXECUTIVE DIRECTOR ERICKSON: Okay, then we had a number of comments related to workforce. Let me find the -- it's actually slide eight in your Powerpoint slide handout, just if you want to reference the different points that came out related to workforce, and again, on you slide there, page numbers that reference the public comment packet.

So the first is on page two of the public comment packet its suggestion that we study the financial securities model used by the financial industry regulatory authority for developing a centralized background check system and that might be a little bit operational. We really aren't developing any workforce recommendations here. So we could take that for what it is.

COMMISSIONER ENNIS: Yeah (affirmative), and I believe a proposal such as this is in discussion. I don't know at what level, but we've certainly talked about it.

EXECUTIVE DIRECTOR ERICKSON: That's correct. Any further discussion necessary related to background checks at this point?

The second public comment we had received was related to primary care and the development of residency programs on page 19 and 20 of your public comment packet. There is a letter from Gretchen Eickmeyer of the Pacific Northwest University of Health Sciences College of Osteopathic Medicine and she notes

that they started training medical students in 2008. They now have 300 total enrolled and that class includes 24 Alaskans.

The first class will graduate this May and nearly 70% will be pursuing primary care disciplines and they recently were accredited to begin eight primary care residencies in Washington and Montana and they're available to be supportive for the -- of the development of future residency, primary care residency programs in Alaska. So it was informational. I think they want to be recognized in any future discussions related to workforce.

CHAIRMAN HURLBURT: And they do have an existing relationship with the family medicine residency here in town.

EXECUTIVE DIRECTOR ERICKSON: Any discussion related to that public comment? We have a couple of comments related to specific types of health care providers. A suggestion that we look at nontraditional and allied caregivers in future work related to the workforce on page 24 and a comment on page 34 of your public comment packet that chiropractors be engaged in looking at and considering primary care service needs and future development. Yes, Allen.

COMMISSIONER HIPPLER: The chiropractor comments has -- a couple of their comments have confused me in the past. They came to our previous meeting and said that they wanted to be a resource, but they didn't have any specific suggestions as to what we needed to do and I still don't know. Are they -- they

do mention -- I believe they mention vaccines, but are they interested in dispensing prescriptions for bacterial infections or they're interested in dispensing prescriptions for bacterial infections, I guess. I need to -- I would be curious to see from them what they're wanting.

CHAIRMAN HURLBURT: Keith.

COMMISSIONER CAMPBELL: In regard to chiropractic specifically, I -- it's a pretty circumscribed license, pretty circumscribed plan of education and I would think that -- I guess I would need to see what sort of education it would take to expand the scope of licensure and the scope of practice.

Everybody wants to practice within their scope and I think that -- I, personally, would have to have that well spelled out before I would endorse, at this point in time, I'm like Allen, I don't know exactly, other than I want -- and I'd want those two specific things spelled out in detail before I'd ever consider a recommendation to expand that sort of thing.

CHAIRMAN HURLBURT: Okay, Jeff.

COMMISSIONER DAVIS: Just a comment, it looks like we've got a little dance going on here. They're saying, "Well, we're willing to help, just tell us what you need," and we're saying, "Well, tell us what you want." So I think it's -- the first proposal should come from the chiropractors is the appropriate group to identify where they think they could

contribute, but that does not seem to be -- and it looks like they're saying, "We stand by to serve, but we don't know how," and we're saying, "Well, how do you want to serve." It just seems like we don't know enough to comment one way or another today.

CHAIRMAN HURLBURT: Yeah (affirmative), and I'd say issues of scope of practice for any group is probably not really a part of our charge. So is there any objection? Maybe we could go ahead and move on to that?

EXECUTIVE DIRECTOR ERICKSON: Yes. There was just a general comment of support on page 30 of the packet for what we've included on page 14 of our draft report related to workforce. Again, we didn't develop any new recommendations this year. We restated our standing recommendations and also acknowledged the good work of the Alaska Health Work Force Coalition, who gave us presentations a couple of times during the year this year and then the final comment related to workforce on page 43 of your public comment packet, if I'm remembering correctly, that's the Public Health Association -- suggested that we continue to address other disciplines beyond primary care physicians.

(Noise from other room)

EXECUTIVE DIRECTOR ERICKSON: Somebody in the other room is having way more fun that we are.

CHAIRMAN HURLBURT: Yeah (affirmative).

EXECUTIVE DIRECTOR ERICKSON: We should maybe take them some of our dessert tray.

CHAIRMAN HURLBURT: Yeah (affirmative), I think probably when we say primary care physicians, we sometimes use that as a generic term, because I don't think we've had any discussion that has excluded a role for physician assistants and nurse practitioners in there. You can have a model like Noah's where it's exclusively physicians, but I don't think any of our discussion has really -- and I think we've consistently recognized that the PA's and nurse practitioners do and have a lot to offer in addressing the problems, so I think it's probably just reminding us of that and I think we've been sensitive to that. Yes.

COMMISSIONER DAVIDSON: And in about half of Alaska, those primary care providers are community health aids and practitioners.

CHAIRMAN HURLBURT: Yeah (affirmative).

EXECUTIVE DIRECTOR ERICKSON: And I think our 2009 report did a good job of describing that.

CHAIRMAN HURLBURT: Yeah (affirmative). I don't know what the numbers are now, but when I was at Tribal System, it was 40% of our primary care encounters were provided by community health aids, so an absolutely critical part of the system. Okay, I think we can move on.

EXECUTIVE DIRECTOR ERICKSON: Are we ready to move on?

CHAIRMAN HURLBURT: Yeah (affirmative).

EXECUTIVE DIRECTOR ERICKSON: Okay, there was only one other comment that I picked up and just put in the "Other" category that didn't seem directly related to any of our existing recommendations or findings and that's on page one, the very first one received, of your public comment packet, but a pretty specific recommendation that the state of Alaska employee and retiree health coverage should include preventive services. We may be getting to that more with out -- more generally, not specific to state employee, but in our study next year on the employer's role in health and health care, designing benefit plans for employees.

CHAIRMAN HURLBURT: Okay.

EXECUTIVE DIRECTOR ERICKSON: Does anybody want to discuss that comment?

CHAIRMAN HURLBURT: I think we're ready to move on.

EXECUTIVE DIRECTOR ERICKSON: Okay, moving right along, the last section that we need to discuss today, then, are strategies for consideration in 2012. So one of the things that I might do, keep your public comment packet handy, but your -- the -- our draft report, public comment report, page 29 and 30 is where we list everything that we're planning on studying next year.

In addition to studying the issues that we're going to study about the current condition, what we want to learn more

about the current condition of this system, we discussed a little bit earlier this afternoon, these are strategies that we're going to discuss to support development of new policies specifically.

We're going to be studying legal barriers. This is what we proposed, and cost drivers, legal barriers to innovation, specifically and cost savings, employer's role in health and health care, both in terms of designing employee health benefits and plans and work site wellness programs and integration of those two, end-of-life care, improving quality and experience, use of technology to facilitate access to care, transparency to all-payers claims database and we'll continue tracking recommendations that we had made in previous years.

So we received a number of letters of support for studying end-of-life care improvement. So I don't know if you want to discuss that at all. At this point, you can find it on page three, five, four and 41 to 42 of your packet.

UNIDENTIFIED COMMISSIONER: I'm sorry, are you referring to the public comment packet, page 41 to 42?

EXECUTIVE DIRECTOR ERICKSON: Those pages are the public comment packet -- are where you'll find the letters that are acknowledging the importance of this issue of improving quality of care, end-of-life and access to care at end-of-life, both in terms of improving the patient's and the

patient's family's experience at the end, but noting too, we had a comment during the public comment periods throughout the year, a couple of different times and studies brought to us that show how improving quality of care, not only improves the patient's experience, but also saves money, moves away -- tends to move away from medicalization of that care.

COMMISSIONER CAMPBELL: Mr. Chair.

EXECUTIVE DIRECTOR ERICKSON: Yes.

CHAIRMAN HURLBURT: Go ahead.

COMMISSIONER CAMPBELL: We're not attempting to prioritize this. It is just however we can fit it into the schedule during the next year?

EXECUTIVE DIRECTOR ERICKSON: That's correct.

COMMISSIONER CAMPBELL: Okay, but I think it ought to remain and be highlighted, quite frankly.

EXECUTIVE DIRECTOR ERICKSON: You're suggesting that it be prioritized?

COMMISSIONER CAMPBELL: Well, I think it'll depend on the time we can get allocated and the quality of the presenters. We've already had some really good comments and it's something to build on and if we can build on that early, that's fine.

EXECUTIVE DIRECTOR ERICKSON: Any other comments? Val.

COMMISSIONER DAVIDSON: I was -- just a question. I'm curious if end-of-life care is a part of the long-term care study or the work that's going to happen next year by the

other group that's looking into this.

EXECUTIVE DIRECTOR ERICKSON: Jeff's shaking his head no. Yeah (affirmative), I don't know if they're going to look at it or not. This is a more specific issue and it was -- initially came up in early discussions in the Commission as a concern as far as a cost driver, the medicalization at the end of life and I don't -- I haven't heard of this being a specific issue, but I'm sure it will be captured because they're looking at the full continuum and the full scope of services, so I'm sure it would come out in the course of their work.

CHAIRMAN HURLBURT: I -- my sense, it's a somewhat separate issue, but it's like I say, SNF is very different than nursing homes and that was not the consensus of the group to see that, but I think that end-of-life care is often very intense ICU care. We spend about one percent of our gross domestic product on it. It's addressing issues of, you know, living wills or durable powers of attorney.

It gets at the issues where people have raised concerned, well, are we talking about rationing of care? That becomes an ethical, philosophical kind of issue that has a lot of dollars attached to it. So I think it can be related to long-term care, but at least in my mind, it's a different area then what I think of is the spectrum of long-term care.

EXECUTIVE DIRECTOR ERICKSON: And I haven't, not that

I've been directly involved, but in the discussions I've heard about, the development of long-term care plans, it hasn't addressed this issue specifically. Although, I would think the availability of services in that planning would be related to this. The -- some policies that this Commission might learn about and develop recommendations related to in terms of what could be done to improve patient choice and the quality of the medical services and the patient involvement, making medical decisions, I'm guessing that long-term care committee that's going to be looking at availability and gaps in services wouldn't be addressing those sorts of things. Keith.

CHAIRMAN HURLBURT: Keith.

COMMISSIONER CAMPBELL: Well, I think that, for instance, a full-blown hospice service isn't going to work in a lot of communities, but you might have an educational component for your local medical staff is palliative care and that would take care of where there isn't very much volume or something like that. So if we could have that sort of an education around here on what the differences are, what the potential for services are, that would be enlightening, I think, for the public.

EXECUTIVE DIRECTOR ERICKSON: Jeff.

COMMISSIONER DAVIS: So maybe it's late, maybe I'm just fading out here, but I'm confused. So we have already identified end-of-life care as something we're going to

consider in 2012 and so the question is just, do we want to modify that in any way based on the comments or.....

EXECUTIVE DIRECTOR ERICKSON: There's -- I don't think there's even.....

COMMISSIONER DAVIS: Is there really a question?

EXECUTIVE DIRECTOR ERICKSON: There's not even a suggestion that we make a change right now, unless.....

COMMISSIONER DAVIS: There's just.....

EXECUTIVE DIRECTOR ERICKSON: We're just discussing the comments, getting ready for next year.

COMMISSIONER DAVIS: So we're just -- so all right, great, so thank you. So I agree with the comments that are here, a strong endorsement of looking at hospice as a piece of end-of-life care and I look forward to us getting into that work.

EXECUTIVE DIRECTOR ERICKSON: So are we ready to move on? The next point related to 2012, page 24, is back to our first commenter, we discussed at the beginning of the day, is the importance -- wanted us to address the importance of the role of knowledgeable and financially responsible consumers, so just reiterating that them again. He made a comment specific -- and this is on page 24 of your public comment packet, that we make sure we're addressing that.

I believe that we will be addressing that as we discuss the employer and employee's role in their health and health

care. I think that's going to come through strongly.

CHAIRMAN HURLBURT: And all of our thrust on transparency and obtaining quality data is really addressed to that end.

EXECUTIVE DIRECTOR ERICKSON: So is there anything anyone wants to do more in terms of making any changes, discussion? Okay, the last points are on page 44 and 46 of your packet. We already discussed this comment once related to behavioral health and our plans to learn more about the behavioral health system next year.

This commenter, again, related to the use of -- concerns about the use of psychiatric drugs in kids and thought that one of the things we might do is capture it in a study of fraud, waste and abuse next year in looking at that, so up for discussion, again, pages 44 through 46 of your public comment packet.

CHAIRMAN HURLBURT: Anybody motivated to make any -- Allen.

COMMISSIONER HIPPLER: I -- I have a question for clarification. Is -- are these comments related to drugs, such as Prozac or are we talking about a different kind of drug here? I'm just not sure.

COMMISSIONER LAUFER: I think it is related to the use of any depressants, ADD medications and psychotropic medicines or what used to be called antipsychotics and the problem is that the diagnoses from my point of view as a primary care doc, are

thrown around a little loosely and people, in particular children, get diagnosed with things. They get put on medications without sort of clear indications.

A lot of medicines are used outside of their indications, but that's where this comes from and this is from a lawyer, who does this professionally and is often defending, you know, people who have been treated sort of "against their will."

You know, we're in a culture that wants to treat everything with a pill and it's probably -- this is my opinion, but I think it's gone too far and particularly with -- in this setting with children and psychiatric medicines.

CHAIRMAN HURLBURT: I found the same thing working in Africa. So it's not just our culture. It's worldwide. Val, yeah (affirmative).

COMMISSIONER DAVIDSON: (Indiscernible - too far from microphone).

EXECUTIVE DIRECTOR ERICKSON: Human nature to get the quick fix. So Dr. Hurlburt, you'd suggested earlier, I mean we are going to now plan to learn more about the behavioral health system generally, that was something that these commenters hoped that we would do. I gathered from their comments, and you had suggested earlier that their suggestion that we look at this specific issue was too operational for the role of this Commission. So folks are nodding their heads. Does anybody want to suggest any change related to

these comments right now?

So hearing none, before I say that we're done with our report, I need to double check, but I think we are. Yeah (affirmative), we're done reviewing all of the public comments and making changes to the 2011 findings and recommendations.

The only other thing we had on our agenda was a quick update. I didn't prepare a handout for you this time, because there wasn't a whole lot that has happened in the past year or in the past year -- since our last meeting just two months ago, a lot's happened the past year, but since our update just a couple of months ago on the Affordable Care Act, but before we do that, I don't know -- this is the last agenda item for today.

It's 3:15. We're supposed to adjourn by 4:00 at the latest. I think this discussion will probably take us 10 or 15 minutes. So I just wanted to check in with you all to see if you need a quick break right now before we wrap up for the day or if you want to just keep plugging through and get her done?

UNIDENTIFIED COMMISSIONER: Press on.

EXECUTIVE DIRECTOR ERICKSON: Press on, okay. I don't know if this is a good strategy or not, but I'm just going to flip through our slides from last time real quick. I know Linda has a couple of things she can update us on related to insurance.

Just a couple of months ago when we talked about the legal challenges to the Affordable Care Act, there was a challenge pending in the D.C. circuit court, appellate court review and since that time, that court actually upheld, that appellate court upheld the Affordable Care Act.

One of the things that was significant about that ruling was that there was a very conservative judge that upheld it and we could actually talk about that for a while. I think this stuff is fascinating and Val could probably do a much better job than I would. It's just interesting to learn about the different perspectives that are considered conservative from in the courts.

There's the more traditional older conservative camp that this fellow was part of that their view of conservative is that it's not the court's business to legislate. It's Congress' and I think that's the position this guy was coming from and said if the Congress passed a bill, it's not our job to legislate on their behalf and to change that, as opposed to the conservative folks who just think that government doesn't have a role in their personal life.

So just two different perspectives and that's when you hear this was a big deal because this guy was really conservative, appointed by Reagan, is considered a very conservative, but that's what that take is and then the other significant thing related to the legal challenges is that the

Supreme Court did decide just a month ago, November 14th, that they would hear this case this year and so we can expect a ruling, probably hearings in March and a ruling in June sometime from the U.S. Supreme Court on the constitutionality of the bill.

So other updates, Linda, do you want to update us on the medical lost ratio regs that actually took effect in January of this year, almost a year ago. The feds finalized the regulations just one week ago on the medical loss ratio and there are some other things that have happened related to insurance provisions.

COMMISSIONER HALL: Yeah (affirmative), maybe I will. All of a sudden, I have no voice, but the final medical loss ratio regs were released probably less than a week ago. There were not a lot of changes. The -- there were some minor changes. Probably the biggest controversy in that entire rewrite dealt with insurance agent and broker commissions and the -- see, whoever is in charge of this now, it seems to change from whether it's HHS or CMS, but that was left as it was, so the agent and broker force are very concerned as we close in on the time when the 80% medical loss ratio will need to be met, that commissions are being cut.

There's a concern about continuing access to the advice of agents and brokers and the National Association of Insurance Commissioners, who has had a role in the bill,

actually, and has a lot of advisory opinions to HHS, had a very split vote on the issue, as I recall. It was like 24 to 26 or I mean, it was very controversial. It's one of the more heated debates I had ever heard with that group.

So there's concern about agents and I think for two reasons; 1) agents are an important part of the insurance business, whether -- regardless of the kind of -- but it is particularly important with the changes in health insurance, but there's also, I think if you watch the -- particularly the exchanges and the development of exchanges, there's an advisory person called what? I can't remember the -- a navigator.

So we all of a sudden have navigators who will be able to give advice to consumers, but they don't have to be licensed. So we have this really unlevel playing field, which is very concerning to me. I mean, our agents go through background checks, fingerprinting, testing, and we want to know that they have -- they're trustworthy. That's part of it. We actually revoke licenses because you weren't trustworthy. You robbed and pillaged and stole or whatever it was.

So anyway, that was probably the biggest debate, but the medical loss ratio is finalized and this year, the statistics will be kept and next year -- where calculated, rebates will be paid and that is a really big deal. It's a big deal for consumers.

It's a big deal for insurers who, some of them struggle to meet those. Some states applied for waivers so they can ease into that, make a transition into that, but I think the estimate from the record keeping last year was 3.9 billion in rebates. I mean, it was a huge amount of money. So we'll see what happens when it's for real.

The other thing I think -- a couple of issues I would quickly update you on, the -- our high risk pool locally still has 46 people. It's had 46 -- 43 to 46 for a long time. Totally, they've processed 70 applications, had 32 terminations and eight reinstatements, but our current net enrollment is 46.

Now, it's not a lot of people for the amount of work and the amount of money. It is, in my mind, but it has allowed additional individuals to get coverage and it is less expensive than the traditional insurance market, the high risk pool in the traditional way that is administered, not by a whole lot, I don't think, Jeff, but it's there.

The last thing I would say that I think is -- was important, it was important to my division, is that we were deemed to have an effective rate review program by the feds. We aren't deemed to have that until January 1. Part of my legislative packet last year was to have rate making authority over all health insurers.

Up until January 1, going backwards, Mr. Davis' company

is the only company that we had rate making prior approval authority over and that's because of organizational style. It wasn't just because we picked them out to do their rate making, but they are a hospital medical service corporation.

So as of January 1, we will be fully, I guess, vested in having an effective rate making program. Right now, because it went into effect, the review of rates went into effect in September, in theory, the feds are reviewing any rates that companies doing business in Alaska file that are in excess of 10%. I only know of one that's been filed in our state and there was a consumer complaint.....

EXECUTIVE DIRECTOR ERICKSON: Was it (indiscernible - speaking simultaneously)?

COMMISSIONER HALL: .....in the process. They referred the complaint to us, which I thought was kind of strange when they're the one doing the review, but it tells me where the future is, but I was pleased to see us have that acknowledgment. Not every state got that. So I was happy with that and we have an actuary on staff and I think that it will change what happens and creates a level playing field with the insurance companies that do business in our state.

The place we didn't get federal recognition was in our external review process and we knew we didn't. We knew our statutes did not have the elements of external review that they needed to, you know, be deemed to continue that and we

had made, not that decision, but we'd made the decision some years ago that as a Division of Insurance and a small staff, we did not want to be involved in the external review of a claim denial.

Most of those are done on medical necessity. They're certainly done by outside experts, but the NAIC model requires the Department to manage that program and we chose several years ago not to implement that. So on a real appeal of a claim denial of an insurer, that will now go to a program somewhere in HHS. I really don't know where at this point and so that's about all of the exciting things that we've done in that capacity.

EXECUTIVE DIRECTOR ERICKSON: Jeff.

COMMISSIONER DAVIS: I'd like to make a comment and then ask a question of Director Hall. First, I'd like to congratulate you and the Legislature for leveling the playing field. That's something that I think has been needed for a long, long time and I do believe we'll have a healthier market going forward as a result of that. So thank you for your efforts in doing that.

My question is, and I think I know the answer, I believe that the requirement for others to file was for plans effective new and/or renewal on or after January 1st, is that correct?

COMMISSIONER HALL: That's correct.

COMMISSIONER DAVIS: Okay, thank you.

COMMISSIONER CAMPBELL: Linda, what -- I read it someplace, but how did the decision come down from the insurance commissioners to -- did they allow or disallow the commissions to affect the 80% loss ratio?

COMMISSIONER HALL: They disallowed that. The commissions are part of the 20% piece.

EXECUTIVE DIRECTOR ERICKSON: Any other questions for Linda, specifically? If not, thank you, Linda. I thought I'd just update you on the health insurance exchange consultant RFP. They had to, not fully re-release the RFP, but go through kind of a secondary process to respond to some concerns that were -- that our contract folks had related to responses to a particular amendment.

So they issued some clarification and invited the respondents to respond to that and they will have a new PEC now just next Friday and I think they expect to have that contract awarded by the beginning of the year and feel as though they're still on track for having a 90-day turnaround time on that initial study that they're requested, so that product by the end of March, early April or so and one -- just one other thing I thought I would update you all on is the -- or just mention anyway, that the patient-centered medical home consultant RFP isn't out yet, but I expect it will be before too long. I think the work that needed to be done on the

insurance exchange diverted a little time and attention.

So does anybody have questions about any other points? We could probably talk all day about the sequestering process and what may or may not happen there and how it may or may not affect the Affordable Care Act, but it's been a long day and I'm not seeing anything else here that's changed in the past couple of months. Yes.

COMMISSIONER DAVIDSON: I just wanted to again, express my appreciation for providing an update on where Alaska is on implementation. It's really helpful. Thank you.

EXECUTIVE DIRECTOR ERICKSON: Thank you. Well, before we wrap up for the day, should we at least acknowledge and thank our two members whose term is ending, whether either one are back -- still not going to let go you, Noah. We might talk you into it yet. He's going, "No."

UNIDENTIFIED COMMISSIONER: Noah told us he's a one-year guy (indiscernible - too far from microphone).

EXECUTIVE DIRECTOR ERICKSON: I was able to meet his wife for the first time just this past week and I thanked her for letting us borrow him and she said, "You know, he really enjoyed it." So you can't deny that you haven't had some fun here with us. We have.....

COMMISSIONER LAUFER: I did enjoy it a lot and I apologize probably for being maddeningly disruptive at times, but thank you very much. It really was a pleasure and I'm

impressed by everybody's, you know, open-mindedness and willingness to, you know, seek truth, rather than win arguments. Thanks.

CHAIRMAN HURLBURT: You said something like that in your first meeting and you have not lived up to your billing, but you have been just so valuable to us, Noah. We appreciate all of your input. Jeff.

COMMISSIONER DAVIS: Dr. Hurlburt, may I propose that in honor of Dr. Laufer's service, from now on, we vote using our left hand? We'll remember Noah.

EXECUTIVE DIRECTOR ERICKSON: Well, one other point too, I mentioned to Noah a few times how much I appreciated having, not just a primary care physician on the Commission, but someone in private practice who has to deal with the business end of medicine, not just the clinical end and that's been really useful and I've taken the opportunity -- I don't know, I didn't refer to it, all of the comments we received on the immunization that mostly came from primary care physicians, I felt like I was being spammed at one point, but I started using that as an opportunity to reach out to some of these folks to apply for Noah's seat and got some interest there. So hopefully, that was helpful. It was a good recruitment tool and then Keith, our consumer representative, who was able to bring all of those years of experience as a health care and hospital administrator and as well as experiences as the

national AARP Chair during the Clinton health reform years, it was amazing to have your expertise at the table and your experience as well and we've really appreciated that. Whether we see you back in this seat or not, we won't know for a month or so, but thank you so much for your time and expert help.

CHAIRMAN HURLBURT: We hope you come back and if you don't, there's an empty seat next to Pat. So we hope you come back that way.

COMMISSIONER CAMPBELL: Well, thank you all. It's been a real learning curve, even at my age, thanks.

EXECUTIVE DIRECTOR ERICKSON: So does anybody have any final questions or comments for the good of the group before we adjourn for the year?

COMMISSIONER MORGAN: Who -- you said some people, some individuals needed to fill out some forms.

EXECUTIVE DIRECTOR ERICKSON: Thank you for reminding me.

COMMISSIONER MORGAN: You forgot, didn't you, and my last statement.....

EXECUTIVE DIRECTOR ERICKSON: You're so good.

COMMISSIONER MORGAN: .....to you, Doc, is widget, widgets, widgets, widgets, widgets, widgets. That's an inside joke.

EXECUTIVE DIRECTOR ERICKSON: I'll pass around the 2012 financial disclosure statements, but I will also send a copy over email to you as well.

CHAIRMAN HURLBURT: (Indiscernible - too far from microphone).

EXECUTIVE DIRECTOR ERICKSON: No, those -- I have a couple who need their 2011 to me. This is for the coming year. Do you want to gavel us out, if folks don't have any final questions or comments?

CHAIRMAN HURLBURT: (Indiscernible - too far from microphone) comments, so.....

UNIDENTIFIED COMMISSIONER: Motion to adjourn.

EXECUTIVE DIRECTOR ERICKSON: Seconded.

CHAIRMAN HURLBURT: Okay, thank you all very much. Thanks for a (indiscernible - speaking simultaneously).

EXECUTIVE DIRECTOR ERICKSON: We're adjourned. We need to be more official. Thank you.

3:30:47

(Off record)

SESSION ADJOURNED