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ALASKA HEALTH CARE COMMISSION

THURSDAY, MARCH 8, 2012

8:10 A.M.

UAA STUDENT HOUSING

GORSUCH COMMONS, ROOM 107

3700 SHARON GAGNON LANE

ANCHORAGE, ALASKA

VOLUME 1 OF 2

PAGES 1 THROUGH 208

1 Representatives.

2 COMMISSIONER STINSON: Larry Stinson, a physician with
3 practices in Fairbanks, Anchorage, and Wasilla.

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

6 CHAIR HURLBURT: I'm Ward Hurlburt. I didn't introduce
7 myself. I'm the Director of Public Health.

8 COMMISSIONER ERICKSON: Deb Erickson, Director of the
9 Alaska Health Care Commission.

10 COMMISSIONER HALL: Linda Hall, Director of the Division
11 of Insurance. I represent the Executive Branch of the State
12 of Alaska.

13 COMMISSIONER MORGAN: Dave Morgan, and I sit in the seat
14 for the primary care clinics and association.

15 COMMISSIONER HIPPLER: Allen Hippler, State Chamber of
16 Commerce.

17 COMMISSIONER DAVIDSON: Valerie Davidson, Tribal Health
18 System.

19 CHAIR HURLBURT: Mike, if you could introduce yourself
20 and then we'll go around?

21 8:12:38

22 (Audience introductions indiscernible - away from mic)

23 8:13:24

24 CHAIR HURLBURT: I'd like to welcome everybody here.
25 There will be others coming in, and we're just about on time.

1 I guess, Jeff, you may have just come in. I said earlier, if
2 you're across the stream, you're in good shape. If you're
3 across the street, you might have a problem. So yeah. And
4 the same for anybody in the audience. As long as you parked
5 in the lot on the south side and walked across the stream,
6 that parking is paid for. If you happened to go across the
7 street and walked across the street, you could be ticketed and
8 you might (indiscernible - microphone interference) lot here
9 because that's one that is paid for.

10 We'll move into our first session, which I think will be
11 interesting, and we'll hear some things that will help us feel
12 good about being Alaskans.

13 COMMISSIONER ERICKSON: Well, just a couple more
14 logistical things before we get started. For those of you in
15 the audience, if you haven't had a chance to sign in at the
16 handout table in the back of the room, if you would please do
17 that at some point this morning, we would really appreciate
18 it.

19 And I think we are right on time, so I think we'll go
20 ahead and get started with the program. We'll stop for a
21 technical check in a few minutes again because we're
22 continuing, I think, to have a problem with our teleconference
23 system, and one of our three speakers this morning is
24 teleconferencing in from San Francisco. And so I'll apologize
25 in advance for the interruptions, but as you all will recall,

1 one of the issues on our agenda for this year for 2012 that we
2 wanted to study was the impact of malpractice reforms in
3 Alaska and the status of the -- and the condition of the
4 medical liability environment for practitioners in Alaska.
5 And we had asked Representative Keller if he could work with
6 Legislative Research to see if they could do a little bit of
7 research for us. They've done that.

8 Behind tab two in your notebooks -- and for folks in the
9 room, there are hard copy handouts on the table in the back,
10 and for folks on the phone, if you can hear me, they're online
11 on the Commission's website, posted on the March 2012 meeting
12 page. But we have, behind tab two, a copy of the Legislative
13 Research memo. They've already completed their work for
14 Representative Keller, and he made it public and shared with
15 us and everyone else. We also have in our notebooks an
16 article that was written in 2009 for the *Alaska Medicine*
17 *Journal* and some updated charts from 2011. That article
18 included charts from 2008 depicting where Alaska fell relative
19 to all the other states in terms of their average malpractice
20 insurance premiums for three specialties, general, surgery,
21 OB/GYNs, and internal medicine docs. And so we have those
22 same charts, but updated for the 2011 premiums, included in
23 your notebooks, so just as a handout.

24 Joining us today then to help us learn more about this --
25 and thank you very much to our speakers and panelists here --

1 we've invited Jim Jordan, who is the Executive Director of the
2 Alaska State Medical Association to give us a little bit of a
3 history lesson on the medical malpractice tort reform in the
4 state and to share with us a little bit his perspective's and
5 ASTHMA's perspectives, the State Medical Association's
6 perspective on the medical liability environment here.

7 And then we've invited the CEOs. We have the Vice
8 President from the two major carriers for medical liability
9 insurance in the state, MIEC, the Medical Insurance Exchange
10 of California, and Andy Firth will be joining us over the
11 phone, we hope, assuming we can get this problem taken care
12 of, and he's the CEO for MIEC.

13 And then joining us from NORCAL Mutual Insurance Company
14 is their Vice President, Neil Simons. Thanks for traveling to
15 Alaska to be with us today. We appreciate it.

16 So why don't we just go ahead and get started, Jim, with
17 your presentation? Actually before we start, it looks like
18 the teleconference isn't fixed yet; is that true? Okay. So
19 we'll check on Andy in a little bit.

20 MR. JORDAN: Good morning, everyone. Thank you for this
21 opportunity to be here, and I guess I should start by
22 providing full disclosure. Number one, I'm not an attorney,
23 though I'm going to be speaking a lot about legal aspects of
24 liability and liability reform, and I express my apologies to
25 Valerie. However, this topic is not new to me. I've been

1 involved with various aspects of liability, civil liability
2 reform for -- in excess of 40 years.

3 UNIDENTIFIED MALE: Hello?

4 COMMISSIONER ERICKSON: Hello? Who's on the phone, is
5 this Andy?

6 MR. JORDAN: It sounded like him.

7 COMMISSIONER ERICKSON: Did it sound like him? Andy, are
8 you on the phone?

9 (Pause - no response)

10 COMMISSIONER ERICKSON: That was interesting.

11 MR. JORDAN: It sounded like him. Anyway, along the
12 lines of full disclosure, in addition to being the Executive
13 Director at the Alaska State Medical Association, I'm also on
14 the Board of Directors of the Operating Company for MIEC, and
15 not to short NORCAL, I've also spent, in a previous
16 reincarnation, over a decade on the board of the Medical
17 Indemnity Corporation of Alaska, which -- I think it was in
18 1992, Neil, that NORCAL purchased the assets and assumed the
19 liabilities of MICA, and I think Mr. Campbell recalls that
20 transition. So I've kind of covered all bases there.

21 What I plan on doing this morning is to give you a real
22 quick fly-by of what's occurred in this state, and I'm only
23 going to go back to 1975 because that was a seminal year in
24 many aspects. And then from there, I'm going to talk about
25 two particular pieces of legislation that occurred in -- well,

1 culminating, I should say, in 1997 and then with an additional
2 piece of legislation that culminated in 2005. And then I'm
3 going to follow that up with a little discussion of the
4 ensuing court cases, which always occur. I don't care where
5 you are, if you have any kind of liability reform, there will
6 be challenges to the constitutionality.

7 So with that, going back to 1975, in 1975, there was no
8 market for medical professional liability coverage in this
9 state.

10 UNIDENTIFIED MALE: (Indiscernible - phone interference)

11 MR. JORDAN: I think he's -- that's Andy.

12 COMMISSIONER ERICKSON: Hi, Andy, can you hear us okay?
13 Andy, are you on the line?

14 MR. JORDAN: I could hear him.

15 COMMISSIONER ERICKSON: Well, you know what, I'm
16 wondering -- if he's not responding, but we can hear, I wonder
17 if we have the either input or output the other way around;
18 they can't hear us, but we can hear them. Do you think that's
19 what's going on, Jordan?

20 JORDAN (IMIG): They can't hear you, but we can hear
21 them.

22 COMMISSIONER ERICKSON: Yeah.

23 MR. JORDAN: Shall I continue?

24 COMMISSIONER ERICKSON: Yes, please.

25 MR. JORDAN: So in 1975, there were no commercial

1 insurers in this state. That precipitated the formation of
2 MICA, and when MICA was created, there were some liability
3 reforms that came along with MICA, primarily codifying the
4 whole realm of informed consent. I'm not going to go on and
5 define all these terms. Should you have questions about them,
6 I'll be more than happy to answer those later, either here or
7 offline.

8 So MICA was formed. MICA was a quasi-state entity and
9 was bankrolled, if you will, by the State, and it was
10 bankrolled under a loan program and required certain payback.
11 There was an uprising in the medical community in that, when
12 MICA was first formed, it was exclusive. You had to have
13 coverage with MICA or no medical license. That did not sit
14 well with many people and ended up with certain physicians,
15 who shall remain nameless -- one in particular who showed up a
16 legislative hearing with an ice axe saying that anyone that
17 comes in and tries to stop him from seeing patients would find
18 that in a very inappropriate place, not conducive to life. So
19 this was rough and ready.

20 The result of that was there were changes in the law and
21 that was parsed in having competitive forces come into the
22 marketplace, and there were several physicians that worked
23 very hard that went out, and this resulted in the endorsement
24 by the State Medical Association of MIEC and that occurred in
25 about 1978.

1 Now I'm going to fast-forward. I already mentioned that,
2 in 1992, MICA evolved and then became NORCAL, and I'm not
3 going to go into the reasons for that. However, MICA was very
4 successful, and it had bottom line positive numbers. And as I
5 mentioned, this was a quasi-state company, and Uncle Sam came
6 along and said, you know what, we don't think that you're
7 enough of a state entity to avoid federal income tax.

8 So not wanting that to rub off on other state programs --
9 and I don't need to mention which one, but the decision was
10 made that the State needed to divest itself of MICA. So then
11 along came NORCAL.

12 Up until 1997 -- and actually, I suppose you could say
13 1/1/98 -- there were no caps in the state on non-economic
14 damages, zero. Unlimited is what it amounted to. That
15 creates a situation of great uncertainty, and as Mr. Simons
16 and Mr. Firth will tell you, an (indiscernible - voice
17 lowered) in the insurance industry is uncertainty and that
18 leads to high costs, high premium rates, et cetera.

19 So the goals in 1997 -- actually starting in '96 and
20 actually prior that -- was to infuse some certainty into the
21 marketplace.

22 Just by way of background, I want to -- this again --
23 this is a 50,000 foot level, and you're interested in what the
24 impact of the various reforms have been. It takes a long time
25 in a small market, like Alaska, to have statistically credible

1 data, a long, long time, and particularly in an area like
2 medical professional liability coverages. A very well-known
3 actuary told me that there is only one area in the property
4 casualty arena that is more uncertain than medical malpractice
5 and that is an area of crop hail insurance, where you're
6 predicting storms. And so that's the environment in which
7 professional medical liability exists.

8 So in effect, at this point in time -- and which I will
9 get to in a bit -- this -- you know, as to the success of the
10 various liability reforms that have occurred here is kind of -
11 - you're looking at it in the realm of the proof of the
12 pudding is in the tasting at this point. One example -- one
13 taste -- to follow on that cliché -- is that, in 1996, the
14 medical professional liability rates for physicians in Alaska
15 was about two times that of what it was in northern
16 California. 2012, today, the medical liability costs are on
17 the same plateau as they are in northern California, and
18 California is held out to be the gold standard, having had
19 substantial liability reform in 1975.

20 So let's fast-forward to 1997, but first, I'll talk about
21 1996 briefly. 1996, there was a major effort to pass major
22 liability reforms. This included all industries, not medical
23 alone. All industries. There was a law passed. The Governor
24 vetoed the bill. So it was back to the drawing board in 1997.
25 Again, same issues. Tremendous amount of effort on all

1 stakeholders' behalf. The result in 1997 -- and I'm only
2 going to hit the highlights, the non-economic damages, which
3 are the most uncertain of the damages. There are economic
4 damages. There are non-economic damages, which are the pain
5 and suffering, and you have punitive damages. I'm not going
6 to talk about punitive damages because they don't come into
7 play in the medical world, number one, and number two, they're
8 non-insurable events. You don't pay for breaking the law.
9 It's just a matter of policy and that has been the policy
10 forever, at least as long as I've been -- had a touch with the
11 insurance industry.

12 Anyway, what happened with the caps on non-economic in
13 1997 is that they ended up with some very interesting elements
14 that they were caps, but they somewhat complicated the
15 prosecution of medical liability cases.

16 There are two levels of caps, first dealing with general
17 medical injury or death. The cap was the greater of \$400,000
18 or \$8,000 times the number of years of life expectancy that
19 the injured patient had. However in cases where there was
20 severe physical impairment or severe disfigurement involved,
21 the caps then went to the greater of a million dollars, or
22 \$25,000 times the number of life years of expectancy. So if
23 you take an injured child, that can very easily get into the
24 multiple million dollar arena of damages for non-economic pain
25 and suffering (indiscernible - phone interference).

1 You have to keep in mind -- and I will digress quickly to
2 say that there has never been an attempt in this state to
3 limit the economic damages. Those are such things as wages,
4 past and future medical care. Those are much more objectively
5 arrived at.

6 Now as you can imagine, that still had some bit of
7 uncertainty there because life of years of expectancy, you can
8 -- you end up having dueling economists, dueling demographers,
9 dueling actuaries. Take your pick of the specialty in that
10 area or anyone who declares themselves a specialist in that
11 area.

12 So I'm going to roll forward to 2005. 2005, the medical
13 community -- and this included the hospital community as well
14 as the physician community -- decided that we needed to take
15 another run at that. Actually, that movement started in 2004.
16 There was a great deal of discussion with legislative leaders,
17 the administrative as to what would be the best way to go
18 about this.

19 As I mentioned, the 1997 liability reform was any and all
20 industry involved. 2005, the advice from the Legislature and
21 Administration was to do a medical-only. So the liability
22 reforms in 2005 applied to health care providers, and what
23 happened there is that there was a new cap that was
24 established that was \$250,000 in the case of death or
25 permanent disability, and it was -- theoretically as measured

1 under the Worker's Comp guides, then the cap would go to
2 \$400,000. Those were the only two variables.

3 Now as I mentioned earlier when -- or maybe I didn't. I
4 know I was talking to Neil about this before, but when you
5 finish in state house, the next stop is the courthouse. And
6 it didn't take long, after 1997, for the first seminal case to
7 pop up, and the name of the case is Evans v. State. And
8 whenever there is a challenge to a state law, the state is
9 always a party to that litigation. In Evans v. State -- and
10 what I find interesting is that this, as well as the next case
11 I'm going to talk about, did not involve the medical
12 community. Evans v. State involved a snowmobile injury to a
13 child.

14 The next case I'm going to talk about, LDG v. Brown, is a
15 dram shop case, and it's very interesting how that plays into
16 the medical world. Anyway, in Evans v. State, there were
17 several unique aspects to this piece of litigation. First of
18 all, the original venue was in Bethel. The venue was changed
19 to Fairbanks for the Superior Court action. Another thing
20 that had to happen is that, typically in any kind of a injury
21 case or medical injury case, you have to have what is called a
22 ripe case, ripe case being that it has been prosecuted to and
23 through damages, typically. This case was recognized as being
24 a very important test of the constitutionality of the 1997
25 law. So all parties in this litigation (indiscernible - phone

1 interference) having this move forward without it being ripe
2 and that's a decision that has to be made all along the lines.
3 So the Superior Court had to make that decision, and then when
4 it moved to the State Supreme Court, the State Supreme Court
5 also had to make that decision, that it was okay to move
6 forward in a case that is not ripe, where the underlying
7 damages have not been adjudicated.

8 So that case began in 1998, and by the time it finally
9 reached the point where there was a decision, that was 2002.
10 That was four years through the process. After four years,
11 what happened was in our Supreme Court, there were only four
12 members that heard the case, and guess what? They split, two-
13 to-two. What happens in a tie, if you will, it's just like in
14 baseball. The tie goes to the runner. In this case, the tie
15 goes to what the lower court's decision was. The lower court
16 did decide that the elements of -- the 1997 legislation were
17 constitutional. The Legislature had the constitutional
18 ability to do what it did with caps.

19 And as a quick aside, as I mentioned, punitive damages
20 are really not of interest. However, the 1997 legislation had
21 a very interesting twist in it. First of all, it established
22 a process for separating out the punitive damages question and
23 prosecution, if you will, from the civil side because punitive
24 damages are more akin to criminal actions. So there was a
25 process that came about that looked more like a criminal

1 prosecution. When it came to burden of proof, it didn't go
2 the full criminal route, but I think it went to clear and
3 convincing. But the interesting thing about that is that the
4 element and why the State had somewhat of an interest in this,
5 other than, you know, the academic constitutional interest,
6 was any punitive damages found under the 1997 act would be
7 split 50/50 between the plaintiff and the State of Alaska, the
8 theory being fines that are levied, they all go to the State,
9 and this was akin to a fine. So that was kind of an
10 interesting twist.

11 One other benefit, I think -- in my view, a benefit to
12 the Evans v. State litigation was it provided some precedents
13 that had, heretofore, not existed either in statute or in
14 court rule and that precedent is the ability to participate or
15 intervene, if you will, at the Superior Court level on an
16 amicus base and that was something that we thought that we
17 would give a try, and by golly, we were successful. The
18 Superior Court allowed participation on an amicus basis, but
19 even more remarkable, the Superior Court allowed the -- I
20 think there was only one amicus participant, and it was a
21 coalition of the medical community, including physicians and
22 docs, the statewide industry represented by the state chamber,
23 and finally, a representative of the oil industry.

24 Anyway, this coalition and our amicus lawyer was actually
25 allowed to argue, orally argue at the Superior Court level and

1 that continued on to the Supreme Court. The Supreme Court
2 allowed the amicus argument to be made, which was precedent
3 setting, as far as anybody knew in the state. This was
4 important in the next case that I'm going to talk about, but
5 as I said, it ended up in a two/two tie. Tie goes to the
6 runner. The ultimate constitutional question is yet to be
7 answered at this point.

8 Then the next case I'm going to talk about is LDG v.
9 Brown. This was a case that did get ripe, but I'm going to
10 start by telling you the time between the first filing of the
11 claim in this instance and the Supreme Court decision
12 stretched from the year 2000 to the year 2009. Very -- as I
13 mentioned earlier, it was a dram shop case. Odd situation.
14 Very interesting in the fact that, at the Superior Court level
15 -- and this happened about 2005 when it got to the damages
16 portion of the litigation that Superior Court Judge Morgan
17 Christen asked for amicus participation, which, again, was
18 very interesting and is the first I've ever heard of a
19 Superior Court judge asking for that kind of participation.
20 And we, in the medical community, spearheaded that. We wanted
21 to, you know, have this ultimate question answered, having to
22 do with the constitutionality of the Legislature setting caps
23 on non-economic damages.

24 So from the time that that happened -- there was an
25 amicus provided -- the Superior Court ultimately went on to

1 the Supreme Court, and this time, there was no tie. The vote
2 was four-to-zero upholding the constitutionality of the
3 Legislature being able to set the caps on non-economic
4 damages.

5 Now that's a long time from when the first legislation
6 was passed; however, what I will mention is that there have
7 been no challenges to the 2005 legislation, and I think, in
8 large part, that is due to the LDG v. Brown decision.
9 However, that's not to say that it could not be challenged.

10 And just in passing, I'll mention a case that is brand
11 new that Valerie probably will have some interest in. She
12 probably is aware of this, and it's Adams v. USA, and this is
13 another point that -- this case gives rise to another point
14 that, I think, is very important for you to know.

15 Adams v. USA is a medical damages case where, in essence,
16 the federal government is being sued. When federal employees
17 are sued, typically, those pieces of litigation are litigated
18 in federal court using the federal rules; however, most
19 typically, the federal courts give comity or the layperson's
20 term is they will try the case under the state's liability
21 laws. So the various tort reforms that have been enacted in
22 the state will apply in federal cases, most often. This
23 particular case, there could be some twists to that because
24 it's very early going, but this actually has potential of not
25 only having certain issues determined by our state Supreme

1 Court, but it also has the potential of going to the United
2 States Supreme Court.

3 So that's where we started. That's where we're at, at
4 this point in time. A couple of things that are also benefits
5 that -- the one benefit, as I alluded to, was the stability in
6 the insurance market. I think that we have a very stable and
7 fine insurance marketplace in the state. Another, as I
8 mentioned, is what has happened to the costs to physicians and
9 hospitals for their -- particularly for physicians; that's
10 mainly what I know -- as to their professional liability
11 insurance premiums. They reduce, you know, tremendously since
12 1996.

13 What I haven't talked about is that they are a real
14 benefit in recruiting physicians. All of the things being
15 equal, it appears like physicians will like to practice,
16 preferentially, in jurisdictions that have a good and what's
17 considered a fair liability environment. The.....

18 PHONE OPERATOR: Excuse me. This is the conference
19 operator. Can you hear me?

20 COMMISSIONER ERICKSON: Yes, operator; we can. Sorry,
21 Jim.

22 PHONE OPERATOR: Hello, this is the conference operator.
23 Is this the moderator for the call for 2474? If you're on a
24 speaker phone, if you would please pick up the phone?

25 (Pause - technical break)

1 8:46:21

2 (Off record)

3 (On record)

4 9:16:41

5 MR. JORDAN: Are you ready? And I'll try to speak loudly
6 and close to the microphone. I was asked, during our
7 technical break, just to circle back on one issue that I just
8 kind of blew by quickly and that was the impact of the Alaska
9 state liability law and how it applies in other settings.
10 Namely, I just mentioned federal employees, but it also needs
11 to be noted that that also applies to the Native health system
12 with those health care providers that either have a compact or
13 a contract with the system, and I think there is certain
14 application in the VA as well as the military. So.....

15 COMMISSIONER ERICKSON: If I could interrupt for a
16 second, too, Jim, there also -- employees of community health
17 centers, federally-funded community health centers also can be
18 deemed covered under the Federal Torts Claim Act.

19 MR. JORDAN: Yes. And also some of these health care
20 providers do double duty. They're also out in the private
21 world, too, and that impacts them from their insurance
22 coverage as well because there is a coverage known that's gap
23 or wraparound coverage that's available to cover those
24 situations, but Deb asked me to make that clear. So thank
25 you.

1 Where I was headed -- and I'll quickly conclude because
2 of the time of the interruptions, but essentially, where I was
3 headed is that there are some ancillary benefits, and I
4 mentioned the recruiting element. I'm going to take this
5 opportunity a little off script here, and I'm going to throw
6 something out, and I'm willing to come back at another time to
7 talk about this.

8 I have talked about this since 2006, when I was involved
9 with the Workforce Commission, and that was -- and this is not
10 original thinking. This is based on what has occurred in
11 Massachusetts. Massachusetts developed, oh, 2004-2005, with
12 the help of a very highfalutin economic consulting firm. I
13 should say -- when I say Massachusetts, I mean the
14 Massachusetts Medical Society. They developed a set of nine
15 metrics that would measure what the practice environment was
16 for physicians in Massachusetts, and these metrics are such
17 that they're comparable to national data. And I suggested,
18 back in 2006, that that's something that we ought to look at
19 in this state as far as workforce issues. The metrics are
20 developed and designed. I think they went back to the 1990s
21 and reconstructed the data, and they continue to do that each
22 year and report it, and this helps. You know, it's kind of a
23 dashboard; where are we in our practice environment? And I
24 would suggest that, you know, you might want to take a look at
25 that. Thank you.

1 Now to quickly finish up, as I mentioned, there has been
2 a great change in the cost set up for the medical community
3 when it comes to their professional liability charges, and I'm
4 not going to get into either Neil or Andy's arena here.
5 Having said that, you know, one of your missions is to look at
6 how you're going to bend the cost curve, and I'm not going to
7 go into this, at this point, in any depth, but I think one of
8 the areas that you have to look at that is connected to the
9 medical liability situation is the practice of defensive
10 medicine. I say that because, nationally -- and the estimates
11 are all over the ballpark, but even at the most conservative
12 low end, it's a lot of money.

13 Nationally, the estimates are from \$45 to \$170 billion a
14 year, and a lot of that is tied into what the national
15 standard of care is and that's one of the elements that -- or
16 one of the causes of action in any medical injury case is what
17 the standard of care is. And what happens, just bottom lining
18 this, is that, in a medical liability case, where is the
19 plaintiffs -- are going to go? They're going to go to a
20 jurisdiction that has the -- you know, a less effective
21 liability set of rules and statutes, such as where there are
22 no caps on non-economic damages or very high caps, and they're
23 going to use the standard of care there, which tends to be --
24 instead of just, you know, a physical examination of a knee in
25 a knee injury, they're going to go to x-ray, MRI, and every

1 other piece of radiologic magic that can be applied and that
2 equates to cost. So I think that's one area that -- not much
3 you can do at the state level. We are under a national
4 standard of care. That's the way the cases are adjudicated in
5 the state. Have been for a long time, and we are amongst
6 about half the states in that arena.

7 Now the last thing I'm going to mention -- and what you
8 do -- and this is kind of to set the stage a little bit and
9 that is that, about three weeks ago, I was at a very
10 interesting conference in Washington D.C., and when I hear
11 data from two different sources that are not always on the
12 same page, I tend to believe the data. There was data
13 provided by representative CMS, and there was another slide
14 presented by a person in the private medical arena in the
15 whole overall guise of bending the cost curve. And what this
16 data is, is 20% of the total health expenditures is
17 attributable to what happens in the care situation, in the
18 care setting, in the care environment. 80% of the costs are
19 driven outside of that environment, health behaviors,
20 socioeconomic indicators. That's a big comp, and I think
21 those are the things that -- you know, some of the things that
22 I've already noticed on your agenda that you'll be looking at,
23 but I think that that's good, so you have an idea of the
24 perspective.

25 What I'm going to conclude with is that I wanted to give

1 you an idea of what kind of a driver economically the office-
2 based physician community in this state. This is data that
3 was put together and commissioned by the AMA and the various
4 state medical associations, including Alaska, and they did
5 this for all 50 states to look at the economic impact of
6 office-based physicians, just a few quick numbers.

7 Office-based physicians, annually, are responsible for
8 \$1.934 billion in economic output, 7,500 jobs. Put the jobs
9 situation in a different situation for every physician in an
10 office-based setting, that equates to nearly six employees.
11 The value of the wages and benefits for all of those employed
12 in this sector is \$1.3 billion. This outpaces any number of
13 other segments of this economy, notwithstanding the oil
14 industry. So I just wanted to give you that perspective to
15 show that, in addition to providing care, it's also -- the
16 folks that I'm here representing today are responsible for a
17 large sector of our economic well-being. Thank you.

18 COMMISSIONER ERICKSON: Thanks so much, Jim. And Andy --
19 we'll take a few questions for Jim before we move on to Andy,
20 okay?

21 MR. FIRTH: Sure.

22 COMMISSIONER HIPPLER: Mr. Jordan, you referenced a --
23 Mr. Jordan?

24 MR. JORDAN: Yes?

25 COMMISSIONER HIPPLER: You referenced a set of nine

1 metrics in the state of Massachusetts. Do you recall what
2 this is called, so that we can research it?

3 MR. JORDAN: I can give you the actual information, and I
4 can put you in touch with the people in Massachusetts that can
5 give you the real down and dirty data. And by the way,
6 they're happy to share these. They're very happy.

7 A side note, you know, why can the Massachusetts Medical
8 Society do this when the Alaska State Medical Association
9 can't? The medical association in Massachusetts owns the *New*
10 *England Journal of Medicine*.

11 COMMISSIONER ERICKSON: So I'll work with Jim to get that
12 and share with all of you to follow up. Does anybody have any
13 other questions for Jim? Well, Andy, why don't we turn it
14 over to you, if you can share some of your perspective from
15 MIEC on what the impact of Alaska's reforms have been in the
16 malpractice environment?

17 MR. FIRTH: Sure. Sure.

18 CHAIR HURLBURT: Maybe Andy, before you start, just --
19 this is Ward Hurlburt. Since we just had a half-hour break,
20 if we need to -- and I think -- because we don't have much
21 time left, and I think this is a real interest to everybody,
22 if we could maybe aim toward ten, 15 ending rather than ten,
23 if we need that time, then you won't feel quite so rushed
24 because I think we really want to hear what you folks have to
25 say. Sorry, Andy.

1 MR. FIRTH: Sure. Sure. I'm available for as long as
2 you need me, Dr. Hurlburt, and my apologies for my inability
3 to travel, perhaps, caused the technical delays. But my name
4 is Andy Firth. I'm the President of MUC, the operating
5 company of MIEC. MIEC has been writing Alaska physicians
6 since 1978, just approaching 35 years. We've been the largest
7 writer of physicians in Alaska for many years, and we're owned
8 and operated by and for the benefits of our physician
9 policyholders. We operate in three other states, Hawaii,
10 California, and Idaho, and in terms of national prominence,
11 we're probably in the mid-30s in terms of national writings.
12 So that's a tiny bit of background on MIEC.

13 I thought that I would just give you a direct response to
14 the questions that were provided to me prior to this
15 conversation and then perhaps backfill with some background on
16 thoughts that support the feedback, and then obviously, take
17 any Q&A that you want to offer, or as you direct, Dr.
18 Hurlburt, just sit on the line and wait for Neil to finish.

19 So the quick feedback on the topics are -- I think the
20 first question was asked, what are medical professional
21 liability premiums impact on affordability? I think, in
22 isolation -- that's an important word -- malpractice premiums
23 have a very limited impact on the cost of health care.

24 The next question was sustainability, and I'll combine
25 with affordability. I think that I can't really separate

1 them, from a malpractice perspective. I think malpractice
2 premiums do play quite a significant role in the context of
3 sustainability and affordability.

4 Have reforms impacted premium rates in Alaska? I think
5 the answer to that is yes. I think they've had a positive
6 impact since 2005. We've got a long history in Alaska, and
7 our premiums have been influenced significantly by tort
8 reforms.

9 How is Alaska doing relative to other states? I'd say
10 that Alaska is doing pretty well, from a malpractice
11 perspective, in terms of malpractice premiums.

12 And are other states doing better on malpractice? I
13 couldn't really point to any particular ones. We'll come back
14 to this. There are some states that have had persistently
15 lower premiums, but as I say, I think Alaska is doing pretty
16 well, at the moment.

17 So coming back to, I think, the key question that I
18 understand the Commission is wrestling is the question of
19 affordability, and I said this; in isolation, malpractice
20 premiums have a limited impact. I'm probably covering ground
21 that Jim may have covered that I wasn't able to hear, but
22 estimates vary about the amount of money that is spent on
23 malpractice relative to all health care costs. They vary
24 between 2% and 5%. So let's just take the top end of the
25 range. If it was 5%, even if we could halve the cost of

1 malpractice premiums in health care, it wouldn't make that
2 much difference in the context of affordability. I think it's
3 perhaps an incomplete observation for me to state that our --
4 the actual dollars of malpractice premiums that we charge
5 individual specialties in Alaska today are the same as they
6 were 25 years ago. That's without adjusting for any
7 inflation. So back in 1986, an internal medicine doctor was
8 paying the same in actual dollars as they are today, and I
9 don't know of any other cost in health care that could make
10 that same claim. Now I think it's important to note that,
11 between in 1986 and today, there has been at least one major
12 cost crisis in professional liability that may have had an
13 impact on health care costs, but I think it's pretty good
14 objective data to observe malpractice premiums being at the
15 same level as they were some 25 years ago.

16 In terms of sustainability and affordability, I said that
17 malpractice premiums do play a significant role. I think --
18 Jim Jordan was mentioning defensive medicine, and I think that
19 it's -- that's a reality of the practice of medicine today,
20 and it seems reasonable to me, at least, that, to the extent
21 there is more defensive thinking and (indiscernible - voice
22 lowered) amongst physicians, they're likely to practice
23 medicine defensively and that clearly is an affordability
24 issue. I think malpractice premiums also play a role in terms
25 of supply of physicians and access to care -- sorry, the

1 supply of physicians is influenced by the malpractice
2 environment. I think physicians make a number of different
3 choices about where they practice, and I think the legislative
4 research document that the Committee has reviewed, I think,
5 addresses this, at least as well as I can, that there seems to
6 be some connection, and obviously, supply of physicians and
7 access to care are deeply intertwined. So I think, in the
8 context of sustainability and affordability, malpractice
9 premiums do play a role.

10 I would pause, just at this moment, to sort of just to
11 reflect on one peculiarity about the practice of medicine that
12 I think the Commission perhaps is already aware of, but I
13 always find somewhat amazing. I can't -- when I think of the
14 profession of medicine, and you know, how noble it is and how
15 much we all rely on physicians and -- sometimes it's just to
16 keep us healthy. Sometimes it's in the context of a crisis.
17 It seems extraordinary, to me, that, as a profession, it is
18 sued as much as it is. I really can't think of another
19 profession in which an individual, who is trying to do their
20 best to look after people, is going to get sued. I think the
21 *New England Journal of Medicine* did a report on this in August
22 of this year, and they state that 75% of low risk specialties
23 and 99% of those in high risk specialties will, at some point
24 in their career, be faced with a claim, and I can't think of
25 any other profession where that's the case. It makes you

1 wonder, sometimes, why physicians do it.

2 Have reforms had a positive impact? I think the answer
3 to that is yes. Malpractice rates are low and stable at the
4 moment. Our own evaluation of the worst time for writing
5 business in Alaska was in the 1990s when prices were about
6 150% higher than they are today. In the early 2000s, the
7 State was on a bad trajectory, as well as most states in the
8 U.S. The Legislature did step in and pass tort reform, as I
9 think Jim discussed earlier. And since -- in that period
10 between, you know, 2000-2006, our prices went up by about 40%,
11 which has a significant impact on how physicians feel about
12 practicing medicine, I'm sure. But since then, our rates --
13 and I think those of NORCAL have rather been flat, but ours
14 have been coming down steadily, and we've also been in the
15 happy positive of returning dividends, which is part of our
16 mission.

17 So I said that Alaska, I think relative to other states,
18 is doing pretty well. I provided some charts that are drawn
19 from the *Medical Liability Monitor* showing where Alaska sits
20 relative to other states in the U.S. Alaska seems pretty
21 firmly anchored in the lower third of the bracket there. I
22 really can't identify why some of those other states to the
23 right, you know, where physicians are paying less, why they're
24 paying that much less. We do operate in Idaho where
25 physicians have consistently been paying less than Alaska

1 physicians. It's -- I'm not sure if there is anything that
2 the Commission can do about that. I think it's societal, I
3 would imagine, is the best conclusion I could reach.

4 If the members of the Committee are looking at these
5 exhibits, I would pause and note that the left-hand scale I
6 still find somewhat breathtaking, the idea that somebody might
7 have to write a check for insurance, you know, for some
8 specialties (indiscernible - voice lowered) \$10,000 seems
9 extraordinary to me, and if you're practicing in OB/GYN or
10 something like that, the check is over \$50,000. It's a pretty
11 dramatic cost, from my perspective, and I don't think it makes
12 that much difference in the context of health care costs, but
13 in terms of the practice of medicine, it still seems pretty
14 significant, to me, and I think that Alaska physicians are
15 just very happy they don't practice in states such as Florida,
16 Illinois, Michigan, New York. I think those characteristics
17 of those states where malpractice prices are that much higher,
18 generally, they do not have very good tort systems or very
19 unfriendly tort systems to malpractice. So I think the
20 Legislature in Alaska has done a good job in trying to
21 address, at least, the malpractice cost side of the equation.

22 I think, at the moment, the situation is relatively calm
23 from a medical malpractice perspective. That can change
24 fairly quickly. In the 30-odd years we've been delivering
25 malpractice for physicians, there has been three very robust

1 crises where prices have gone up dramatically, and in some
2 states, they've stair-stepped and stayed relatively high. In
3 places, like Alaska, prices have, in fact, come down. So in
4 the current climate, it's relatively stable, and I don't think
5 that there is a great deal of anxiety amongst physicians about
6 malpractice costs at the moment. That's not to say that we
7 don't get complaints about the premiums we charge them, but
8 things are relatively stable. Uncertainty will have an impact
9 on MPL, on medical malpractice pricing. I can go into that in
10 some detail, but if you.....

11 UNIDENTIFIED FEMALE: (Indiscernible - voice lowered)

12 MR. FIRTH: I'm sorry?

13 COMMISSIONER ERICKSON: Andy, that wasn't us. There
14 shouldn't be anybody else on the line able to speak, so.....

15 MR. FIRTH: Okay.

16 COMMISSIONER ERICKSON: Go ahead. Thank you.

17 MR. FIRTH: So if the Commission is interested in
18 understanding what drives malpractice costs or how uncertainty
19 might drive malpractice costs, I'm happy to address that, but
20 it seems to be a little bit beyond the scope of what you're
21 interested in.

22 So I would just summarize. I would say that malpractice
23 costs, in themselves, are not significant drivers in health
24 care costs. I think that malpractice costs tend to reflect
25 what's going on in a particular area, what societal pressures

1 are going on, what the legislatures are doing. I think we're
2 more the canary in the coal mine than we are the gases.

3 Just to address that one point that Jim was talking about
4 with defensive medicine, I think, in general terms as a
5 malpractice carrier, we want our physicians covering the
6 bases. We do think that there is, perhaps, some help for
7 physicians in trying to address defensive medicine by
8 following evidence-based medicines, and those initiatives that
9 are coming out of the current efforts, federal efforts perhaps
10 may be helpful. I think, for us, while we may like defensive
11 medicine from a protection point of view, we don't value it as
12 much as a well-documented file. I think, generally, we find
13 that, when we get the opportunity to respond to a claim made
14 against a physician, even in the absence of a well-documented
15 file, we're able to resolve a case or convince a plaintiff
16 that there is no case, and 90% of the time, without making any
17 payment to them. There is a tremendous amount of waste in
18 malpractice, mostly to do with cases being brought that should
19 never be brought in the first place, but that's just a
20 frustration that physicians have to deal with and that's one
21 of the major reasons why they have to buy malpractice premiums
22 dealing with cases that should never really be brought.

23 So those were my quick comments. So if there are any --
24 I'm happy to take any questions or do as -- or sit tight and
25 wait for the next speaker.

1 COMMISSIONER ERICKSON: That was very helpful, Andy.
2 Thank you, and I think we do have, at least, one question for
3 you.

4 COMMISSIONER KELLER: Yeah (affirmative). Thank you,
5 Andy. This is Wes Keller. From my perspective, there is a
6 huge increase in federal regulation, and maybe an
7 understatement, particularly in health care. The end result
8 of that is that there are more medical providers that become
9 criminals, and there's, you know, a lot of push toward
10 prosecution by the Justice Department.

11 The reason for bringing that up as a backdrop, that does
12 not affect, right, malpractice insurance rates. I mean, it's
13 a liability for medical providers, but I think Jim, earlier,
14 said, you know, very clearly, that, when you get into legal
15 issues and punitive, there is no insurance for that. And so
16 in that liability, I just wondered if you would comment if I'm
17 seeing a problem that exists and how that relates to you?

18 MR. FIRTH: Sure. I think you're absolutely right.
19 There are a lot of regulations being imposed on physicians,
20 and even if they -- even the most diligent find it very
21 difficult to comply with all of them. There often is an
22 impact on their malpractice premiums when they contravene or
23 allege to contravene federal regulations. Usually -- you
24 know, our mission as an organization is to provide as much
25 protection as we possibly can that we're expert in to insulate

1 physicians from both economic and reputational harm, and when
2 there are alleged transgressions in some way, federal
3 regulations then will often be involved in quite an expensive
4 defense process. We usually can't indemnify them for fines,
5 but we -- as an organization, we seek to defend physicians
6 against things that might impact their reputation or their
7 economic health. And so we do provide coverage in our
8 contracts for that, but it's defense expenses. But I think,
9 as I alluded to earlier, defense expenses are a huge driver in
10 our business. Every case we open that we close successfully,
11 i.e. don't pay the other side anything, costs us, on average,
12 something of the order of \$9,000 to \$10,000. So to the extent
13 there is more federal regulation and more claims arising out
14 of that, that might lead to more instances where we have to
15 open a claim file and spend money defending a physician.

16 COMMISSIONER KELLER: Now I'd like a follow-up, if I
17 could? Actually, I was a little surprised with your answer,
18 if I heard you right, that it does have an impact, direct.
19 Then if you would go -- if you -- this -- maybe you don't want
20 to go there, but the Health Exchanges that are coming, as I
21 see them, their role is to enforce the increasing number of
22 regulations tied to PPACA. I was just wondering if you wanted
23 to speculate what -- you know, what you are preparing for as
24 this develops, you know, in the court case and whatever. You
25 don't have to answer that, but.....

1 MR. FIRTH: No. I'm happy to. I think we're going to be
2 -- our organization's norm is to always -- has to be reactive.
3 So it's very difficult for us to anticipate -- we're not going
4 to adjust our premiums based on what we think might happen. I
5 mean, there is a certain amount of projection that goes into
6 premiums. We do worry a little bit that one of the things
7 that's going to happen if some of these regulations are put
8 into place with bundled payments and accountable care
9 organizations and the like is that, when people are injured,
10 it's going to increase the likelihood that one of the things
11 they're going to claim is that the physician was acting -- his
12 decision making was influenced by his economics, his or her
13 economics. You know, generically, we throw that into the
14 bucket of the allegation of economic practice of medicine as
15 opposed to the medical practice of medicine. And in difficult
16 claims, in difficult circumstances, when the allegation is
17 that the physician was practicing with a focus on his
18 pocketbook, not in the best interest of the patient, those are
19 the sorts of things that worry us because they do inflate
20 costs, and they're much more difficult to defend, and if there
21 is any element of negligence, it will inflame a jury and all
22 those different things. I don't know if I'm precisely
23 addressing your question, but that's the concern looking down
24 the road with PPACA, but as I say, we also think there are
25 opportunities for improvements in eliminating waste and claims

1 payments. You know, if we have a higher instance of high
2 satisfaction and patient satisfaction surveys and the like,
3 then maybe physicians will know if their patients are upset,
4 and if they're upset, then maybe they'll talk to them, and if
5 their compensation is paid based on how happy their patients
6 are, maybe that will result in fewer claims. So it's almost
7 impossible for us to predict what the future will bring, but
8 we'll try and react in a way that doesn't cause harm to our
9 policyholders.

10 COMMISSIONER ERICKSON: Jim has something to add and then
11 we'll go to Keith's question.

12 MR. JORDAN: Thank you. Representative Keller, just to
13 kind of put this in a little perspective from the physicians'
14 standpoint, the type of coverage that Andy is just talking
15 about, I think, is very important to physicians in smaller
16 states. A lot of the things that you read about in the
17 newspaper have to do with the recent activities of the
18 Recovery Audit Contractors under the Medicare program, and
19 this is my perspective.

20 My perspective is that, if the efforts were focused on
21 Los Angeles County, Dade County, Brooklyn, New York, and
22 Dallas, Texas, you would come up with very large numbers. You
23 get out in the hinterlands, the big numbers aren't there, but
24 yet, all of our physicians are drug under that, which, to a
25 certain extent, in my opinion, is that it's, you know, killing

1 a mosquito with a baseball bat. Thank you.

2 COMMISSIONER ERICKSON: Keith?

3 COMMISSIONER KELLER: Yes. This would be for both you
4 and Neil, when he gets to it, but what kind of education
5 programs, or even remedial ones -- after you find a series of
6 like claims that you've had to pay on, what do you, from an
7 educational point of view, to try to get your members, rate
8 payers, whatever to come up to speed on that particular aspect
9 of what you've found in your claims data?

10 MR. FIRTH: I got about 80% of that. I think the
11 question was, what do we -- how do we try and educate our
12 policyholders about -- and this is the bit that I was missing.

13 COMMISSIONER KELLER: Yes. About -- if you see a pattern
14 of claims, omissions, whatever, what are your -- what are you
15 doing to educate your.....

16 MR. FIRTH: Well, we -- I think one of the things -- and
17 I don't know if Neil will support me on this, but we find it
18 really very difficult to communicate effectively to our
19 policyholders. They're extremely busy practicing medicine.
20 You know, frankly, malpractice premiums are a major irritant,
21 and nobody really likes to -- you know, even if we're owned by
22 our policyholders, they still resent us. The -- so
23 communicating with physicians who are busy is really quite
24 difficult.

25 One of the things that I'm a little bit more optimistic

1 in the future is that, as physicians consolidate perhaps into
2 slightly larger groups, they'll -- we'll find a mechanism so
3 that malpractice premiums aren't treated as a cost of doing
4 business, that physicians will take control of this, instead
5 of outsourcing it to us and trying to minimize costs on their
6 behalf, that they'll embrace malpractice as being something
7 that they can address and drive the cost down.

8 So I think, just to answer your question, it's very
9 difficult for a malpractice company to communicate measures
10 for physicians to improve their risk. They've gotten used to
11 buying insurance to protect themselves from those risks as
12 they emerge, but maybe in the future with some consolidation
13 into larger groups -- we're seeing some evidence that, in the
14 very, very large groups, doctors appoint internal risk
15 managers amongst their peers, and they listen to their peers
16 in ways that they don't listen to non-MDs who are insurance
17 geeks who charge them premiums and that's just the reality of
18 it. I hope that wasn't too candid for some of the physicians
19 in the room.

20 COMMISSIONER ERICKSON: Well, let's hear from Neil. So
21 if anybody has additional questions, why don't you hold those?
22 And Neil might want to actually respond to the conversation
23 that was just going on, but why don't you take the floor for a
24 little while?

25 MR. SIMONS: Great. Thanks. I'll jump in on this one

1 particular question. I agree with Andy that it's difficult to
2 get physicians to listen to us when we have help to provide,
3 and yet, we try to do that at every turn.

4 With NORCAL -- before I get into my comments, just quick
5 by way of background, our book of business is probably a third
6 of the size of MIEC's. So in terms of identifying trends that
7 are unique to Alaska, we don't necessarily always see those as
8 readily as, say, other venues, or maybe Andy does with his
9 larger book of business.

10 That said, we do see things, at times, that we find an
11 opportunity to provide some educational services on, and I
12 think a lot of the trends that we may see in other venues
13 translate very directly to Alaska physicians. They're generic
14 themes in terms of documentation follow-up, all of the things
15 that are pretty standard out there. And so we have, actually,
16 a pretty robust CME program that's no cost to our
17 policyholders. They can do it online. We send out, monthly,
18 a publication, which they can read and take for CME credits.
19 For some of our other groups, we actually do onsite
20 assessments and risk management presentations. We work
21 closely with the Alaska physicians and surgeons, our endorsing
22 partner up here, and have worked with them to do presentations
23 for them.

24 So there are things that NORCAL does, and no doubt, that
25 MIEC does as well. I think the challenge, as Andy said, at

1 times, is to get the physicians to listen and to kind of avail
2 themselves of all the good things that the carrier will
3 provide for them.

4 COMMISSIONER ERICKSON: Thank you. Well, do you want to
5 go ahead and make your comments now? Yeah (affirmative).
6 We'll hold them for now.

7 MR. SIMONS: Thanks. Well, good morning. It's really
8 nice to be here. It gives me a chance to visit our office
9 here in Anchorage and our staff here, and I, first, also
10 wanted to, on behalf of my CEO, Scott Diener, apologize for
11 his inability to be here. He is beginning our board meeting
12 this week, and unfortunately, he was just not able to get
13 away, but I'm glad to be here, and I want to thank you for
14 opening up the skies and having the sun shine for me.

15 I think, first of all, Jim did an outstanding job of
16 talking about the history of tort reform in this state and
17 providing some perspective in regards to its impact. Really
18 with Andy's comments, I, in large part, agree wholeheartedly
19 that the effect has been a positive one. I think that the
20 medical professional liability carrier's role, in part, is to
21 help access to medicine and to health care, and I think that
22 keeping costs down in medical professional liability, as some
23 of us talked at the break, is simply one piece of a larger
24 puzzle. I think the other pieces that you're looking at over
25 the duration of your Commission assignment here are far more

1 difficult to deal with than probably the medical professional
2 liability one.

3 So you know, obviously, tort reform, for us, is
4 paramount. There -- you know, there's a difference between
5 the rates that we charge, say, now and what we may have
6 charged in the past. The rate level numbers that we've seen
7 here are, basically, accurate. I think that you can see that
8 the rates that NORCAL and MIEC and the other 10% of the
9 carriers here have charged as a result of health care tort
10 reform -- excuse me, medical liability tort reform really do
11 draw a direct connection.

12 One of the things -- and I don't want to be overly
13 redundant to the comments Andy made, so I'm going to kind of
14 jump around from where I may have started originally, but in
15 terms of the caps, which are kind of the crux of the issue
16 with tort reform, without caps or with very large caps, you
17 have a significant amount of uncertainty in terms of how
18 you're able to develop your rates. You just don't know what
19 is going to happen in terms of some of these cases.

20 The non-economic or the pain and suffering, if you will,
21 you know, within California, we're lucky enough to have our
22 micro-law in place since 1975, and it has placed a \$250,000
23 cap on the non-economic damages. That certainly has had a
24 result of keeping our rates as low as they have been for all
25 these many years, but if you don't have that or if you have a

1 very high cap or one that is complicated that can allow for
2 significant dollars to be spent, then you get awards that are
3 large and unmanageable at times.

4 I, a number of years ago, was at a training seminar, and
5 it was a medical professional liability symposium, and they
6 were giving case studies for lawsuits around the country. And
7 this one particular example was what we would call a bad baby
8 case in Ohio, and it was a birth case, and the baby lived, and
9 there were significant damages. There were lifelong
10 complications on the economic side in terms of payments, and
11 the jury came back with a \$50.5 million verdict, and the
12 majority of that was not pure economic damages. And so the
13 question to the jury later was, how did you arrive at \$50.5
14 million? Their response was that -- excuse me. The baby died
15 in this case. Their response was, the baby died at 5:05 a.m.
16 So they took those numbers, and they, in their wisdom, came
17 out the with dollar figure of \$50.5 million. So without a cap
18 in place, you get these large numbers, and I think that others
19 have talked about the venue, having a contributing factor to
20 the jury pool and how things come out. You know, I look at
21 the chart that was included in the article that Andy helped
22 write a couple years ago, and while I think everything is
23 probably still accurate, you look at some of these other
24 venues that are on the right side, and in large part, they
25 have probably societally jury pools that are not going to

1 necessarily come up with that. Southern California --
2 California, obviously, is a big state. Not as big as Alaska,
3 but there is a great diversity in terms of populations and
4 types and so we're able to slice and dice that pretty well and
5 realize that, in southern California, you just have a jury
6 pool area that is going to give you larger awards. The joke
7 amongst claims folks is that you don't want to venue your case
8 in downtown Los Angeles. They call that the bank because jury
9 awards come out of there quite large.

10 The question of rates -- overall, we've talked about
11 there are some examples in some of these publications in terms
12 of what those rates are compared to MIEC and others. I just
13 wanted to kind of remind everybody that rates are very
14 different within any carrier's spectrum of specialties. Say
15 you have a psychiatrist who will be paying, you know, X
16 dollars and then you'll have an obstetrician who will be
17 paying many times that, and each carrier will develop its own
18 rates depending on its experiences and cost structure, et
19 cetera. So while there is generally consensus or consistency
20 among carriers in the general types of specialties in primary
21 care, et cetera, there are always going to be those nuances
22 between the different carriers and the rates.

23 We have talked -- Andy talked about dividends, and I
24 would touch on that as well. Excuse me. When there is a
25 change, such as a tort reform that we had here in 2005 that

1 had really a solid effect, there is also, sometimes, a little
2 bit of a lag in terms of what the effect will be. Medical
3 professional liability claims are ones that take longer to
4 reach resolution than an auto claim. It's just the nature of
5 it. There is the need to work up a case and get it into the
6 trial system and retain defense experts who are increasingly
7 more expensive as we go forward. And so there is that little
8 bit of a lag there, but nonetheless, you know, Andy mentioned
9 that his rates had gone up significantly in the early part of
10 the 2000s. NORCAL's -- excuse me -- had as well. Since 2005,
11 our rates have either been flat or they've come down either
12 12% or 6% or 7%. I would like to think that that was -- well,
13 it is, in part, due to the tort reform. It's not entirely due
14 to that, but it is -- tort reform has absolutely played a role
15 in helping stabilize those rates and those costs. When you
16 look at a claim that, in the prior tort reform venue, would
17 have added, you know, several hundred thousand more dollars to
18 that claim because of the cap being higher, well, you do that
19 a number of times, and all of a sudden, the cost of business
20 is just that much higher.

21 On the dividend side, we are very pleased to be able to
22 return even more dividends than we had before because of the
23 results. Now the dividends, just to distinguish from the
24 rates, the rates are what a carrier charges in anticipation of
25 what they think is going to happen into the future. The

1 dividends, of course, are monies that we return, and my
2 company and Andy's are similar in that we're, effectively,
3 mutuals and we're owned by our policyholders and what money we
4 don't need we give back. So then we have returned
5 consistently since 2005 anywhere from 6% to 12%, often times,
6 for the most part, 10% in dividends. Again, I think that's a
7 pretty direct correlation to the positive impact of tort
8 reform for this state.

9 Looking around the balance of the country, you know,
10 there are 50 different ways or more to handle tort reform and
11 medical liability concerns. There is not, as we all know, a
12 consistent approach. Some states -- many states still don't
13 have any tort reform. Some are slowly starting to adopt it
14 and with varying ranges of effectiveness. I think that,
15 again, there is that lag effect that you see once tort reform
16 has gone in, but I think, overall, it's safe to say that those
17 states with some measure of tort reform will see professional
18 liability costs go down, thereby increasing accessibility, et
19 cetera.

20 I think the advantage that the Alaska physicians have in
21 having 90% of the market with these two particular carriers is
22 that we are not commercial carriers, and I think that the
23 commercial carriers are ones that are seeing the need to have
24 a different profit margin, et cetera. It is far more bottom
25 line philosophy, and you know, Alaska is a state that is

1 uniquely one that enjoys having most of its coverage provided
2 by two carriers who are really there for physicians, and
3 ultimately, health care in the patients, and I think that that
4 equation has worked extremely well for the state, for the
5 patients, et cetera.

6 So rather than just, you know, being redundant a little
7 bit to Andy's comments, that's pretty much the extent of how I
8 wanted to convey our view on tort reform for this state and
9 elsewhere. In short, it's a good thing. At this point, we
10 think that it is working well. We're very pleased with the
11 outcomes and would be happy to stay with this configuration,
12 if necessary.

13 COMMISSIONER ERICKSON: Thank you very much, Neil. I
14 would like to go to Dave first, since he was holding his
15 question, and then Keith and then Ward. And please remember
16 to hold the mic really close to your mouth.

17 COMMISSIONER MORGAN: Yeah (affirmative). Dave Morgan.
18 This question you may not be able to answer. Since,
19 basically, we don't have a medical school, all of our
20 physicians have to go through a much more, I think, detailed
21 review by the licensing board. Do you think that's also
22 helping? I.e. I know, in the state I originated from, if you
23 graduated from, if you graduated from the University of
24 Kentucky or University of Louisville schools, it was almost
25 just a check of the box kind of to get your license and put

1 your shingle up, but since most of our physicians come up,
2 have to go through a licensing review, do you think that
3 helps? And also, I think, we have a lot of our health
4 professionals that work either for Indian Health Service,
5 community health centers, or the VA that are employed.
6 Therefore, they go through a background hiring process. Do
7 you think that may have some impact on our claims or not?
8 Maybe it's a philosophical and metaphysical question; I don't
9 know.

10 MR. SIMONS: I'll jump in first. The lack of having a
11 medical school here, under the scenario you draw, I'm purely
12 speculating, but I don't think that's a hindrance at all, and
13 I don't know, at all, that that's a factor in having the
14 licensure process be what it may or may not be here in Alaska.
15 I would suspect and hope that the Alaska board would recognize
16 and welcome whatever physicians would like to come up here and
17 work and do a good job at that.

18 MR. JORDAN: Yeah (affirmative). If I might, Mr. Morgan,
19 I think that, you know, the idea of having a medical school is
20 not the most critical issue. I think the real critical issue
21 is that what we need up here is we need more residencies.
22 This statistic has held for a long, long time; 70% of all
23 physicians coming out of a residency go into practice within
24 100 miles of where they complete their residency. We have one
25 residency in the state that's a family medicine residency who

1 are venturing off onto the pediatricians. There have been
2 some proposals involving psychiatry, and the residency
3 standards are set by a national credentialing organization.
4 So there is a lot of continuity from state-to-state. So I
5 think, you know, a lot of that is vetted up front by the
6 quality and meeting those quality standards of the residency
7 program.

8 COMMISSIONER MORGAN: Well, I wasn't really -- my
9 question -- you're going at the part of the question that
10 wasn't really the issue. By going through those processes to
11 either be hired by the Indian Health center program, public
12 health, VA, and also having to go through a very detailed -- I
13 know our licensing to bring in a health professional is very
14 detailed and a background check and have they had a lot of
15 claims or what type of claims. Could that be a factor in --
16 if it's like every economic hit that I've seen, usually you
17 have 5% or 10% that do 50% of the damage or problem. Could
18 that be a natural filter to possibly keep out guys who, in the
19 Lower 48, jump from state-to-state, kind of keeping ahead of
20 this kind of stuff, was really my question, not the issue of a
21 medical school.

22 MR. JORDAN: Well, to take that a step further, I think
23 that the licensing regime in other states is not that much
24 different than what it is here.

25 COMMISSIONER ERICKSON: I think Dr. Stinson has some --

1 he was on the medical board for a while and is itching to say
2 something here.

3 COMMISSIONER STINSON: Yeah (affirmative), Dave. We
4 addressed all those issues, and we looked for patterns like
5 that, and the majority of people, unless they were coming
6 right out of training, would often have one, maybe two marks
7 on a record, but when we would review, most of the time, we
8 could decide to let people be licensed. If there were people
9 with multiple licenses in multiple locales with multiple
10 different flags, at best, they would be asked to come for an
11 interview and they would be interviewed by the board, and it
12 was after they were interviewed by the board we would decide
13 what to do.

14 COMMISSIONER ERICKSON: So Keith, your question?

15 COMMISSIONER CAMPBELL: Yes. Recognizing that it's not a
16 very competitive market and we have two mutuals and a kind of
17 small commercial, what inducements do you have as companies to
18 keep from cannibalizing each other in such a small market to
19 keep your client base? And maybe that's proprietary, but I
20 would like to know.

21 MR. FIRTH: I'll jump in for a second. I mean, I think
22 one of the things about competition amongst mutuals is that
23 the top line isn't as important as a stable bottom line.
24 We're driven not by being bigger or more profitable, but our
25 mission is to minimize cost, and we have a Board of Governors,

1 and I'm sure NORCAL does as well, that focuses on that issue.
2 I think it seems counterintuitive to think that having more
3 competitors would reduce prices. Clearly, if either of our
4 organizations were looking to maximize profits, we wouldn't be
5 lowering rates and we wouldn't be paying dividends. We'd be
6 keeping them. So I'm not sure if we need inducements to
7 behave any differently than the way we are because we're
8 constitutionally built around minimizing costs.

9 MR. SIMONS: I would agree. I would love to take more of
10 Andy's business, but at the end of the day, it's good, as Andy
11 says, for the state of Alaska physicians to have two carriers
12 whose functions are so similar in that our goal is not to make
13 money; our goal is to provide a service and return any monies
14 we don't need.

15 COMMISSIONER ERICKSON: Dr. Hurlburt?

16 CHAIR HURLBURT: I have a question, but before I raise
17 that, I want to respond a little to David's comment and
18 question.

19 From having worked in a number of states, been involved
20 in credentialing processes for physicians, my observation --
21 and I understand that the longstanding Executive Director of
22 the State Medical Board retired here, and I guess I don't know
23 what's happened on replacing her, but my experience and my
24 observation has been that, with a background that -- in any
25 group -- in any group of people, you're going to have some

1 problems, and the numbers of problems among physicians will be
2 relatively small, but they will, unavoidably, be there. And
3 my experience has been that the State of Alaska and the
4 Medical Board and the Executive Director have been more
5 forthright and courageous and open in dealing with those
6 issues than any of the other states that I was in. Sometimes
7 where I was involved with credentialing providers,
8 particularly credentialing them in a health plan situation, we
9 would turn up problems, and it seemed like the State Medical
10 Board ought to be carrying that more than we would. So I
11 think it's been one of the things that I felt we, as Alaskans,
12 could feel very good about.

13 Now it's shown up, sometimes, that the percentage of our
14 physicians who have been disciplined has been higher than in
15 many other states, not because we have more bad apples, but
16 because the Board has been very diligent in dealing with that,
17 and I think that there (indiscernible - voice lowered).

18 My question is -- and Neil, you addressed it, but in
19 looking at the graphs that we have, we're between northern and
20 southern California in the state because we see so many
21 examples, like Alaska, like California, where there is a
22 before and after of what happened to the environment when the
23 damages were limited and what happened to the environment,
24 what happened to the premiums, that they were lower, and it
25 didn't inflate the cost of medical care so much, but you

1 talked about it was the culture between northern and southern
2 California, but is that really the whole reason why, within
3 one state with the same set of laws, that there is more of a
4 golden ring mentality in southern California and that pretty
5 much explains a two-to-one ratio in premiums?

6 MR. SIMONS: Well, I hope I don't get in trouble with my
7 own state, but it's a pretty broad statement, but I think it's
8 accurate, and if Andy wanted to comment, that would be good
9 and probably helpful, but there are.....

10 MR. FIRTH: Well, I think that anything -- we sort of
11 asked the question the other way around. I mean, are the
12 lawyers any less litigious or any less capable in northern
13 California? I don't think so. I think that they're just as
14 capable. Are the doctors that much worse in southern
15 California? No. I don't think so. The only variable that
16 any of us have ever really been able to identify is the
17 uncertainty that's created by jury pools that are capable of
18 making decisions that we don't think are supported by the
19 (indiscernible - voice lowered). I mean, it's not to say that
20 we blame jury pools. You know, we can't lay everything at the
21 door of the society, but there is a higher degree of
22 uncertainty about getting cases resolved in southern
23 California than there is in northern California, even though
24 the lawyers are just as good, the doctors are just as good,
25 and that uncertainty inflates cost. You know, if you go try a

1 case in southern California, you better have a good chance --
2 a really good chance of winning it. You're much more likely
3 to accept the fact that you're probably going to have to pay
4 more to settle a case in southern California and that's what
5 drives the rates. And that's certainly true if you take
6 Pennsylvania or Illinois, or even in states, like Illinois,
7 you'll have regional variations. Illinois is not exactly
8 huge, but you know, trying cases in Cook County is very
9 dangerous and so the prices that the insurance carriers charge
10 are significantly higher than they are, say, along the
11 Springfield border.

12 MR. SIMONS: I would agree, Andy, and just to put it, you
13 know, in the larger perspective, you know, NORCAL writes
14 business in Pennsylvania. We have a little bit in Delaware.
15 We write in Rhode Island, obviously, Alaska and California,
16 and we have just purchased a company a handful of months ago
17 that writes nationally, licensed in about 30 different states.
18 So the point being that any number of factors contribute to
19 what goes into the premium development, but the societal ones,
20 the respective jury pools coupled with lack of tort reform, if
21 that's the case, are really the drivers that get to the rates
22 at the end of the day.

23 COMMISSIONER ERICKSON: Linda?

24 COMMISSIONER HALL: I would like to make a couple
25 comments about the question and the competitiveness,

1 cannibalization, if you would put it, Keith, of a marketplace.

2 As a regulator of the marketplace, it is concerning to
3 me, at times, to only have two carriers. Jim and I -- Jim,
4 who -- Jim has not identified as part of his history -- was in
5 my position prior to the position he's in today. But the two
6 markets that do dominate medical malpractice are, in my
7 observation, very committed to the marketplace and not
8 interested in having the whole marketplace. Rarely do I see
9 an insurance company who wants all of the marketplace. They
10 prefer that there is some share there. They don't want all of
11 the risk in a state.

12 In my tenure in this position, I have seen two markets
13 leave the state for different reasons. One was market share.
14 They had a presence, and they had that same book of business
15 for a while, couldn't seem to grow, and it was geographically
16 located, and at some point, determined that they had had
17 significant enough losses that it just wasn't worth the
18 resources it took to write, and it does take resources for a
19 company to decide to do business in a state. They have to do
20 filings. They have to meet our regulatory requirements,
21 licensing fees. So it's a conscious decision to do that, and
22 it is a use of resources that you determine where you will get
23 the best return on those resources.

24 The second company left for different kinds of reasons,
25 namely we disapproved a rate increase. They had been in

1 business in Alaska for a long time and had very stable rates,
2 and all of a sudden, filed a rate increase, and rates are
3 public. So once they're filed and approved -- well, we didn't
4 approve it, so it probably wasn't public, but it was -- they
5 asked for 150% rate increase, and we denied that rate
6 increase. And so we were the bad guys. They left the state;
7 the letter to all their said because the Division refused to
8 approve their rate increase. That was true. They certainly
9 didn't say what their rate increase was.

10 So there are different reasons you see companies in and
11 out of a market. I'm comfortable with the two companies that
12 we have today. I think they're both committed to the market.
13 It is somewhat disconcerting, however, to have only two, but I
14 think these are companies that really care for their
15 policyholders. They have programs, and they're committed to
16 helping make that. They do training. They do a lot of
17 things. So as the regulator of the market, it's not a
18 situation that I really normally am comfortable with, and I
19 like more. More is better with choice, but in this case, when
20 I look at premiums, I am very pleased with where we fit
21 nationally. It's one of the few areas that we are not number
22 one, and it's a good place to be. So I mean, I would
23 compliment both the companies, and I think they've done a good
24 job for our providers.

25 COMMISSIONER ERICKSON: Jeff?

1 COMMISSIONER DAVIS: Jeff Davis. And Andy, you made an
2 observation earlier that I've been sitting here contemplating
3 and just guessing that you and probably Jim, you know, having
4 been in this business for a long time, have some thoughts
5 about it and that is that you observed that, given that
6 physicians are in the healing arts and held in high esteem,
7 it's rather puzzling that they are sued so often, and I just
8 wondered if you had any thoughts about why that might be.
9 Thanks.

10 MR. FIRTH: Well, I think your guess is as good as mine.
11 I think it's -- there is nothing more personal than, you know,
12 sort of the laying of the hands and the treating, and I think
13 bad outcomes and disappointments and lack of understanding, I
14 think those are all, you know, drivers. I think the TV shows
15 about the physicians as well, I think they create expectations
16 that are just unreal. I really don't know. It's -- perhaps
17 there other people in the room who, you know, can offer
18 thoughts on this. We do know that there are some
19 characteristics about physicians. Some people can -- there
20 are studies that have been that there is a far higher
21 incidence of alleged -- of negligence that don't result in
22 claims being brought and that can only be because the
23 relationship that a physician and a patient have, you know,
24 prevents the patient from, you know, going -- taking the step
25 and suing them. You know, I'm sorry. That was a bit of a

1 non-answer, so I'll stop rambling.

2 MR. SIMONS: I would just add that, as Andy said, when
3 something wrong -- bad happens, it's a deeply personal
4 experience for the patient. I think that, in general, we, as
5 patients -- all of us are also patients -- we put the health
6 care provider on a pedestal, and the expectation is so high
7 that, whenever anything goes wrong, the patient feels deeply
8 wronged. I think the patient population doesn't realize that
9 medicine is as much an art as it is a science, and in that
10 regard, when there is a mistake that happens, they want
11 retribution.

12 COMMISSIONER ERICKSON: Yes. Go ahead, Jeff, and then
13 Keith.

14 COMMISSIONER DAVIS: I knew I was putting you both on the
15 spot, but I appreciate your comments and your speculation
16 because -- well, not because, and it's similar to what I was
17 thinking, but I think an informed opinion on what drives this
18 was valuable. Thank you.

19 COMMISSIONER CAMPBELL: Well, as a hospital
20 administrator, I was always taught never to admit to the
21 patient or his family that something might have happened
22 because, if you apologize, it will come home to bite you on
23 the stand.

24 And I read an interesting article -- I don't know where --
25 -- about someone with the thought that, if a physician or a

1 hospital, whoever contemplated or had made a mistake or they
2 thought they had made it or the family had thought there had
3 been a medical mistake, if they could go and sit down, I
4 guess, in some sort of a mediation type thing, that would not
5 be -- part of that decision over the apology would never be --
6 couldn't be entered into some succeeding court case, and I
7 just wondered if you had ever heard of that, and if you'd
8 given it any thought.

9 MR. SIMONS: Sure. It's the "I'm sorry" approach, and
10 increasingly, there is a protection, if you will, by various
11 states for just that sort of statement. California recently
12 enacted something a handful of years ago that tried to address
13 this and provide some protection. I think there are a handful
14 of other states. You know, at NORCAL and I'm sure probably
15 the case with Andy's company, we have come full circle and
16 actually recommend that our physicians do that in a proper way
17 because, at the end of the day, if you can, as a physician,
18 mitigate the concerns and the anxieties of the patient and
19 appear more human, then it does have an effect, potentially,
20 on the losses at the end of the day.

21 MR. FIRTH: Yeah (affirmative). I think that's right.
22 There's a national movement around state apology laws. I
23 mean, that would be something that Alaska could look at, but I
24 don't think it would make a massive difference in the context
25 of malpractice premiums. I think, even if there aren't

1 apology laws, organizations, like ours, would encourage
2 physicians to be candid about expressing remorse, not
3 admitting fault, but saying, you know, sorry this happened,
4 and we'll find out what happened, you know, what went wrong,
5 but more often than not, there isn't negligence. You just
6 don't want the expression of sympathy to be interpreted as an
7 admission of guilt.

8 COMMISSIONER ERICKSON: Jim and then Val?

9 MR. JORDAN: Just a quick comment on that, and what Neil
10 and Andy have said is spot on, but the one thing I wanted to
11 mention is that -- and I didn't in my remarks, and it was my
12 fault, my bad. And you know, we talked about this being a
13 small marketplace, very difficult to come up with
14 statistically credible data.

15 The one thing that I would caution you in moving forward
16 in your deliberations is that there are all sorts of other
17 things in addition to "I'm sorry." There is, you know,
18 concepts of medical courts, and you know, take your pick.
19 There is a whole bunch that you read about in the popular
20 press. What you need to keep in mind before you think about
21 venturing in that direction and suggesting that is that,
22 because the marketplace, it's so small, it's going to take a
23 long time to get credible feedback and credible data. So I
24 just caution you to be very careful in what you jump into. In
25 some cases, it may be better not to be first so that you go

1 into, you know, pilot programs in more populous states that
2 have more quick feedback, if you will, because of the size of
3 the marketplace and the credibility of the data. Thank you.

4 COMMISSIONER ERICKSON: Val?

5 COMMISSIONER DAVIDSON: Most people don't sue because
6 they've been wronged. Most people sue because they haven't
7 felt heard.

8 COMMISSIONER ERICKSON: So do we have any additional
9 questions for our speakers? I think not. Well, thank you
10 very, very much. Jim, and Andy, and Neil, we very much
11 appreciate you taking the time to come educate us on this
12 topic. This has been very helpful, and I'd like to ask the
13 Commission members, we're planning on not taking a break,
14 again, just as a reminder, and we actually took an additional
15 15 minutes out of our second session this morning, but we'll
16 have time later today to make some time up, too, if we need
17 to.

18 Before we get started with the next session though, I
19 just wanted to check with everyone. Do you have a sense that
20 your questions on this topic have been answered or do you have
21 additional questions, at this point, that you think will
22 require follow-up at a future meeting? Very good. David?

23 COMMISSIONER MORGAN: I can only, I mean, looking at the
24 charts, the first credo of a physician is do no harm. I think
25 we've got to be real careful about the -- you know, making a

1 problem by thinking we need to fix something that may not need
2 fixing is all.

3 COMMISSIONER ERICKSON: Very good. Well, thanks again,
4 gentleman, and thank you, Andy.

5 MR. FIRTH: Thank you. I'm (indiscernible - voice
6 lowered), and I appreciate the opportunity to speak.

7 COMMISSIONER ERICKSON: We are just taking a very short
8 break to turn on the computer and get the PowerPoints going,
9 and while we do that, I want to acknowledge and welcome that
10 Commissioner Streur has joined us in the room. And I'm just
11 getting my computer turned on.

12 While we work on this, for those of you who are on the
13 phone, hopefully, you can hear us better now than you could
14 first thing in the morning, and the PowerPoints -- we'll be
15 using two PowerPoints over the next hour-and-a-half, and both
16 of those are posted on the Commission's website on the March
17 2012 meeting page, if you want to try to follow along. And
18 for Commission members, the PowerPoints that we'll be using
19 are our Meeting Discussion Guide, which is in your front
20 packet, if you want to have a hard copy available, and Linda's
21 presentation is behind tab three in your notebook. And for
22 folks in the audience here, both of those presentations are
23 available on the back handout table as well. We lost a few of
24 our members, so maybe we'll wait just a few minutes to start
25 up here.

1 (Pause - set up presentation)

2 COMMISSIONER ERICKSON: If the Commission members could
3 come back and join us at the table from our non-break, I'd
4 appreciate it. And I -- as we get started here, I intended to
5 introduce you all first this morning, and some of you have
6 already had a chance to meet our brand new administrative
7 assistant with the Commission. Colleen Bobby, welcome. And
8 you all will have a chance to get to meet her, the Commission
9 members, over time here, and you'll be getting follow-up
10 emails from her related to any of our logistical and
11 administrative work.

12 Before we jump into Linda's presentation, I wanted to
13 just set it up a little bit and reference the area of our
14 agenda for this year that we're addressing with this because,
15 this one, we really are just getting a start.

16 One of our topics that we're considering for this year is
17 the issue of state policy barriers. Are there state laws or
18 regulations that create barriers for the provider community,
19 for the health care industry in making it harder, in some
20 ways, to be innovative, to control costs, to improve quality?
21 And so that's one of our tasks that we've set for ourselves
22 for this year is to explore that question, and we really are
23 just getting started with that conversation in this session
24 this morning.

25 And I wanted to do a couple of things. I wanted to touch

1 base with all of you to see if you have specific suggestions
2 for how we explore that question. I've talked with the heads
3 of the trade or the professional associations for three major
4 areas of the industry, with the physician community, the
5 hospitals, and the health insurers, and one of my thoughts was
6 to have -- this was bad timing for them today for a variety of
7 reasons, but one of my thoughts was to have them come to a
8 future meeting to share with us their perspective on this
9 question from the part of the industry that they represent and
10 also thinking that it might be helpful to hear from them what
11 their -- most of these organizations have a legislative policy
12 agenda that they set each year and thinking that that might
13 give us a sense of areas where they're identifying where they
14 either need some help or identifying a problem.

15 I am assuming -- and you can correct me, if I'm wrong --
16 that, as our role is to make recommendations to the Governor
17 and the Legislature and effect state policy, we're going to be
18 focused on state policy in this discussion. That's the way
19 we've described it, not on federal laws and regulations, where
20 we might have much less of an impact, but we can have a
21 conversation about that, too.

22 Let me bring up a couple of points first and then open it
23 up and see if you have any response to those -- my few
24 comments there.

25 One, as we delve in deeper into the state policy arena,

1 assuming we're not going to address the federal environment, I
2 think it's really important for this group to understand the
3 significance of the federal regulatory environment within
4 which the health industry operates because it's huge. And I
5 have just a snapshot of, essentially, a laundry list of those
6 areas of law that effect health care at the -- federal law
7 that effect health care. And also because it's so huge and
8 complex, if we stay focused on state policy, we're going to
9 need to understand and distinguish between the two as we move
10 along. If we're addressing -- start addressing a problem or
11 if someone from the industry brings up a problem, we need to
12 make sure that it's a state policy area, not federal. And
13 also to the extent that the Supremacy Clause in the U.S.
14 Constitution preempts any state law, another area and reason,
15 we will need to understand how federal law might be impacting
16 in some way, state law.

17 So those were just three points, and with deference to
18 our attorney at the table, if she would have anything to add
19 at any point to correct or enhance these very dangerous waters
20 that I'm wading in -- so I took a stab literally just off the
21 top of my head to list the areas -- specific federal laws, and
22 some were just too broad. So at the bottom of this list, for
23 those of you who are on the phone, if you're following along
24 in the discussion, the Commission's Discussion Guide
25 PowerPoint, I'm on slide three now, the Federal Regulatory

1 Environment, and I put, at the top of the list, the Patient
2 Protection & Affordable Care Act, but going on down through
3 the American Recovery & Reinvestment Act includes a whole
4 separate law, the Health Information Technology & Clinical
5 Health Act, which is where resources are appropriated and
6 direction authorities for national standards to be set related
7 to Electronic Health Records and Health Information Exchange -
8 - that's huge.

9 Just a couple of other areas -- and we might we hear a
10 little bit from Linda here just in a few minutes related to
11 ERISA, the Employee Retirement Income Security Act, which
12 limits states' ability to regulate the health insurance
13 industry to the extent that -- for self-insured plans.

14 I'm not going to list all of these in detail. I just
15 thought I'd call out a couple others. Of course, HIPAA is
16 huge, the Health Insurance Portability and Accountability Act,
17 in terms of how it impacts protected health information and
18 protection of that information, just one aspect of how it
19 impacts the industry. EMTALA, the Emergency Medical Treatment
20 and Active Labor Act, which, among other things, requires or
21 prohibits hospitals and emergency departments from turning
22 away patients who show up, regardless of their ability to pay
23 the bill.

24 And then on down through -- I'm going to skip through
25 Antitrust, which is huge. I just tried to get a sense of what

1 the issues around antitrust laws and how they impact health
2 and stumbled across, I think, it was a ten-volume, Val, set of
3 books on antitrust and health law. It was \$2,500 for -- I was
4 not going to go there -- through tax laws, labor laws, and
5 then the Medicare and Medicaid laws and they pick direct
6 reimbursement for providers in those two areas, of course, are
7 huge as well. So just again, a snapshot. We're not going to
8 spend time studying and talking about that right now.

9 And then for the State Regulatory Environment, in
10 addition to the state constitution, which Commissioner Streur
11 actually had reminded me was important to the health industry,
12 and I've got a few notes about that on our next slide. I'm on
13 slide four, for folks on the phone.

14 Linda is going to help educate us about the area around
15 insurance law. We asked her to do that specifically today. I
16 know some of you know, and it's public information, and I'm
17 still in denial myself, but we're going to take as much
18 advantage of Linda's time and expertise as possible because
19 she has announced that she'll be retiring here, and I think
20 her bosses keep pushing the date back, but in the next couple,
21 three, four months. We just keep -- we'll keep making the
22 date later, somewhere in there. So that's why we're focusing
23 on insurance law today, but public health laws, the state
24 Medicaid laws, provider licensure and certification, and
25 again, this was off the top of my head. So I could use help

1 from folks, if I'm leaving an important area of law out. I
2 didn't cite specific acts here, but just general areas of law,
3 Facility Certification, Certificate of Need, and Workers' Comp
4 and then specific provisions in our constitution, and one that
5 I understand is relatively unique to our state constitution.
6 We actually had some attorneys from Georgetown University Law
7 Center who specialize in public health law who helped us with
8 a process to modernize our state's public health laws just a
9 few years back, and maybe we can learn about that next year,
10 if we put public health as a next area of our health industry
11 to study in the coming year. They pointed out how significant
12 the Right to Privacy provision in our state constitution is
13 and how unique it is among state constitutions, so that's
14 something to keep in mind.

15 Our public health laws, public health is an area that is
16 retained by the state levels of government as opposed to
17 federal government. It's predominantly a state responsibility
18 and is noted in our state constitution as a core function of
19 state government here.

20 And then as well, the protection of the retirement
21 systems is something that's important to understand. We heard
22 from Commissioner Streur and Commissioner Hultberg at one of
23 our meetings this past year about the work that they're doing
24 and how they're starting to collaborate together on aligning
25 policies related to health and specific to Commissioner

1 Hultberg's responsibility as the administrator of the health
2 plans for state employees as well as for the state retiree
3 system. I don't know if you remember one of the details she
4 pointed out in that presentation was how limited her ability
5 is to impact the employee retirement plan, and it's because of
6 this provision in our constitution that protects the
7 retirement systems for retired state employees and employees
8 of political subdivisions in the state that are part of the
9 PERS and TRS.

10 So just -- and I took a stab at throwing up just a few
11 examples of issues that I know have been on the health
12 industry's priority list for addressing the Legislature just
13 very recently and in past years, and they run the gamut around
14 licensure and certifications. Just as one example, one that
15 would have been a little more distance history that Keith
16 tells us history lessons about periodically was the expansion
17 of the scope of practice for nurse practitioners. Would that
18 have been in the '80s, Keith, or earlier, about then? Just
19 again, as one example related to state law and licensure
20 provisions. There is some frustration on the part of
21 providers around how the background check program is working.
22 That program is being modernized right now, but that's, in
23 part, in response to a state law that was passed in 2005, I
24 believe.

25 Training requirements, I know there is a frustration

1 right now that there is a requirement -- I'm not sure if it's
2 in law or regulations -- for nurses authorized, certified to
3 train certified nurse assistants, CNAs, that they have to have
4 a level of training, themselves. That seems onerous, I think,
5 to some providers, especially in rural areas, again just as an
6 example.

7 Labor issues. Nurse overtime and hospitals. A law that
8 passed, I think, just this past year, there are usually some
9 requests related to reimbursement and Medicaid on the radar in
10 any given year. Requests for support, financial support for
11 the Legislature aren't unusual, and just, for example, around
12 construction projects, those sorts of things, special requests
13 for earmarks for -- to support facility construction, just as
14 an example. Again, I just wanted to throw those out as some
15 examples to be priming the pump a little bit as we think
16 forward to what you all want to do to explore this question
17 more this year.

18 So before we get into Linda's presentation then, does
19 anybody have any either questions or comments on my
20 introduction, any ideas, thoughts for direction you might want
21 to provide me, as we move forward with planning future
22 discussion sessions this year on the state policy barrier
23 question? Allen?

24 COMMISSIONER HIPPLER: Thank you. Thank you. I would
25 love to see an analysis of any state policies or regulatory

1 barriers or liability issues that prevent a vibrant
2 telemedicine community.

3 COMMISSIONER ERICKSON: Very good. We'll make a point of
4 focusing on that, really, in two different areas because we
5 did include, as well on our agenda for this year, use of
6 telecommunications technologies to support access to care, but
7 we'll make sure that we're paying attention to that question
8 in both of those areas, the state policy barrier area and our
9 telemedicine/telehealth discussions.

10 COMMISSIONER CAMPBELL: Along with that, I don't -- I
11 think it's probably a barrier in telemedicine if you go
12 outside the state for medical advice and that person may not
13 be licensed in this state. Somebody who knows more about
14 licensure than I do, at this point in time, could -- but that
15 should be clarified, I think, because that, in years past, has
16 been a major barrier. As long as you're licensing the state
17 on the telephone, that's fine -- or telemedicine, but
18 (indiscernible - voice lowered) U-Dub or someplace, it might
19 be a barrier (indiscernible - voice lowered).

20 COMMISSIONER ERICKSON: I will make sure that that
21 question is on our list as well. Thank you. Any other
22 comments, questions, or ideas?

23 Hearing none, let's move into Linda's presentation.
24 Again for folks on the phone, this presentation, the Health
25 Care Insurance Rate Review is the title. That is available on

1 the Commission's website on our meeting page, if you want to
2 try to follow along.

3 COMMISSIONER HALL: I will try to speak as close to the
4 mic as possible, although now I'm sounding like a frog. I
5 apologize. I've been a frog, on and off, for the last month.
6 So it comes and goes.

7 Deb and Ward asked me to do some talking about rate
8 review in Alaska. I cannot promise you that this is any
9 riveting topic, but it is important for, I think, this group
10 to have some understanding. The presentation is one I did, I
11 don't know, two or three weeks ago for the health subgroup of
12 Commonwealth North, and Deb and Ward found it interesting and
13 asked me to do it again. So you can blame them, if it's not.
14 How about we start with that? I find it very difficult to
15 make rate review particularly exciting, but if you can go to
16 the next slide.

17 Just a little discussion outline of my intent of what
18 I'll cover today. Certainly, some of the Affordable Care Act
19 impact on our rate review, I think that's been a lot of news.
20 I will, hopefully, be able to explain to you how that really
21 impacts what we do on our state as opposed to some general
22 terms that you read in the media. Our rate regulations, the -
23 - I'm going to talk some about market shares, pending health
24 rate filings, one of Jeff's we'll talk about, critical drivers
25 of health rate increases, and then some things that do deal

1 with the Affordable Care Act and what we'll be able to do
2 after 2014 for risk adjustment, things called risk corridors
3 and reinsurance, and I'll try not to be technical.

4 The next slide is one that I use with some regularity.
5 Rep Keller will recognize it. It actually was done by my
6 actuary at the request of a legislator when I was talking
7 about this topic, and someone asked me, can't you give us a
8 visual? And that was probably four or five years ago, and
9 this has become known as Linda's famous pie chart, and we use
10 it quite regularly to demonstrate, when we talk about health
11 insurance and regulation, what part of the marketplace we
12 really regulate. And you can see the little colors. The
13 yellow 15% is really our private marketplace. This is the
14 part that our state statutes impact. It's the part we have
15 oversight authority for.

16 Deb mentioned, in her presentation, some of the federal
17 laws that preempt us from regulating the 34% self-insured.
18 Those are ERISA plans, self-insured plans that are covered
19 under the federal law. Walmart is self-insured. Alaska
20 Airlines is self-insured. Any large employer is self-insured
21 for their health insurance, and we have no oversight
22 authority. Moreover, when we pass state laws, it does not
23 impact that group. So where my pie chart comes in is, when we
24 talk about mandates, who do they apply to? They only apply to
25 that little yellow slice of the pie, and it's taken some time

1 and my educational efforts to make sure people understand when
2 we're passing laws to mandate anything, whether it's
3 notification coverage mandates, whatever it may be, it doesn't
4 impact the majority of the Alaska population.

5 These statistics are probably from late 2010. We've
6 updated these a couple times, but I thought it was important
7 for you to understand the actual marketplace that is regulated
8 by the state, and it, in fact, is pretty small. Certainly,
9 Medicaid has regulation in the state and that's done under a
10 totally different set of laws, but you can recognize the rest
11 of those and understand, but it's just a visual that kind of
12 sets the framework for what I'm going to talk about.

13 The next information, I'll talk a little about the
14 Affordable Care Act impact on health rate review. In order
15 for a state to make a determination that a rate is reasonable
16 or not, the state has to have an effective rate review
17 program. HHS evaluated all the states and their rate review
18 programs probably about a year ago and determined whether or
19 not we had an effective rate review program. If we did not,
20 in the state, have such a program, we weren't deemed to have
21 an effective rate program, then they would do the evaluation
22 of the particular rate. If a rate is deemed unreasonable, HHS
23 will post that information for consumers. HHS has no real
24 teeth in terms of rate review. That posting on their website
25 is their punishment. They have no authority to disapprove a

1 rate. Most states do today, but the federal government does
2 not. Even though they may be the one who deems a rate
3 unreasonable, they can't tell an insurance company you can't
4 use that rate. So it's really a rather bizarre system. I
5 guess I would say some of what I see when we talk about, you
6 know, look at all these unreasonable rates and we'll save
7 money is kind of hype because, if they're really unreasonable
8 rates, the federal government cannot say don't use that rate.
9 They don't have any disapproval. They can pressure states to
10 disapprove those rates, but that rate regulation still rests
11 with the state.

12 Effective rate review program requires a number of
13 things, and I've listed them here. I'm not going to read them
14 for you, but we will echo these things when we talk about what
15 we've done in our rate regulations. We have regulations that
16 implement a statutory change that was effective January 1, but
17 these are the things that we need to really look at a rate.
18 It's a complicated process. I have an actuary on staff, and
19 we review the various kinds of things that -- it also tells
20 you what we have to do. We have to post a link on HHS that
21 shows what the company does, for starters, and Jeff can
22 probably talk about this as well as I can, but I'm going to
23 give you a couple examples in a minute about what happens with
24 the rate.

25 We also, for the first time, have to have a mechanism for

1 public comment, and we do that on our own website, and we link
2 to the healthcare.gov website, actually. There is a lot of
3 information that the insurance companies post. There is a
4 place for consumer input, and ultimately, we have to report
5 the results of our rate review. Once we say yes or no to a
6 rate, we do have to report that to HHS. So there are some new
7 steps for us.

8 As I indicated, HHS determined that Alaska had an
9 effective rate review program as of January 1 of this year.
10 In the preceding year in 2011, part of an insurance bill that
11 was passed by the Legislature did contain the provisions that
12 we would have prior rate approval for all insurance rates. Up
13 until then, we only had the ability to do prior approval of
14 rates for hospital and medical service corporations. It's a
15 specific type of entity. Premera Blue Cross happens to be the
16 -- really example we have in our state of a hospital medical
17 service corporation. So the only rates that we actually took
18 in, reviewed, and said yes or no were Premera Blue Cross. We
19 now have that ability for all insurers writing health
20 insurance in our state. So that is what gave us full
21 effective rate review program status.

22 This next step is something you've probably heard a
23 significant amount about, Medical Loss Ratio. It's been
24 debated nationally by the National Association of Insurance
25 Commissioners, who made the recommendation to HHS about the

1 components of a Medical Loss Ratio. It is probably a
2 requirement that is driving some smaller carriers who have
3 smaller books of individual health insurance out of business.
4 We've already had one such company tell us they are no longer
5 going to write individual coverage in our state, and I will
6 talk about that in a minute.

7 But the Medical Loss Ratio really means that 80% of the
8 premium money must be paid toward claims as defined in the
9 Act. Claims are -- and you've got a little formula there.
10 Claims are defined as claims, reserves for those claims, and
11 quality improvement. Quality improvement was highly debated.
12 We all can pretty much figure out what a claim is. I broke my
13 leg; it's a claim when somebody fixes it. But quality
14 improvement and what should we include were things -- there
15 were certain things, such as follow-up, that you come back for
16 your follow-up care. We've talked about that here, the
17 importance of taking all of your prescription. If you get a
18 prescription for ten days, you may get a call from the
19 doctor's office. Some of those things were actually included
20 in the fairly lengthy list of quality care. Some things were
21 denied. There is a -- I can't remember now. It was a --
22 there is a new database, SC9. Is that what -- you know what
23 I'm talking -- ID9. ICD9 or 10. It's very expensive for
24 insurers to convert. It was a big thing at the time. It's
25 amazing how fast I forget all this stuff. It was a very -- it

1 was expensive for insurers to convert data. They wanted that
2 as part of the quality improvement; that was not added. So
3 there were a variety of things in this area. Agent
4 commissions was another piece. There has been a lot of talk
5 about insurance agents' commissions, where they fit, whether
6 they will continue, really, to be able to survive with this
7 kind of formula and their commissions being part of the 20%
8 that goes for expenses.

9 The bottom line of this formula is earned premium. So
10 you're really dividing claims by premium and have a ratio, so
11 that, you know -- and we've defined all the terms. They're a
12 several sheet page -- there is a several sheet report that
13 insurers will do to put their expenses, their premium, the
14 various components to this calculation. If you don't hit this
15 80% and you're selling individual or small group policies, you
16 have to make -- pay rebates to consumers. Very expensive
17 proposition for an insurer, not only the cost of the rebate,
18 but the calculation, the -- just the whole administration of
19 paying that rebate.

20 I was at a meeting this week where HHS announced that,
21 not only would the insurer have to send a letter to the
22 consumer with the rebate explaining why they were getting it,
23 apparently, they're going to require the insurers to send the
24 letter of why you're not going to get a rebate. I didn't know
25 if you'd heard that, Jeff.

1 Again, we're talking some very significant expense to do
2 this, but that was something that came out of the meeting that
3 I heard this week with the HHS people. So this is a big deal.
4 There is a waiver period between now and January 1 of 2014
5 where various states have applied for waivers to allow their
6 companies to transition into this 80%. Many states have 65%
7 as the Medical Loss Ratio required in their state. So going
8 from 65% to 80% is a big change. So as I said, Medical Loss
9 Ratio is a very large component of the change in health
10 insurance and rates.

11 Now the second piece is, right now, we have a 10%
12 threshold for rate increase. That was set nationally as a
13 standard and that is the threshold at which an insurer must
14 put their rate justification on the healthcare.gov website and
15 go through -- and it's really an interesting exercise to go to
16 that website and look at it isn't really a rate filing. It's
17 actually done in English where you can understand it. There
18 are even Q&As. The threshold will become state-specific
19 sometime soon. States will have the opportunity to justify
20 why 10% isn't where their threshold should be, but this was
21 the preliminary threshold set up by HHS. I would imagine that
22 we will be looking to make ours a little bit higher. Most of
23 our rates are higher than the national averages, and we may
24 well want a threshold that's a little higher than that.

25 Continuing, beginning on 1/1/2012, all insurers writing

1 health care insurance must file their rates with the Division
2 and they must implement the regulation.

3 The second bullet point is very important to me, that you
4 understand. This is a rate standard that has been in our
5 statute for a number of years for all lines of business. This
6 is our bottom line of, when we do rate review, what we look
7 for. The rate cannot be excessive. It can't be inadequate,
8 and it can't be unfairly discriminatory, but we're looking
9 both at excessive, which you understand clearly, but
10 inadequate is also important, and we have an obligation to
11 make sure a rate is adequate to pay claims.

12 One of primary missions is to ensure the solvency of the
13 companies who write business in our state, and to do that, we
14 do financial examinations, but we also do rate review, looking
15 at what is needed. An insurance policy is a contract. It's a
16 piece of paper, and it doesn't mean anything until you have a
17 claim. And when you have a claim, as the regulator of that
18 marketplace, I want there to be money to pay that claim. So
19 if we demand that an insurer write business at a rate that is
20 lower than needed to pay claims, then we are jeopardizing
21 financial solvency, or at least, financial stability. So we
22 don't want excessive. We don't want excessive profits, but we
23 also don't want inadequate.

24 Now what we look at to determine those things may be
25 different. I mean, it's very complicated at times. We, as I

1 said, have an actuary on staff, and I am going to talk about
2 some of the things that we do look at, but it's important to
3 see this overall standard, and it applies to all rates. So
4 when we look at rates or even when we have a complaint, this
5 is the standard that we use. The unfairly discriminatory part
6 -- it seems a little strange as part of a rate standard --
7 really ensures that risks of like characteristics are treated
8 the same, so you don't get treated differently because you're
9 wearing a blue shirt and Rep Keller has an orange shirt. I
10 told him today it looked like he dressed to match the room.
11 You know, we don't do things based on those kinds of
12 characteristics. We're looking at characteristics that are
13 about the kind of condition you're in. So it's part of a rate
14 standard. We don't want discriminatory rates.

15 There is, here again, some kinds of some of the standards
16 that we set in our regulation. We have standards for the
17 actuaries, and we have -- we require descriptions of rating
18 formula and corresponding assumptions. That part sounds
19 simple. It's probably the most comprehensive piece of what we
20 look at. We have -- an insurance company has to file a
21 methodology and their actuarial justification. We talk about
22 various things.

23 I want to talk a little about cost and utilization trend
24 analysis. That's really -- when you're doing a rate for
25 insurance, you're basing that rate on historical cost, and

1 really, this is for any kind of insurance. What we use -- the
2 primary piece you start with is cost. What were your claims
3 in the past? And we'll get -- you can see, down at the
4 bottom, we're using four years' worth of claims data in the
5 health insurance arena. We use different amounts of
6 background claims history for different kinds of insurance,
7 but we're going to look at that cost, but that's what it cost
8 in the past. And where we go, where the assumptions come in,
9 where trend comes in is, how do we make that rate apply to
10 what you're going to pay in the next year? That's where
11 assumptions, utilization trend analysis, cost trends, those
12 are the types of assumptions and methodologies that go into
13 rate making that insurers present to us. They have an
14 actuarial staff, and we have an actuarial staff. Sometimes,
15 we have dueling actuaries. We have one public rate hearing
16 for Worker's Compensation rates, which really is a dueling
17 actuary presentation. It's kind of interesting to watch, but
18 we do these types of trending to try to make this rate we have
19 approved today really fit what the insurer is going to pay
20 over the -- not the next 12 months because you have to have it
21 here, but it usually is for a 12-month period.

22 We look at target loss ratios, the enrollee risk profile.
23 Do we have a group of people who have particular illnesses?
24 We estimate trend. We look at, are you going to have to pay a
25 rebate? All of those things impact cost.

1 Rate revisions, these are things that they have to file
2 with us. What kind of rate revisions have you done for the
3 past four years? What are your premiums, your claims,
4 individuals? It's very detailed analysis.

5 This will give you an idea of our market share by
6 company. This is our individual market. We survey our market
7 every year, and these little graphs are a little hard. The
8 colors are kind of similar. I think we can see the 70% that
9 Premera has. Golden Rule has a little asterisk by it. They
10 have indicated to us they will no longer be writing in the
11 individual market in Alaska, probably as of, I believe it's
12 August. But those are companies that -- but it also gives you
13 an idea that we do have a number of companies who write
14 individual coverage.

15 When we talk about the medical malpractice and we talk
16 about two companies, it makes me nervous. I'd rather see
17 this. Golden Rule is leaving our market. We are getting lots
18 of consumer calls. Where do I go for coverage now? I've
19 gotten calls from legislators or more like I've been button-
20 holed in the hall of the Legislature. I have a constituent
21 with a pre-existing condition; what can they do? Their
22 company is no longer writing. Difficult situation. My --
23 there is only one place, one answer and that will be ACHIA,
24 with a pre-existing condition. I can't -- none of the other
25 companies -- they need to be declined, but they really don't

1 have any option.

2 The next slide shows us our small group market, and as
3 you can see, the premium volume \$111 million, and we have a
4 little different combination of companies who write in the
5 small group market. Again, however, we do have several
6 companies. We have a gorilla in the marketplace, I would call
7 Jeff at times. A gorilla in -- yes. You do have to remember
8 that. You know, we are talking this percentage, but it's this
9 percentage of only 15% that's really the private market, which
10 is why I started with that overview. So when you look at
11 health insurance providers overall, this 74% is really of the
12 15%. So keep that in mind.

13 Large group. Large group is predominately self-insured,
14 but we do have some large group written as traditional
15 insurance. And again, we have different providers who may
16 work in this marketplace.

17 The next thing I want to talk about are pending filings,
18 so you get a little idea of how rate filings are being done
19 under some of the new federal laws. ODS is a small group
20 writer, and in October before our rate review authority was
21 effective, they had a rate filing, which they had to make with
22 HHS because we -- our filing didn't become effective. So HHS
23 will be making a determination and have made it since these
24 slides were prepared. If I had been more efficient, I would
25 have updated them, but I was out of state so I didn't.

1 ODS filed a 25.98% rate increase, and HHS has
2 subsequently determined that that was not unreasonable. I'm
3 not sure what option they had, but they did make that review.
4 I don't know that it says much that they say it's not
5 unreasonable because they can't disapprove it. So I kind of
6 started out with that. They really don't have any teeth to do
7 anything, but this is a quote out of their filing.

8 "The primary driver of this premium increase is a high
9 level of medical services that our Alaskan members are
10 consuming." So it goes on with some statistics that are
11 interesting; 29 members account for \$4.7 million out of the
12 \$10 million. 29 out of 3,100 -- yeah (affirmative). It's
13 interesting to -- these are the kinds of statistics, they're
14 anecdotal to a great extent, but it's very telling, and I
15 think the kinds of situations we've talked about in this group
16 and where can we make an impact, I would have to assume those
17 claims are the kind of claims we see in ICHIA. They're
18 diabetes. They're heart conditions. They're things that may
19 well be able to be treated by a different type of care, but I
20 just felt that that was a very interesting statistic to share.

21 The next filing we've had since this rate review went
22 into effect was the Premera individual filing. This was filed
23 on January 17th, so it was the first rate filing under our new
24 rate laws. They've changed for all companies, including the
25 hospital and medical service corporations. Premera requested

1 a 12.5% rate increase, and again, I've included some of the
2 significant increases that they've indicated, costs associated
3 with medical professional services for inpatient hospital
4 stays, outpatient advanced imaging, physician services for
5 emergency room visits. I mean, these are cost drivers that
6 we're seeing. These were part of that 12.5% rate increase,
7 which was also approved. It is public because it has been
8 approved at this point.

9 Those are examples for you. If you go on healthcare.gov,
10 click Alaska, you can actually look at these filings, the
11 information about them. There are some really good
12 descriptions that, I think, have been made consumer-friendly.
13 It's a much more transparent process than it used to be. I
14 think it's worth consumers looking at, getting a better feel
15 for -- or you, as consumers and members of the Commission, to
16 get a feel for where we are and how these rates are done. I'm
17 going with the next one.

18 These are the things that we see as the primary drivers
19 of rate increase. Provider payment level, certainly, is
20 probably number one. Increasing cost in utilization of health
21 care services, including expensive new technologies and drugs,
22 we see that -- we're seeing -- and I know the Milliman study
23 didn't see Alaska as having significantly different
24 utilization rates than the rest of the country, but whether
25 it's different or not, they're certainly increasing. We see

1 an increase in utilization that -- when you combine costs and
2 utilization. If cost goes up, utilization doesn't necessarily
3 have to go up, but still, the per visit charge is going up.
4 We see utilization of certain services going up. We see the
5 drugs -- pharmaceuticals are -- have increased enough. They
6 are a noticeable piece of what we look at, increased.
7 Emergency transportation services are expensive. Those have
8 become a significant portion of the cost of medical services.
9 When it becomes a factor in a rate filing with us, we begin to
10 see those kinds of things and that is a factor, and you've all
11 heard me say it, and I need to get it in one more time that
12 these same cost drivers impact Worker's Compensation rates.
13 They're paid, as you are aware, at a different level. Benefit
14 levels impact rate increases. Obviously if you had more
15 benefits, you had more cost and that may or may not be a
16 mandate, but it is -- benefit levels can be designed by
17 employers, and they sometimes try to design a plan to reduce
18 their costs.

19 I am very concerned when we ultimately have a definition
20 of essential benefits under the new health care law. Those
21 essential benefits will determine cost, and we will, as a
22 state, be able to define our essential benefits, but there are
23 certainly guidelines to doing that. I think the Feds gave it
24 to us because they didn't want to do it, really, but it is
25 going to be a chore to design those essential benefit

1 packages.

2 The enrollee risk profiles, you know, what do we have?
3 Age, gender, health conditions. There will not be a lot of
4 factors that can be used in rate making after 2014.

5 The next slide starts with 2014, the risk adjustment.
6 There will be an allowance of payments to health insurers
7 based on the at-risk -- the health of their at-risk
8 populations, and there are a variety of mechanisms that, I
9 don't think, are totally defined yet. We don't know how
10 they'll work or not work, as the case may be, but there are
11 only three factors that will be able to be used: age, and
12 there are limits of the ratios; tobacco status; location and
13 family size. That's what you can use to vary a premium, not
14 much. Jeff is over here shaking his head.

15 The risk adjustment factor, again which is not defined
16 yet very well, will ensure health insurers are compensated for
17 the risks they enroll.

18 And moving on, this is an example, and this is not
19 particularly my area of expertise so bear with me. I can
20 pronounce algorithm, but that's about as far as I go.

21 The risk assessment will determine if the individual or
22 the small group being insured represents an average risk or
23 the deviation from the average risk. There will be weighting,
24 and this is an example of a risk weight. If the group -- I
25 think this is an individual. You can weight various factors.

1 You're 32 with diabetes and asthma and some type of low cost
2 dermatology needs, this risk is weighted at 2.8. And in
3 theory, the insurer -- which is on the next page -- will be
4 compensated somehow for that. You've got a higher than
5 average enrollee in your plan. They're really trying to
6 encourage insurers to compete on efficiency and quality, not
7 on the ability to select risk. You really can't select risk
8 anymore. There are no pre-existing conditions. Consequently,
9 they're trying to protect financial soundness via risk-based
10 capital requirements. States will assess charges to plans
11 with lower risk and provide payments to plans with higher
12 risk. We have no idea how that's going to happen. This is a
13 whole new venture and determine -- we're going to charged
14 Jeff's company because they got a better than average risk and
15 then we're going to take that money we charged them, I guess -
16 - this is how I think it's supposed to work -- and then we'll
17 pay that to ODS because they got the short stick. They got
18 the higher risk individuals. I'm truly not sure how that will
19 ever work.

20 The risk corridors are also in the first three years of
21 Exchange operations. The insurer pays HHS if their claims are
22 less than 97% of the target loss ratio. HSS pays the insurer
23 if their claims are greater than 103% of the target ratio. So
24 we have two entities here paying and taking money from
25 insurers to balance each other. It's a whole different kind

1 of marketplace.

2 If plans lose money, HHS has to make up the difference.
3 Of course, that assumes that there is money for them to do
4 that with. Companies may intentionally set rates low to gain
5 market share. I'm skeptical; can you tell?

6 There are no -- the rules have not yet been released, as
7 far as I know, for some of these programs and how they'll
8 operate. So right now, you're getting what I know about them,
9 which is not a lot. We also will have a reinsurance
10 mechanism. This is something that, I think, has a potential
11 to work in our state. We used to have a reinsurance
12 mechanism. Nobody used it. It was expensive, and none of our
13 insurers used it. So we took it out of statute four years ago
14 maybe. Something like that. We may have to put it back in.

15 There will be a state non-profit entity to administer
16 this reinsurance program to compensate insurers when
17 individual losses exceed certain thresholds. It really is
18 like a mechanism we had in force earlier that just was not
19 utilized. Insurers would make annual payments to the non-
20 profit entity to fund the program, and a pool of \$20 billion
21 is to be paid out from 2014 to 2016. I doubt that our share
22 is very great of that \$20 billion. If it's like the high risk
23 pool, we -- as a small state, we get small shares of those
24 large pots of money, which is reasonable.

25 I have ended with a slide with lots of reference

1 material. There is a lot of material here. Some of it I
2 can't explain very well. I will tell you my staff did this
3 presentation and probably can explain this better than I do,
4 but none of us really know where some of these issues will end
5 up because the final rules have not been promulgated. I'm
6 very comfortable with the rate review programs. We've been
7 doing rate review for a long time.

8 There was some criticism of me and my Division for not
9 taking the rate review grants that were offered by the federal
10 government. We're a small state. At the time, we had one
11 company for which we did rate review. You just saw the number
12 of companies we have in total. I have a credentialed actuary
13 on staff who is very good. I didn't know what I was going to
14 do with a million dollars. I mean, I watched you when the
15 million grants came out. You had to take a million. You
16 couldn't take less. I heard one of my counterparts on a phone
17 call with HHS -- well, we have 600 -- and this will get rough
18 -- \$650 million worth of projects we could do. I mean,
19 \$650,000; I'm sorry. Good. Thank you for doing that. Is
20 that acceptable? No. You have to apply for the full million.
21 So the program itself, ultimately, that did change, but we did
22 not see anything that we would do differently than we already
23 do. We now have statutes and regulations in place that
24 require certain types of filings be made with us. We have an
25 actuary who reviews them. We have a staff of five in our Life

1 and Health Department who review filings, and I think the fact
2 that we're deemed to have an effective rate program by HHS was
3 the indication that we do have the capacity and the expertise
4 to make adequate rate filings. So with that, I will stop and
5 answer questions, hopefully. Ward?

6 CHAIR HURLBURT: I have two questions, and they're based
7 on the presumption that, looking at your pie charts of market
8 share, those dollars amounts represent gross premium revenue
9 for those three lines.

10 COMMISSIONER HALL: Those dollar amounts at the top,
11 that's correct.

12 CHAIR HURLBURT: So it's about \$384 million. The first
13 question is, to put that into context, how much of that is the
14 responsibility that you carry in your office? In other words,
15 we just -- we only talked to you about health insurance, but
16 there is other kinds of insurance. So how big a segment is
17 that? And secondly, if I look at that \$384 million in gross
18 premium revenue for 15% of the lives in the state, that's only
19 5% of the \$7.5 billion that Mark told us is spent on health
20 care in this state. I don't know if you've looked at that or
21 if you have any thought as to, am I missing something or why
22 is there a disparity between 5% and 15%?

23 COMMISSIONER HALL: I'm not sure I understand what you're
24 asking.

25 CHAIR HURLBURT: The \$384 million is 5% of the \$7.5

1 billion a year that Mark Foster has told us is spent for
2 health care, but that represents, in your first pie chart, 15%
3 of the lives of the state. Now there would be some amounts of
4 co-pays, deductibles, and co-insurances there, but that would
5 total out to be roughly smaller than what would be the health
6 plan's share of the cost, I would think.

7 COMMISSIONER HALL: The only explanation I would have is
8 that, in the public programs, the self-insured programs are
9 certainly going to, but I don't know why there is the
10 difference. I don't know what Mark used to come up with that
11 figure. I know what we collect in premium because we collect
12 premium taxes on it. So I mean, our premium is -- I am pretty
13 comfortable that's what it is, and I can't explain that
14 difference, Ward.

15 The first part of your question asked the overall premium
16 that we're responsible for, and I don't have a figure, but
17 it's in the billions. I'll tell you we collect a 2.7% premium
18 tax and that generates about \$50 million in revenue, which is
19 usually very surprising to people that we do generate -- and
20 that is not -- we also generate another \$10 million in fees
21 that we're a receipts-based agency. So we don't use General
22 Fund premium tax dollars and so the \$50 million is only 2.7%
23 of the total premium, and I'm sorry I don't have that off the
24 top of my head. We do several lines of business
25 (indiscernible - voice lowered), you know, a large one. We're

1 comp premium tax funds, a division of Work Comp, so this is
2 small compared to.....

3 CHAIR HURLBURT: Yes. It's less -- about 20% or less of
4 the total premium for all these insurance plans. Is it more
5 work for you than 20%? I'm just trying to get a sense. Is
6 this particularly challenging compared to other kinds of
7 insurance, life insurance, property and casualty or not?

8 COMMISSIONER HALL: No. I think it's not. It was
9 something that we -- when we had the -- passed the legislation
10 to take the rate review responsibility for all the companies,
11 we did not have a fiscal note for that because it was
12 something we could absorb in the day-to-day work that we do.
13 With the staff that we already have, we felt we had sufficient
14 resources. So it is a small -- it's certainly well less than
15 20% of the premium rates that we review. So it's not a
16 significant effort on our part.

17 COMMISSIONER DAVIDSON: So what about preparing for
18 exchanges? So either the possibility of having state
19 exchanges in which people can purchase insurance or we're not
20 going to be ready and we're going to have a federal exchange,
21 how does that intersect with your office?

22 COMMISSIONER HALL: I think there -- I mean, certainly,
23 my office will have a role in any kind of exchange because the
24 companies who do business in exchange have to be licensed by
25 us. The policy forms have to be approved by us. I mean, we

1 will have a role.

2 Today, there is a contractor who is working -- a vendor -
3 - on making recommendations for what this state should do
4 toward an exchange. I don't think -- it's not just sitting
5 there. Commissioner Streur is in the audience, and he's
6 shaking his head no at me. Josh Applebee is the staff on HHS
7 who is the policy person right now for where we are with the
8 exchange development, and I think it would be -- he can far
9 better describe state efforts than I can, but there are things
10 going on, Val. I don't think we're -- it's not like we're
11 ignoring the exchange and we'll fall into having a federal
12 exchange, but it's an internal work right now with internal
13 resources, and I think it might be good to have Josh come in
14 and make a presentation to the group.

15 COMMISSIONER ERICKSON: Wes?

16 COMMISSIONER KELLER: I can't help myself. This is a bit
17 of a comment, but I'm trying to solicit some more comments
18 maybe from Linda. But your famous pie chart, I have become
19 intimately familiar with it, and I want to explain why.

20 I would guess -- I was just sitting here thinking. I
21 think about half of the advocacy I get in a Legislature is to
22 put a mandate on that 15%, and when I get into a discussion
23 with some of these advocates, many of whom are -- I'm not
24 going to say representing the Department of Health and Human
25 Services, but many of them come and are working closely there

1 -- they say -- they tell me that, if we can just make the 15%
2 pay, then the rest of the system will fall into line and make
3 payment on this needed coverage, whatever it may be. And I
4 just wanted to put that clearly on the record. It's just
5 fascinating, to me, that that happens, and the reason, of
6 course, is that the Legislature has no jurisdiction over the
7 self-insured, of course, over Medicare or whatever, you know.
8 There's no direct handle there. So it's pretty well
9 understood, you know, by many -- and I'm going somewhere here,
10 and this is where I'm soliciting your comment. When we start
11 to go into the area where -- this is very significant in
12 controlling costs. That's why I'm bringing it up. When we go
13 into the area of using medical insurance to cover behavioral
14 health issues, that is an extremely hot topic nationwide. I'm
15 sure that's not news to anybody here, but you can see where
16 it's the same issue. In other words, some of the advocacy has
17 to do with trying to get the private sector medical insurance
18 to cover things that are either on the horizon because of
19 PPACA or just nice things that we maybe should do as society,
20 you know, but this is the driver, and I just want everybody on
21 the Commission to understand or get a glimpse anyway of the
22 level of pressure there is on that very item.

23 COMMISSIONER HALL: And you're looking for a comment from
24 me?

25 COMMISSIONER KELLER: Specifically on the behavioral

1 health coverage, and I know that's almost a sacrilege to bring
2 it up, but I was wondering if you would dare. You're leaving
3 anyway, right?

4 COMMISSIONER HALL: So I can say whatever I want? I'm
5 still quite restrained. I've never -- yeah (affirmative).
6 I've never been restrained, so that doesn't matter whether I'm
7 leaving or not.

8 We have adopted some mental health parity laws. I guess
9 I'm going to attack what you just said in a different way.
10 Not attack you. I thought you thought might go there. I do
11 agree that sometimes some of the mandates that are adopted are
12 then adopted by some groups, not necessarily the large
13 employer self-insureds, which is the biggest chunk of that pie
14 chart. The State may adopt them. Some of the union health
15 trusts may adopt them. Medicare certainly doesn't adopt them.
16 I -- self-insureds do not. It's probably what I look at and
17 see creating a gap between small employers and large
18 employers, and we continually put a burden on small employers.
19 It may only cost 1% or a half-a-percent or whatever it costs
20 because we never know for sure, and even with the -- there is
21 a huge mandate bill right now, and there is great debate, and
22 we've tried to do research to see what does it really cost.
23 But when you start putting that additional burden on small
24 employers and it's not a level playing field with large
25 employers, I think that creates another group of people who

1 drop insurance coverage and then we have that white piece
2 that's uninsured that becomes larger and larger.

3 The other thing I think we need to be aware of with
4 mandates -- what did I hear? I was in Louisiana earlier this
5 week. They have, like, 42 or 46 mandates. I think we have
6 14. I mean, we have a low number of mandates. But if states
7 have mandates and keep mandates on the books that are not part
8 of the essential benefits plans, those states will be forced
9 to pay for those mandates, not the individual that gets the
10 policy with the mandate, but the state. I don't know how that
11 would work either, but that is part of the federal law. I
12 mean, there are other issues, to me, with mandates right now,
13 and adding more mandates is that we might end up paying for
14 them.

15 COMMISSIONER ERICKSON: Can -- I just wanted to follow-up
16 on that a little bit and follow-up on Val's question, too. Do
17 you have a sense of, since the State's going to be responsible
18 for defining the details of what will, within the confines of
19 the federal law, constitute the essential health benefits
20 package, what do you think the Division of Insurance's role in
21 defining the essential health benefits package for the
22 Insurance Exchange will be, do you have a sense?

23 COMMISSIONER HALL: Well, I think we'll -- I guess I
24 would hope that we would have a fairly large role in that,
25 since we're the ones that look at forms and know what is out

1 there. Most of the guidelines are pointing in the direction
2 of taking what is in -- the benefits that are in the -- like
3 the packages that the three largest insurers already write.
4 So it would be something that's already in place and that's
5 one of the things that is allowed under the federal law is to
6 take, in your individual markets, your small group, and your
7 large group, the benefits that are in their packages and that
8 becomes your essential benefits. It's something that's really
9 already in place, so it wouldn't be a huge change.

10 COMMISSIONER CAMPBELL: Will the central benefits be
11 regulation-only or does the Legislature have to weigh in on
12 that?

13 COMMISSIONER HALL: I can't answer that, Keith. I don't
14 know. I'll leave it at that.

15 COMMISSIONER ERICKSON: Allen?

16 COMMISSIONER HIPPLER: I'm looking at your PPACA risk
17 adjustment window talking about the only factors that
18 actuaries can consider as age, tobacco status, location and
19 family size. That is -- that's a federal deal, and the State
20 has no authority. We can't give them more factors to
21 consider?

22 COMMISSIONER HALL: That's true.

23 COMMISSIONER HIPPLER: Are you even going to need
24 actuaries?

25 (Pause)

1 COMMISSIONER ERICKSON: Jeff and then Keith?

2 COMMISSIONER DAVIS: So as the only entity that was
3 subject to rate review up until January 1st, I'd just like to
4 compliment Director Hall and the staff at the Division for
5 their professionalism and the amazing job they've done as a
6 regulator in applying the standard that Director Hall so
7 eloquently laid out. This is a dual role; protect the
8 consumer, but you can't protect the consumer if you don't have
9 a viable market, and to walk that line, they have done
10 admirably. We work in three markets, and there is no other
11 market that we work in that has this kind of professional,
12 open dialogue relationship, and we certainly appreciate it and
13 appreciate Director Hall for her leadership in creating that
14 environment. Thank you.

15 COMMISSIONER CAMPBELL: I'm having a tough time, and it's
16 probably going to take some time to get my mind around what
17 the new insurance industry, health insurance industry is going
18 to look like. I mean, it's -- I thought I understood the old
19 one, but this one, I am having a real tough time with. So any
20 information we can gather as it comes available, we need to
21 stay on top of it. Thanks.

22 COMMISSIONER HALL: I think you could tell, by my
23 presentation, that we're having a difficult time with that.
24 We get a lot of guidance from HHS on areas, and I'll give you
25 an example. We're in a period right now of silence. They are

1 not releasing anything new. They're cancelling -- we have
2 weekly calls that are regulators and HHS. They've cancelled
3 the last two weeks, which means they don't want to answer any
4 questions. It's a very difficult environment. So we get
5 these kinds of pieces, but until they issue guidance, the
6 guidance may not look like the actual law. That's one of the
7 problems we have. There is a great deal of interpretation.
8 And so when we don't have the guidance pieces yet, we really
9 don't know how they're going to be interpreted, and it is very
10 difficult to anticipate what pieces are going to be required
11 going forward, and I think I don't understand all of it. And
12 I spend a lot of time reading and looking at it, and I have a
13 very qualified staff, and they read and talk to me, but I
14 don't think any of us -- and as I said, I just came back from
15 a meeting of my colleagues around the country, and there are
16 huge unanswered questions.

17 COMMISSIONER ERICKSON: Ward?

18 CHAIR HURLBURT: Let me go back to my other question and
19 combine your comment, Linda, and Wes' and maybe direct the
20 question at Jeff. The \$384 million in gross premium revenue
21 for health insurance for the 15% of the population translates
22 to 5% of the total health care expenditures using Mark
23 Foster's figures. Now if a health insurer is going to do
24 their job, they should be able to manage costs, including
25 their administrative charges, to less than they might be

1 without their value added, but not that kind of disparity with
2 15% of the population that, you know, arguably, might be a
3 healthy 15%, but it just seems like such a gross disparity
4 because, as we look for leverage or as you get pressure, why
5 if you could just fix this, then we can fix the other 85%,
6 well, now we're talking about the other 95%. So in helping us
7 to understand the levers, do you have any thoughts, Jeff, of
8 what's the difference between \$384 million, which is 5%, and
9 15% of the lives? Does it make any sense?

10 COMMISSIONER HALL: Let me back up with the question.
11 We're talking two different things, premium versus health
12 expense. So you're really talking -- which could make it
13 worse, in some ways, but you are really talking two different
14 things.

15 COMMISSIONER ERICKSON: And there's.....

16 CHAIR HURLBURT: A little co-pay, a little deductible, a
17 little co-insurance, but most of it is going to be covered by
18 the premium dollars for most policies or you're not going to
19 have the policy.

20 COMMISSIONER ERICKSON: Well, just one other point, too,
21 before we throw this ball to Jeff, the hot potato, is that
22 \$7.5 billion represents all health spending, and the personal
23 health expenditure portion of that might be a more relevant
24 number to look at, and off the top of my head, I'm not
25 remembering the exact amount, but I'm thinking that was closer

1 to \$6 billion and that the difference was other things, like
2 public health and some other expenditures that didn't go into
3 Mark's personal health expenditure bucket, and I don't know if
4 that helps a little bit, but I'm.....

5 CHAIR HURLBURT: Public health is \$100 million, a little
6 more.

7 COMMISSIONER ERICKSON: Well, no. The State Division of
8 Public Health's budget is \$100 million. So we can go back to
9 Mark and ask him to break that out in more detail for us.
10 Maybe that would be helpful because I know the total health
11 expenditures we look at spending per capita is about \$10,000,
12 but if you look just at the personal health expenditure
13 portion, it's just a little over \$9,000 per capita that we
14 spend in this state.

15 COMMISSIONER DAVIS: I'll try to catch the hot potato,
16 and I'm just speculating, Ward, that there are a number of
17 things going on.

18 One is that we see employers increasingly buying high
19 deductible plans so that the actuarial value may surprise you.
20 It may be in the 50s or the 60s, meaning that, of a claim, on
21 average, 50% to 60% of that would be paid. So you have to
22 multiply the premium somehow by that. Also we know that,
23 looking at commercial populations versus Medicaid, for
24 example, there is a very, very big difference, and the
25 Medicaid population is big enough in the state to have a real

1 impact on that total spend. And then I do think there is some
2 impact from the utilization, care management, integrated
3 health management work that's done, but does help people to
4 have a different health status and to case manage through
5 complicated care, and there probably is a difference in health
6 status to begin with, particularly if you're looking at that
7 uninsured block that's 16% and the insured that's 15. So I
8 think some combination of all of that probably leads to the
9 difference in the math. So if I've answered that, can I
10 comment on one other thing, Mr. Chair? All right.

11 Since Keith opened it up and it really is about -- this
12 discussion is about regulation and the impact it has on health
13 care costs and health care insurance, you've just heard
14 Director Hall comment on the Affordable Care Act and some of
15 what that will create, and it is really a very uncertain time
16 in the world that we're moving into and something that, I
17 think, the Commission will want to look, and it comes down to
18 some pretty basic fundamentals.

19 The laws of insurance are that -- there are three things
20 that make something an insurable act. We heard that crime is
21 not an insurable act. So there are three things,
22 characteristics that something has to have to be insurable.
23 One is it has to be unpleasant, something I don't want to have
24 happen to me. You know, buying a new car is not an insurable
25 act because I may want a new car, right? You can't insure

1 that. So something that you don't -- an adverse event that is
2 not predictable to the individual. So if we were talking
3 about fire insurance, we wouldn't know -- we know that that's
4 an adverse thing. We don't want our houses to burn down, and
5 we wouldn't be able to predict whose house was going to burn
6 down, unless they were an arsonist, then different factors
7 there. And then the third thing is that it has to be -- that
8 adverse event, although not predictable to the individual, has
9 to be predictable to a population. So this is where actuarial
10 science comes in. They look at 100,000 people. They don't
11 know whose house is going to burn down, but they can tell you
12 how many houses will burn down and how much those houses will,
13 on average, cost. Therefore, you can predict the cost of that
14 adverse event to a population.

15 So where the Affordable Care Act goes is breaks one of
16 the fundamental laws of insurance, which is the predictable to
17 the individual, by saying that an insurer must issue a policy
18 to someone, regardless of health status and health condition,
19 so back to Allen's question about the four things that are
20 available, because, if I go visit Dr. Stinson and I know that
21 I need a procedure tomorrow that's going to cost a significant
22 amount of money and I can walk out of his office and go and
23 get a policy and then come back and get that procedure when
24 I'm now covered, that was not an insurable act because it was
25 predictable, to me, that I was going to have that thing done,

1 and it was something that I wanted done. So when you break
2 that fundamental law, then you don't really have insurance
3 anymore. The antidote was supposed to be the individual
4 mandate, which is, okay, certain parts of the population are
5 sick, but if everybody has to buy it, if everyone is in the
6 pool, then you can spread those costs, but it's highly
7 unlikely that the individual mandate is either going to
8 survive and/or be effective. So that's not really the
9 antidote.

10 So I think the challenge before us -- and it leads to
11 only one of many reasons I'm sad that Director Hall is
12 resigning -- is, as Alaskans, we have to figure out where we
13 can write rules around how this will all work that make it
14 work because it's been fundamentally broken by this Act, in my
15 opinion, and we have to figure out alternatives. For example,
16 could you have open enrollment periods that limited the time
17 that people with pre-existing conditions could buy coverage,
18 and can they be narrow enough that they become effective? Can
19 you have then a rule that says, if you're in and then you're
20 out, you're out for X, two years, three years, whatever it is?
21 You know, those sorts of things because the risk adjustment,
22 the reinsurance, the risk corridors, I'm highly speculative of
23 how those will work. You saw the numbers for the insured
24 market. If you have one carrier that's the majority of that,
25 who do you spread risk to? I mean, there are just lots of

1 questions around this that are very important that need to be
2 answered.

3 And I'll just finish with one final thing. Director Hall
4 mentioned the federal Pre-existing Condition Insurance Pool,
5 PCIP, which was created to span the time between now and 2014.
6 So someone with a pre-existing condition could go into the
7 federal pool, subsidize with \$13 million federal dollars
8 administered by ACHIA, separate from ACHIA, and our experience
9 with that Pre-existing Condition Pool has been that the per
10 member, per month costs since July are \$9,000 a month per
11 person, and what has happened is exactly what you would
12 predict. People buy the coverage, go in, get their whatever
13 done, drop out, and then the next one comes in behind them.
14 So it's averaged about 48 people, but it's a different 48
15 people enrolling through.

16 So to this question of regulation, I know, you know,
17 we're talking about a federal law, but there are state --
18 there are things that the states, in my opinion, are going to
19 have to do to try to make this work and who knows what's going
20 to look like when 2014 rolls around. So thank you for
21 indulging me with that.

22 COMMISSIONER DAVIDSON: But I think the point of the
23 Affordable Care Act isn't necessarily about insurance
24 companies alone. It's about -- the thing that everybody is so
25 -- people think either the Affordable Care Act is either the

1 greatest thing since sliced bread or the worst thing that ever
2 happened to this country, and the truth is somewhere in the
3 middle. The truth is health reform has been happening in this
4 country for 500 years. It just happens a little bit over
5 time.

6 The thing that everybody is struggling with right now is
7 uncertainty, and the devil you know is a lot easier to deal
8 with than the devil you don't. And the truth is those costs
9 have always been there. It's a question of, who pays for that
10 cost? Is it a direct cost? It is an indirect cost? And
11 that's really -- the Affordable Care Act is really looking at
12 -- honestly, no matter how it plays out and how those
13 regulations are going to be implemented or interpreted, the
14 truth is the costs are still going to be there. They will be
15 shifted, to some degree. There will be some savings for some
16 people. There will be expense for other people, but it's the
17 change that people are having the struggle with, in my
18 opinion.

19 COMMISSIONER DAVIS: May I, please? So Val, I agree with
20 you because we wouldn't be sitting around this table if the
21 situation prior to March 23, 2010 was a sustainable one. It's
22 not and so change does have to happen, and my point is that we
23 have the opportunity, as Alaskans, to make this work and that
24 that's a responsibility of all of us who have any role to
25 play. We all have a role to play, whether it's personal

1 health or whether it's as a voter or whether it's as a
2 regulator or an executive in the business, but that's our
3 charge and that's our goal is to say, how do we have a
4 sustainable and effective market under these conditions? And
5 I told you the story of, you know, my wife taking me to the
6 woodshed over this and saying, you know, your job is not to
7 complain about the lie; your job is to make it work, and she's
8 absolutely right.

9 The overarching point was it's going to look very
10 different, and I don't know what it's going to look like, and
11 we have a lot of people depending on having an insurance
12 company around to pay for it. Exchanges won't work, unless
13 there are payers in the Exchange and that's a fundamental part
14 of the Act. So how are we going to have payers that are
15 financially viable? And you're right; the costs are already
16 there, but they're going to be shifted over to a payer who has
17 to have a way to pay for that and that's really the
18 uncertainty is how that will look. And I think you do have to
19 look to -- your favorite term -- personal responsibility. You
20 know, people are going to have to say yeah (affirmative); this
21 is only going to work if I'm in and I'm not in just for my
22 three months and then out, but I'm in and I'm paying my
23 premium, and we make it work because that's the source of the
24 funding as well. So it's just -- you know, the point is we
25 have a chance to work together to make this work. It's going

1 to be really hard and it's going to be really different, and
2 no one knows exactly what that will look like come 2014.
3 Thank you.

4 CHAIR HURLBURT: So picking up on Val's evolution over
5 centuries that we're continuing to see and my 5% and 15%
6 disparity and your response, are we seeing evolution? If the
7 -- if what the employers are insuring is 50% to 60% of the
8 actuarial risk, is that moving toward a concept of real
9 catastrophic insurance and leaving a bigger portion of the
10 predictable commodity, more commodity type risk with the
11 individual who will then have more skin in the game and may be
12 more interested in controlling? Is that what you're seeing in
13 your business, a shift that may represent the evolution that
14 Val talked about?

15 COMMISSIONER DAVIS: Well, I think that's certainly one
16 piece. There are a lot of things in play here, and we've
17 talked about a number of them, but one is that employers are
18 increasingly -- and whether they're insured or self-funded
19 doesn't really make a difference in terms of behavior, as I
20 see it, but they're increasingly saying you,
21 member/employer/dependant, have to have some skin in the game
22 here. And then you're also seeing a lot more activity towards
23 worksite wellness and activities around that and motivating
24 people and finding ways to do that. You're seeing -- I think
25 we're on the verge of some pretty interesting stuff where --

1 you know, when we were listening to our earlier speakers talk
2 about having continuing education online and available for the
3 physicians but not getting, you know, their attention perhaps,
4 I thought well, I bet if you start giving them a discount on
5 their rate for participating in certain levels of continuing
6 education, you might, you know, see it. And probably the
7 reason that's on my mind is that we're getting that question.
8 Well, I'm here at the gym five days a week, and I'm eating
9 healthy, and I've got a BMI of 25. Well, what about me? I
10 think that we're on the verge of technologies that will
11 support that kind of individualization of a policy, if you
12 will. Your premium goes down; your coverage goes up, if you
13 do certain things.

14 Now, you know, we're all Alaskans, and we've got it in
15 our constitution that you have a right to privacy and
16 everybody worries about all of that stuff, but you know,
17 encouraging people to take the steps that lead to the 80% of
18 the determinants of health, not just folks on the 20%, I think
19 is really is where things are evolving as well as being able
20 to identify people with conditions sooner and have effective
21 ways to intervene. We've completely redone our approach to
22 care management. We've completely redone our approach to
23 hospitalization, focused on preventing re-admissions and those
24 sorts of things. Working with primary care doctors, the focus
25 is how you extend and make effective primary care. I mean,

1 all those things, I think, are really where the evolution is
2 happening, and the good news of the Affordable Care Act is
3 that it's on the agenda and you can't ignore it anymore. It's
4 -- you know, there's the iceberg; we're headed for it. Now
5 what are we going to do about it? So there is -- I probably
6 left out a few other things, but that's where employers'
7 discussions are going and discussions with providers are
8 going, in my world.

9 COMMISSIONER ERICKSON: Dave, do you still have a comment
10 or question?

11 COMMISSIONER MORGAN: Well, you know, evolution is a
12 tricky thing. A thousand species don't make it per month or
13 something, I read once. Our evolution of our tax system, we
14 didn't have an income tax until 1913, and at that time, only
15 1% of 1% paid it because of the rules of it. Something that's
16 over 2,000 pages with 900 areas where the Secretary shall
17 promulgate regulations is an awful lot of evolution in two-
18 and-a-half or three years.

19 I think what concerns me so much is, at least reading
20 what is happening in the Lower 48, you're seeing insurance
21 premiums really skyrocketing because any time there is
22 uncertainty, ask the people that buy and sell oil, you know.
23 So we're faced with that situation. I agree with you we have
24 to manage our way out of this in some ways. It's just that
25 dealing with that much that quick is always an opportunity

1 where something unintended could really hit and really create
2 problems, not in the economics of it, but who pays for what
3 and who it gets shifted to or from.

4 I think, of course, there are things that are good and
5 there are some things that are bad. I think the real problem
6 is a large hunk of this we don't know if it's good or bad.
7 What will be the net change, and what will be the net cost?
8 Is the effect of this Act, in itself, unsustainable? And I
9 think that's the 2,000-pound asteroid in the room is, what's
10 going to hit and what is it going to do to us? It's already
11 causing massive dislocations, in my mind. And evolution is,
12 we think, a natural state. The markets, over 500 years,
13 evolve and change depending on (indiscernible - voice lowered)
14 and people and weather, and suddenly, you don't need gold.
15 You can use paper for money. You know, I mean, there is a lot
16 of stuff, but can you cram that much that quick without really
17 having a real big problem? We can't do anything about that;
18 you're right, but on the other hand, we can just do what we
19 can do and get through it as best we can.

20 COMMISSIONER ERICKSON: We're going to give Jeff the
21 final word, but then we need to break for lunch.

22 COMMISSIONER DAVIS: It's optimistic, so I'm going to end
23 on optimistic. There's -- Linda -- or I guess Deb listed
24 ERISA as one of the things, the federal regulations that
25 affect health care, Employee Retirement Income Security Act

1 passed in 1975 or '76, I think. There was no ERISA. There
2 was no regulation of retirement plans to speak of prior to
3 that, and I believe it was about 600 pages, which was, you
4 know, massive for the time. Well, I was speaking with,
5 actually, Karen Jordan, Jim's wife. I was invited to speak to
6 a group called the ERISA group in Anchorage, the people who do
7 this for fun. They think about ERISA. And as we were
8 talking, we said wow, there are a lot of parallels here
9 because she was there when ERISA was passed and was, you know,
10 a retirement actuary. And everybody was sitting around the
11 room saying, oh my gosh, this is just a disaster. This is
12 terrible. Look at all these pieces; it isn't going to work.
13 Well, guess what? We probably can't imagine a world without
14 ERISA now, and it did evolve, and it changed, and it went back
15 and forth, and it was really messy, but we got there. And I
16 think that that's how this will unfold. It's not going away,
17 no matter what. It's not going away, but it will -- and I
18 would predict it will not be implemented as it exists today,
19 but it will be implemented in some form that will change over
20 time and we can make this work.

21 COMMISSIONER ERICKSON: Good. Well, it's time to break
22 for lunch. Thank you very much for the presentation, Linda.
23 And we're going to ask -- we actually have time on our agenda
24 this afternoon to talk about the Affordable Care Act
25 specifically, and we're going to go over the whole thing and

1 continue this conversation.

2 Before we break, I just wanted to let folks in the
3 audience here know that you're welcome to take part in the
4 lunch with us, but I would ask that all the Commission members
5 get in line first and grab your box lunch and bring it back to
6 the table because we are going to reconvene in about 25
7 minutes, and so if you could eat lunch quickly, that would be
8 good. Thanks.

9 12:08:40

10 (Off record)

11 (On record)

12 12:43:57

13 CHAIR HURLBURT: Let's come back together, and we have --
14 I think we'll have enough time, about 45 minutes, for our
15 public comment time. We have several folks signed up, both
16 here in the room and on the phone. And I think we've got
17 enough time that we could allow four or five minutes, up to
18 that much, if you have that much time, for the public comment.
19 We'll start with the folks in the room here and then open it
20 up to the folks who have let us know on the phone. We do know
21 about three folks on the phone now, and then when I get
22 through, we should be able to open it up if there are another
23 one or two more there. So we'll start with Fred Brown with
24 Health Care Cost Management Corporation. If you just -- yeah
25 (affirmative). Thank you, Fred.

1 MR. BROWN: Thank you, Mr. Chairman, Members of the
2 Committee. My name is Fred Brown. For the record, I am the
3 Executive Director of the Health Care Cost Management
4 Corporation of Alaska. During your fall meeting, I testified
5 and asked that you be sure to, as quickly as possible, release
6 the results of the Milliman report. You did, and I sincerely
7 appreciate that, and I just wanted to express my thanks for
8 your willingness, as Deb described, to wade into multiple,
9 dangerous waters.

10 Generally, I think that's the purpose of my testimony
11 today is to simply thank you for your willingness to take on
12 difficult issues that do need to be addressed. I see, as was
13 discussed this morning, that one of the items on the agenda --
14 and it will be a topic of ongoing discussion -- is with regard
15 to state policy barriers to health care innovation and cost
16 containment.

17 With respect to the Milliman report, itself, as you know
18 as a result of that release, there has been spirited
19 discussion. Linda mentioned the Commonwealth North and then
20 also that's a report that's been referred to in the course of
21 one of those examples of areas with barriers to health care
22 innovation and cost containment, that being Worker's
23 Compensation, and I'll just give an example of how it's
24 inertia, as much as anything, I think that inhibits our
25 ability to move forward.

1 Our organization has, throughout the course of this
2 legislative session, supported Senate Bill 116, which is a
3 small, even baby step forward toward trying to get a handle on
4 some of the rising health care costs in Worker's Compensation.
5 Some would say that, if you're going to do Worker's
6 Compensation reform, it needs to be comprehensive. The former
7 Chairman of the Alaska State Chamber of Commerce described
8 this effort as simply being a pilot project, and in summary,
9 what it was is an effort to allow representatives of
10 management and representatives of labor to be able, together,
11 to sit down and negotiate with providers not only quality of
12 service but also perhaps discount rates, and in exchange,
13 offer and provide steerage of the injured worker toward those
14 providers.

15 The result has been that there have been several
16 hearings, and even last week, inertia continues to slow the
17 process. There was an amendment offered to the bill, which
18 would remove from the bill the opportunity for labor and
19 management to negotiate with providers, and the rationale
20 given was that injured workers should have the freedom to go
21 without limit to the providers of their choice.

22 This bill was simply an effort to respond to the
23 observation made by the Alaska Compensation Medical Services
24 Review Committee back in November of 2009 where, at page ten,
25 they said that, although providers were allowed to negotiate

1 discount rates, there was no ability to enforce that, and
2 therefore, the provision was ineffective because, again, the
3 injured worker was free to go to the provider of that worker's
4 choice.

5 So again, the baby step forward was attempted, and yet,
6 inertia tries to slow the process by saying that there cannot
7 be an opportunity to provide steerage. So once again, let me
8 just say thank you. Congratulations. Continue to stir those
9 dangerous waters. Thank you.

10 CHAIR HURLBURT: Thank you very much. I appreciate that.
11 We will continue to look at these issues. The next we have is
12 Katie Senter who is a WWAMI student here in Anchorage.

13 CONFERENCE OPERATOR: Excuse me, sir. This is the
14 Conference Operator. If you in that office could talk louder,
15 it is very, very hard to hear on the conference call what's
16 being said in the room.

17 CHAIR HURLBURT: Thank you, operator.

18 CONFERENCE OPERATOR: Thank you.

19 CHAIR HURLBURT: If everybody could talk as close to the
20 microphone? Maybe, Katie, if you could pull it closer to you
21 a little bit.

22 MS. SENTER: So again, I'm Katie Senter. I grew up here
23 in Anchorage. I'm one of the fourth year WWAMI students, and
24 I am going into general surgery. I do plan on coming back and
25 practicing someday, which I think is kind of the spirit of the

1 whole WWAMI program. And I know that you guys are moving
2 towards a more independent medical school system, but what I
3 would beg is that you do, like, retain some affiliation with
4 the University of Washington, as it's actually a really --
5 it's been a big help to be affiliated with the University of
6 Washington as I go out and interview for residency selection
7 spots. So that's what I have to say. Thanks.

8 CHAIR HURLBURT: Thank you very much. I appreciate your
9 comments. I'm not sure, were you in here when Jim Jordan, the
10 Director of the State Medical Association, was here?

11 MS. SENTER: Uh-huh (affirmative).

12 CHAIR HURLBURT: His comment was that, from his
13 perspective, he thought what we needed more of was more
14 residencies rather than an independent medical school.

15 MS. SENTER: And I agree with that as well.

16 CHAIR HURLBURT: Appreciate your perspective. Thank you.
17 Thanks for coming. The next that we have is Faith Myers with
18 Mental Health Advocates, and I believe everybody has a copy of
19 the testimony that Faith brought in.

20 MS. MYERS: Mr. Chair, Commission Members, my name is
21 Faith Myers. I am a mental health advocate and also a mental
22 health consumer. There are real consequences, tragedies when
23 psychiatric patients cannot file an urgent grievance.

24 By improving the complaint appeal process for psychiatric
25 patients, Alaska will improve patient quality of care, better

1 opportunity for recovery, and Alaska can also reduce the
2 tragedies in the community that occur as a result of the
3 present poor grievance procedure law, AS 47.30.847, and the
4 resulting state requirements. Improving the grievance
5 procedure law for psychiatric patients will, in a variety of
6 ways, reduce the cost to the community. Senate Bill 55, or
7 something similar, should be adopted into law. Every
8 psychiatric patient in Alaska has a right to file a complaint,
9 but does not have a right, by state law, to reasonable due
10 process or a right to file an appeal in the facilities or to
11 the state. If a state locks up a severely mentally ill
12 individual or allows private hospitals to do it without
13 guaranteeing an excellent grievance procedure and oversight,
14 at some point, patients will be abused to whatever degree you
15 want to imagine. Outpatients with a severe mental illness who
16 want to file a complaint don't have a right to get an answer
17 for 30 days or more. Severely mentally ill individuals have
18 access to guns, alcohol, illegal drugs, knives, and no access
19 to a reasonable grievance procedure within a psychiatric
20 facility or to the state and no access to an urgent grievance
21 procedure process.

22 Alaska ends up with stories in the newspaper of a naked
23 man walking in the parking lot at state-run Alaska Psychiatric
24 Institute, a grown man punching a seven-year old girl in the
25 face in the street, a woman being shot by police in the

1 parking lot at Wasilla, a disturbed man being shot by police
2 in Anchorage. There is an incredibly long list of tragedies
3 that possibly could have been averted by instituting a
4 statewide fair grievance procedure law for psychiatric
5 patients.

6 The State Senate is not going to get a lot of support for
7 Senate Bill 55, which, when passed, will improve the grievance
8 procedure law for psychiatric patients. Before Maine and
9 Georgia improved their psychiatric patient grievance
10 procedures, patients were abused for years and some died.

11 Where was the Department of Health and Social Services? Where
12 was the Disability Law Center? Every state has one. Where
13 was the Joint Commission for the Accreditation of Hospital
14 Organizations? Where were the patient advocacy organizations
15 in those states?

16 There is not going to be a lot of support for Senate Bill
17 55, but it needs to be passed, and it needs to be statewide.
18 We are asking the Alaska Health Care Commission to support the
19 improvement of the psychiatrist patient grievance procedure
20 law. Thank you.

21 CHAIR HURLBURT: Thank you very much, Faith. Did you
22 have any additional comments? We appreciate your coming.
23 You've probably seen the agenda. We will be talking about
24 some behavioral health issues tomorrow. The Health Care
25 Commission is the creation of the Governor and the

1 Legislature, and we do create an annual report by January 15th
2 of each year, in which the report does go to the Governor, to
3 the Legislature, and we do make recommendations in that. We
4 do not -- and by our nature, we really cannot -- advocate with
5 the Legislature regarding any specific bill, but I suspect
6 you're aware already with our relatively small-sized
7 population that the Legislature operates in a very open
8 process, and advocacy groups and citizens are provided the
9 opportunity, when there is a hearing on the bill. And I think
10 that heartfelt stories, like you're sharing here, are often
11 telling, and if you've not done that, I would recommend that
12 you do that. I think that's your opportunity, but by the
13 nature of the way of the Health Care Commission is
14 constituted, it really wouldn't be any specific bill that we
15 would be advising the Legislature on while it's being
16 considered, but there is opportunity and we do appreciate your
17 comments.

18 MR. COLLINS: Can I just make one comment? And that is
19 you don't have to go through.....

20 COMMISSIONER ERICKSON: Go the mic, right in the center.

21 MR. COLLINS: I thought you could hear me. Just one
22 comment, you don't have to support the legislation. I mean,
23 if you have any influence with the HSS, they haven't a patient
24 complaint for five years. (Indiscernible - voice lowered)
25 You could talk about that with them. You could also just ask

1 the Governor to improve the grievance procedure. He could do
2 it with an Executive Order. So you don't have to support the
3 bill. You can do it a dozen other ways. If you think there's
4 a heartfelt -- there are a dozen other ways this Committee
5 could help, and I'm going to ask you to do it. Thank you very
6 much.

7 CHAIR HURLBURT: Thank you for coming. Next, we'll turn
8 to folks on the phone. First is Katie Cranor from SEARHC.
9 Katie?

10 MS. CRANOR: Hi, there. Can you hear me?

11 CHAIR HURLBURT: We can hear you just fine, Katie.

12 MS. CRANOR: Okay. Great. So like you said, my name is
13 Katie Cranor, and I am currently employed at SEARHC, South
14 East Alaska Regional Health Consortium, in Juneau, and I work
15 at the Front Street clinic location. My professional training
16 is in clinical counseling, and currently, I serve as a Mental
17 Health Therapist for the Front Street clinic where I provide
18 mental health care to individuals experiencing homelessness.
19 Anyone who receives care at our clinic is experiencing
20 homelessness. The goal of my public comment today is to
21 illustrate the complexity of mental illness, substance use,
22 and the experience of homelessness.

23 We can each recognize glimpses of compromised mental
24 health in ourselves when we experience the death of a loved
25 one, a startling event, like a car accident, or the rush of

1 fear when we lose sight of our child in a public place. For
2 us, these are glimpses of our own fragility, our
3 vulnerability, and an active reminder of the inherent
4 interconnectedness of our physical health and our mental
5 health. Of course, these experiences do not individually mean
6 that we are mentally ill. They are opportunities for us to
7 recall that we think and function differently, quite
8 literally, under stress.

9 For most of the individuals that I sit with as a
10 therapist, this glimpse at mental strain that I just
11 illustrated, this is their reality all day everyday. For
12 individuals who lack consistent, basic life necessities, such
13 as food, water, and shelter, mental health is bound to suffer
14 and poor coping skills are likely to surface.

15 Throughout my years of service in emergency shelters and
16 in health care clinics that serve those without homes, I
17 consistently observe that homelessness, mental illness, and
18 substance use, abuse, and dependence are interconnected. Each
19 feeds and supports the other.

20 On the page in front me, I have drawn an equilateral
21 triangle. On one point is homelessness, on another, mental
22 illness, and the last, substance use. I invite you to
23 consider the stark reality that this triangle is a self-
24 perpetuating system for which resolution and/or treatment of
25 one point will not inextricably resolve the issues of the

1 others.

2 To unpack that statement a bit, I intend to communicate
3 that the treatment and/or resolution of substance use,
4 dependence in our abuse will not always resolve mental
5 illness. Giving someone a home will not cure, though it may
6 minimize, substance use. The experience of homelessness,
7 mental illness, and substance use are singly and cumulatively
8 persistent and pervasive.

9 The stories of trauma, abuse, and neglect permeate the
10 experiences of those whom I sit with on a daily basis.
11 Consider Mike. He's a man in his 40s who experiences the trio
12 of struggles that we are engaging with. He pursues the
13 opportunity for inpatient substance abuse treatment. For 28
14 days, he is sober, engaged in individual and group therapy to
15 increase his awareness about his substance abuse, like what
16 are his triggers, what is he seeking to numb by using alcohol?
17 And at the conclusion of treatment, he is optimistic about
18 life, wants to maintain sobriety, and is committed to life
19 without alcohol.

20 For a variety of reasons, Mike leaves treatment and has
21 nowhere to go, no home to welcome him, no support network to
22 help bridge him to sustainable living and encourage his
23 continued abstinence. Where does Mike go? He returns to the
24 streets, to the people he has called family, to a world of
25 drinking to cope. Soon, he is depressed, considers committing

1 suicide. The cycle continues.

2 Or consider Jason. He's a man in his 30s who struggles
3 with schizophrenia and calls the streets home. He easily
4 loses track of time and misses critically important medication
5 management appointments to keep his schizophrenia maintained.
6 When he doesn't receive medication, he uses heroin and meth to
7 make the voices in his head stop. He's homeless. He needs
8 help, and the only option he can rely on is drugs.

9 I, in this testimony, do not propose a solution to what I
10 believe is a systemic injustice that has been nurtured and
11 feed without intent throughout generations of turning the
12 other way. I do suggest that the cycles of homelessness that
13 are perpetuated by the complexity of mental illness and
14 substance use can benefit from a marked increase of public
15 knowledge and communal effort to extend compassion to those
16 who fell through the cracks long before they checked a
17 demographic box identifying them as homeless. Thank you for
18 hearing my testimony.

19 CHAIR HURLBURT: Thank you, Katie, and thank you for what
20 you do there. So I guess, last week, that Juneau has the
21 largest per capita homeless population in our state and so you
22 have a challenge there, and we do appreciate what you do.
23 Thanks for your comments.

24 MS. CRANOR: Thank you for hearing them.

25 CHAIR HURLBURT: You bet. The next would be Dorothy

1 Green with Polaris House.

2 MS. GREEN: Good afternoon, can you all hear me clearly?

3 CHAIR HURLBURT: Yes. We can, very well. Thank you.

4 MS. GREEN: Good because I'm struggling with hearing you.
5 I'm Dorothy Green. I'm the Director of Polaris House in
6 Juneau, Alaska. I am our -- we are also a member of Alaska
7 Peer Support Consortium.

8 Polaris House is an international center for clubhouse
9 development, model program. We serve adults with a history of
10 mental illness. We provide a variety of community support,
11 such as supportive housing. We provide a place for members to
12 come, to work, to engage, to help others. We help them return
13 to employment, maintain employment, and other -- a wide
14 variety of support, such as maintaining third-party benefits,
15 communicating with doctors, and other services.

16 Over the past six years, six years ago when I began
17 working here, 65% of our members were chronically homeless and
18 not able to access shelters. Today, 23% are homeless, while
19 65% of our members continue to report that they were homeless
20 when they began being a member of Polaris House. We served an
21 average of 266 people last year. We have an average daily
22 attendance of 23. We helped 22 members become employed last
23 year, and they earned, collectively, a little over \$200,000.
24 Over the past six years, we've helped 70 people become
25 employed, and they have earned, collectively, over \$845,000

1 with an average wage of \$11.24 per hour. But this is a Health
2 Commission meeting, so what does this have to do with health
3 care?

4 Individuals who struggle with chronic homelessness are
5 more likely to struggle with mental health and substance abuse
6 issues. As a result, they die prematurely. They're at an
7 increased health risk for such disorders, such as seizures,
8 COPD, muscular skeletal disorders, tuberculosis, hand and foot
9 problems. They face significant barriers in accessing
10 traditional health care. They are more likely and have
11 significantly higher rates of visiting ERs, emergency room
12 visits. They have a higher number of days in a hospital due
13 to physical illnesses. They have higher and longer
14 psychiatric hospital stays, and they use more days in detox
15 beds and in accessing substance and alcohol treatment.

16 However, our members report to us, and the statistics
17 show, that, even though our program looks nothing like a
18 traditional clinic or a doctor's office, nor do we pretend to
19 be in any way, shape, form, or fashion, our members to us
20 that, after becoming a member, obtaining housing and having
21 community support, they were not only often able to return to
22 work and earn a significant wage that improved their quality
23 of life, but they found themselves going to the emergency room
24 less often, going to the hospital less often, spending fewer
25 days in psychiatric emergency room visits at a savings of

1 \$2,000 a day, an average stay here in Juneau. They need detox
2 beds and sleep-offs less often, almost non-existent, in fact.

3 They also report that they are more likely to see a
4 psychiatrist and follow their recommendation. They are more
5 likely to see a primary care physician and follow those
6 recommendations as well. This adds to tremendous savings of
7 programs, not just Polaris House, but other peer support
8 programs, like Polaris House. Inner communities provide a
9 significant benefit to all. Because we, for years, have
10 treated the body and not the mind, we have to treat -- they're
11 connected. We have to treat the body and the mind together as
12 a whole person. We looked at people -- cigarette smoke years
13 ago and realized that people who smoked were dying years
14 before others. We looked at secondhand smoke and went, you
15 know, people who don't smoke are dying of the same diseases
16 that people smoked did. Same thing with people who worked in
17 mills and shipyards. Why are they dying earlier? We found
18 solutions that began to work on having our loved ones not die
19 before they needed to.

20 While today, most of you, one in four of you sitting here
21 today is directly affected by mental illness by somebody in
22 your family or you personally, but you're going to -- the
23 members of your family who have mental illness die 20 years
24 earlier than other family members. You will see your
25 brothers, your sisters, your parents, your children passing

1 away long before they needed to. I would just encourage you
2 all to incorporate psychiatric services and mental health
3 services into the mainstream of health and continue to -- and
4 provide greater opportunity with less stigma for people to
5 access the services and to support nontraditional services
6 that make a huge difference in reducing the overall cost of
7 mental health services in our state. Thank you for letting me
8 speak to you for a few minutes.

9 CHAIR HURLBURT: Thank you, Dorothy, very much. Those
10 were some gratifying statistics and stories that you had to
11 share in your work there. I think you probably do have our
12 agenda, and if you have time tomorrow to call in, we'll be
13 devoting most of the morning, from 8:00 to about 11:15 or
14 until 11:45, talking about behavioral health issues. So we
15 would welcome your calling in.

16 The next one we have is Barry Creighton with Ionia.
17 Barry, please?

18 MR. CREIGHTON: Yes. Hello. Just checking the sound
19 here. Are you coming through? Hello?

20 CHAIR HURLBURT: Just fine, Barry. Thank you.

21 MR. CREIGHTON: Yes. Well, my name is Barry Creighton.
22 I'm a founder and representative of Ionia, which is a consumer
23 run residential mental health organization in Kasilof. We're
24 about 50 people, parents and children, and we've been here for
25 about 25 years.

1 In the beginning, we were several families who were in
2 Boston studying macrobiotics, the basic, simple diet, and
3 these families that we gathered had members of the family that
4 all had behavioral health problems, and what we found is that
5 a simple diet, a macrobiotic diet, which is basically whole
6 grain, vegetables, was something that had a profound effect on
7 this, that it didn't cure -- it didn't so much cure the
8 condition, but dropped the symptoms so far down that the
9 behavior, the mental health behavior wasn't worrisome and
10 actually more just became sort of idiosyncratic behavior. And
11 actually from our gathering, none of us actually had to have
12 mental health or psychotropic drugs.

13 I'm also on the Alaska Mental Health Board as a consumer.
14 On this phone call, I'm not representing the Board, however.
15 And I'm also on Central Peninsula Health Clinic, a federal
16 clinic that actually has a federal behavioral health program
17 attached to it. And on this board also is Dr. Deedee (ph) who
18 is a private physician in Soldotna. She happens to also be
19 getting a degree in public health. This board has met at
20 Ionia a couple of times, and Dr. Deedee was very impressed
21 with the food, the simple food and the peer support in this
22 organization, and asked if what he could do is write this
23 thesis on Ionia, which we gave permission.

24 As a representative of this clinic, we both have been
25 attending the public health conferences in Anchorage for

1 several years, and well, one of the things that's in the
2 public health clinic, the board is very aware of is that
3 obesity and diabetes (indiscernible - voice lowered)
4 increasing at the clinic, and you could say, in society in
5 general. And this year, the public health conference asked us
6 to -- Dr. Deedee and a couple of us at Ionia to make a
7 presentation at the public health conference. And Dr. Deedee
8 in doing his thesis, is, you could say, making a rather
9 scientific study of this simple diet that we found to be so
10 impressed and found that just about all of the necessary
11 ingredients are in that diet for health and that one -- and
12 he's been interviewing various people, first and second
13 generation people here and found them all to be healthy, both
14 in the mental and the physical aspect and that's -- and in his
15 presentation to the public health conference, that's what he
16 had a slide show of, some of Ionia and also a lot of
17 statistics about how the food actually has sufficient
18 ingredients in it for health and also doesn't lend itself at
19 all to the obesity and the other kinds of problems that dealt
20 with that. And actually, the presentation was very well
21 received at the health conference, and actually, we have the
22 possibility of being re-invited next year.

23 One of the things to mention that the previous speaker
24 also mentioned is it's Ionia kind of service that's basically
25 taking -- we built our own houses. We built our own community

1 building, et cetera. It's actually a very cost-effective way
2 in the sense of -- compared to, as she was saying, \$2,000 at
3 API or whatever physician when somebody (indiscernible - voice
4 lowered). So that's just one of the factors to add in the
5 sense of -- but also in our world, we profoundly found --
6 which Dr. Deedee is very much confirming -- that physical
7 health and mental health are profoundly interlinked and that
8 by a simple, foundational frame of reference of white food and
9 a way of life both can be addressed. Anyway, that's all, and
10 thanks for the time.

11 CHAIR HURLBURT: Thank you very much, Mr. Creighton.
12 Appreciate your comments there. Is there anybody else online
13 who wanted to comment? Thank you all who made comments and
14 all who've called in. We'll take a -- yes?

15 MS. KILGORE: I'm sorry. I -- do you have five minutes?

16 CHAIR HURLBURT: Yes, four or five minutes.

17 MS. KILGORE: This is Cheryl Kilgore with Interior
18 Community Center in Healy at Fairbanks, Alaska.

19 CHAIR HURLBURT: Let's make sure we get your name.
20 You've got it; okay. Cheryl, go ahead.

21 MS. KILGORE: Thank you very much. I'm the Executive
22 Director of a Community Health Center in Healy and Fairbanks,
23 Alaska, and we provide comprehensive primary care services in
24 medical, dental, and integrated behavioral health. Last year,
25 we saw 7,700 people; 58% had incomes below 200% of federal

1 poverty, and 39% had no insurance of any sort. Like many of
2 the folks that have been earlier, we believe in holistic
3 health, and we actively seek partnerships with the community
4 to help us help people navigate through a rather complicated
5 system of care, so that they get the care that they need in a
6 comprehensive, ongoing way because, truly, all of us want to
7 serve as (indiscernible - voice lowered) ongoing source of
8 care and make sure that people get their needs addressed.

9 We've been trying in the last five years to actively
10 collaborate with our community partners and become a patient-
11 centered medical home. Like other communities, we have gaps
12 in services, particularly in behavioral health, sometimes
13 specialty medical care, and we also deal with workforce
14 shortages that I know you're working on as well.

15 I want to just talk a little bit about what Kelly
16 Shanklin and I have discussed. Kelly is the Executive
17 Director, as you may know, of the Fairbanks Community
18 Behavioral Health Center. We both are doing the same thing in
19 terms of trying to work together to make sure that we address
20 each comprehensive need and serve as, even though we're
21 different entities, a coordinated source of care and
22 developing some relationships with our primary care center,
23 the behavioral health center, and the hospital, so that we are
24 able to truly fulfill people's needs in the most efficient and
25 effective way possible.

1 It's had it's challenges, as you can imagine, because
2 we're separate entities with separate kinds of policies and
3 procedures, and one of the things that I just wanted to talk
4 about is it would be a dream if we could actually have a
5 single point of entry for people with their consent, so that
6 we wouldn't have, when somebody goes from my center to the
7 hospital or from our center to the behavioral health center,
8 to have people duplicate their information to qualify them,
9 for example, for the scheduled discount. It would be a dream
10 if actually somebody that was seen here by our psychiatric
11 nurse practitioner (indiscernible - voice lowered) benefit
12 from more intensive care management, a consult with a
13 psychiatrist, if we could actually have an agreement whereby,
14 if needed, that person can get in very quickly without having
15 to duplicate the paperwork and maybe even redo an assessment.
16 I know we're working on that within this community, and it
17 would be very helpful if the State Health Care Commission,
18 working with the Legislature and (indiscernible - voice
19 lowered), would help facilitate some of these kinds of
20 activities in a way that would allow us to better serve people
21 in a more cost-effective, efficient manner. I know we all
22 want that because we want to improve people's health outcomes,
23 and I do appreciate the work that the Commission has done to
24 help bring this to the public's attention and the
25 policymakers, so that we can serve people better, and

1 hopefully over time, reduce the costs and improve outcome.
2 And I just want to say that, from our perspective, we're
3 getting together, and we would appreciate all the support that
4 we could get to help us get this together and truly be more
5 effective for all. Thank you.

6 CHAIR HURLBURT: Thank you, Cheryl. Appreciate your
7 calling in. Is there anybody else online with any comments?
8 Again, thanks to everybody, both here in the room and online.
9 We'll take a break and get together about 1:40, just a little
10 over 15 minutes, and start talking about some Commission
11 business. So we'll take a break until 1:40.

12 CONFERENCE OPERATOR: This is the Conference Operator.
13 Would you like me to put you back on lecture for the remainder
14 of your call?

15 COMMISSIONER ERICKSON: Yes, please.

16 CONFERENCE OPERATOR: Thank you.

17 COMMISSIONER ERICKSON: Thanks, operator.

18 1:22:11

19 (Off record)

20 (On record)

21 1:41:12

22 CHAIR HURLBURT: Thank you. We want to -- this next --
23 this afternoon, we'll be talking about Commission business and
24 then talking about recommendations that we've had from the
25 prior year, fracking them -- kind of an update on where we

1 are. So Deb, if you could go ahead and lead us on this first
2 part?

3 COMMISSIONER ERICKSON: We are going to be jumping, for a
4 few minutes, back and forth between a couple of different
5 PowerPoints, if you can tolerate that, but first, I want to
6 just start off with giving you a few updates related to
7 general Commission business and one specific to our members.
8 We currently have, technically, four vacancies, and we've been
9 working literally since August. So we're going to start even
10 earlier this year, but I think the Governor's office
11 understands we're going to start working a little bit harder
12 and being a little more diligent in trying to get folks online
13 and vetted through the system.

14 Part of what we ran into is we're a body that does not
15 require legislative approval of the Governor's appointments,
16 and we got backed up behind all of the bodies that do require
17 legislative approval to make sure that they got on the docket
18 before the Legislature this year.

19 We currently have -- I'm anticipating that two of the
20 four members who reapplied will be reappointed. I'm hopeful
21 about that. I can't probably say anything more than that, and
22 we have two exceptional candidates at the top of the list for
23 the other two vacancies, which are Colonel Friedrichs' seat,
24 which is technically a seat for somebody associated with
25 health services for the Veterans' Administration, and then the

1 primary care physician seat. Well, we had a few specialists
2 apply for that. We reminded the Governor's office that the
3 statute specifies a primary care physician, and we do have, at
4 least, one really excellent candidate on the top of the list
5 for that. So as soon as they're vetted -- they really tried
6 hard to get the appointments signed by the Governor before our
7 meeting, but -- so I'm hopeful that we're close.

8 And one of the reasons I wanted to note that for you all
9 was I've been holding off on scheduling the rest of the
10 meetings for the year until we knew for sure who our four new
11 members were, but I hate to wait too much longer because we're
12 going to need to get those meetings scheduled and want them on
13 your calendar. So hopefully within just the next week or so,
14 I'll be able to share an announcement with you and then we'll
15 start working hard on getting the rest of the meetings
16 scheduled for this year. So does anybody have any questions
17 either about our potential new members or the calendar for the
18 year?

19 I think one other thing I would note about that, because
20 now I'm thinking it is not too early, we have -- each year,
21 we're going to have folks rotating off the Commission.
22 Anybody who is appointed from -- in this new go-around on will
23 be appointed to a three-year seat, but as you know and just to
24 remind the public who might be listening, to start off, folks
25 were allocated to either one, two, or three-year seats. We

1 had to stagger them, starting off. And so the four who we're
2 trying to fill now were all in one-year seats, initially. The
3 new appointees will be in three-year seats. The seats
4 rotating off in the two-year time slot -- so the folks will be
5 -- whose terms will expire in January of 2013, the end of this
6 calendar year, is our provider seat. It's more general health
7 care practicing. It has to be a practicing health care
8 provider, the seat that Dr. Stinson is in. The seat for
9 Community Health Centers that Dave is in and the seat for
10 health insurers that Jeff sits in right now -- and so just
11 know that, if you're interested, you may reapply for those
12 seats. So I mention more than any other reason right now, so
13 the three of you could be thinking about whether you would be
14 interested in reapplying because we'll be asking earlier
15 rather than later that question.

16 COMMISSIONER KELLER: Can I move that nominations be
17 closed?

18 COMMISSIONER ERICKSON: Yes; you may. We would prefer it
19 if you have no choice, but -- yes, David?

20 COMMISSIONER MORGAN: My intent is to reapply, unless not
21 eligible.

22 COMMISSIONER ERICKSON: Okay. I will remember that.
23 What's that?

24 COMMISSIONER DAVIS: Were you looking for an answer?

25 COMMISSIONER ERICKSON: No. I was not, but we'll take

1 the answer now, if you have it. I'll be following up with you
2 individually on that question.

3 The next thing I wanted to do -- it's not on the agenda,
4 but I wanted to share with you all -- I think I provided an
5 electronic copy at one point, and this is available on the
6 Legislature's website as well, and I'll be posting it on ours,
7 but we were invited to present to a Joint Committee hearing of
8 the House and Senate Health and Social Services Committee at
9 the beginning of February on the Commission's 2011 report, and
10 then again, we had actually the entire hearing at a subsequent
11 House Health and Social Services Committee for a presentation.
12 And so I wanted to make sure, if you hadn't had a chance to
13 see it, I included in your notebooks behind tab one, a
14 printout of the slides, and I wanted to take a second, since I
15 think we have time, to point a couple of things.

16 One, because the question has come up or the -- well, I
17 guess some things that we've discussed in meetings that we
18 hadn't really captured in terms of either data or in a graphic
19 that I did share with the Legislature and wanted to just run
20 by you really quickly.

21 One of the things that I'm hoping we can get to this year
22 that's on our list is how we're going to measure the
23 indicators and processes for measuring how the health system
24 is improving over time. And in our conversations about value,
25 while we've been very focused on cost this past year, cost and

1 pricing in the system, a reminder from you all periodically
2 that we really -- the conversation really needs to be,
3 ultimately, about value and how do we measure the value of the
4 overall system. And so we started that conversation,
5 actually, with the Legislature and made a point in these
6 Committee hearings that, while the information that we were
7 presenting to them that we learned during 2011 on cost and
8 pricing was just one piece of the puzzle and that the
9 Commission would be looking and trying to understand the
10 question of value even better as we move on, and especially
11 with our measurement system. And I had -- and this was a
12 little depressing to me, but I guess -- well, I don't know if
13 was surprising or not. I had used, in the presentation to
14 them, just to give them a sense of what I was talking about,
15 where we have information on coverage and on costs that we
16 haven't really talked about information related to quality and
17 outcomes and found a couple of national report card sets of
18 metrics on the questions of quality and overall health, health
19 outcomes, and those were available both from the federal
20 government and also through some private foundations, but two
21 of these measures -- I'm on slide ten of this presentation
22 related to quality -- the Agency for Health Care Research and
23 Quality puts together a state dashboard, and they use a
24 hundred different health care quality metrics and rank all of
25 the states against each other, and we fall out at 38th of

1 their most recent data from 2010 relative to the other states.
2 And then the United Health Foundation ranks the health of
3 states, and they rank us, in their most recent 2011 report,
4 the 35th. So I suppose the good news is we have plenty of
5 room for improvement, but I mostly just wanted to show you
6 that to give you a sense -- I think we might look at these two
7 report cards, at least to get some ideas, if not to make a
8 decision whether we think they're so well done that we would
9 use them. I think folks might take exception with that, but
10 as we have that conversation in the future, those are the
11 sorts of things we'll be looking at are the different
12 indicators that are included in these other areas and what you
13 all think are the most critical things for us to be measuring
14 over time to evaluate whether our health system is improving
15 or not.

16 A couple of things I wanted to highlight for you in this
17 presentation, just because it's something that we have talked
18 about, I wanted to show, too, because I don't know that you
19 had seen this. I had created a few slides, just pulling out
20 from the Milliman report some of the price comparisons, and
21 I'm on slides 24 through 27 in that presentation. And I just
22 pulled out some sample price comparisons for the professional
23 prices and reimbursements, and it's pretty stunning. While we
24 look at the general averages, it's -- it gets folks' attention
25 when they look at prices for individual services and how we

1 compare to other states. So specifically for the mean
2 commercial comparing us to other states, but then thought it
3 was really important to share with the Legislature -- for them
4 to understand the cost shifting that goes on between different
5 payers and so a couple of these slides are within Alaska, the
6 fee in the fee schedule or the average reimbursement for
7 commercial for those same procedures. And we're able to see,
8 on all of those cases, that Worker's Comp is the highest and
9 Medicare is the lowest in virtually every case.

10 And then one other thing that I wanted to show you on
11 slides 33 and 34 -- just because this is something we talk
12 about a lot but hadn't really used any sort of graphic before,
13 I pulled together a couple of graphics for the presentation to
14 the Legislators, and one is the top, and I think is partly
15 what, Dr. Hurlburt, you were trying to get at with some of
16 your questions to Jeff and Linda earlier during Linda's
17 presentation, the extent to which a small proportion of the
18 population -- and this is recent data from the U.S. Agency for
19 Health Care Research and Quality at the U.S. Department of
20 Health and Human Services, that 5% of all Americans during
21 2009 required 50% of all the health care spending in the
22 country and that figure for the top 1% of the population
23 actually spent 20% of all health care spending. I think that
24 goes to some of the comments we heard during the public
25 hearing as well as some of the really special and unique

1 health challenges that folks with really complex situations
2 and conditions have and how much that drives health care
3 spending in the state. So that's something maybe we can have
4 more of a conversation with our presenters from the behavioral
5 health sector tomorrow as well, not to suggest that these are
6 all behavioral health issues, but that's just a complicating
7 factor for some folks who have really complex and multiple
8 conditions and that the 50% of all U.S. residents who used the
9 least amount of resources were responsible for just 3% of all
10 health care spending. This is personal health expenditures
11 during 2009.

12 So I pulled that little graphic together with the little
13 people and the pennies to make it a little more noticeable,
14 but then just this final point that I wanted to share with
15 you, again something that we talked about, and I think Cheryl
16 Kilgore from Fairbanks from the Interior Neighborhood Health
17 Center who just testified during the public hearing was making
18 an excellent point about this, the importance of -- and
19 understanding that this really what we're trying to get at and
20 our strategy. If we can figure out recommendations for the
21 Governor and the Legislature for state policies that would
22 support keeping those 50% of folks who are healthy, healthy
23 and to the extent we could help move any of the folks above
24 that line down, but then for those who do experience some need
25 for health care services, that we're coming up with

1 recommendations with strategies that will improve the
2 coordination and management of care and provide other needed
3 supports for the folks with the most complex conditions and
4 making sure, for everybody else, they're getting high quality
5 evidence-based care to keep them from getting any worse.

6 So it really was just for informational purposes. I
7 wanted you to see how I was capturing the conversations around
8 the table, beyond what we put in the reports in graphic forms
9 for presentations and not just to the Legislature. I've had
10 an opportunity to make presentations before a few other groups
11 over the past two or three months, too, on our report, like at
12 the Alaska Health Summit.

13 So I would welcome any comments or suggestions you have
14 as I share, like, PowerPoint presentations with you. One,
15 you're welcome to use them, if any of you are interested in
16 using them for any purpose ever. So let me know if you want
17 to have access to or want help putting a presentation
18 together, but then if you see anything that I'm doing that you
19 have suggestions for improvement, I would very much welcome
20 that. Yes, David?

21 COMMISSIONER MORGAN: I was in the audience at the
22 presentation for the Joint Committee, and I will say that I
23 thought that the -- I think Wes was there, but I thought it
24 went over very well, and I think keeping it short and sweet
25 worked the best.

1 My question, which you probably wouldn't want to put into
2 the presentation, is, that 5%, I would really love to know
3 what the majority diagnoses are. I think we all can guess,
4 but I've really never seen the next layer presented, like, of
5 that 5%, 25% is diabetes and this is how much it costs. I
6 don't know if it's possible, but you don't have to do it down
7 to, like, Milliman, but you know what I mean? There are
8 probably five, ten chronic -- these diagnosis diseases or
9 whatever, but it'd be interesting to look at those because, I
10 mean, take Medicaid -- and probably Jeff can talk more on
11 this, but take Medicaid. If that number holds true, you're
12 basically talking about 9,000 people consuming \$900 million
13 worth of stuff, you know. It's almost like -- and I've said
14 this before, to the chagrin of a lot of people. It's be
15 cheaper to give them a million bucks and a round-trip ticket
16 to the Mayo Clinic, if you do the math on it. So it would be
17 nice just -- I don't even know if it's possible, but it'd be
18 nice to know how that 5% breaks down of what it is, not -- I
19 mean, I'm talking in \$100 million increments or \$50 million
20 increments.

21 COMMISSIONER ERICKSON: Other questions or comments right
22 now? Keith and then maybe Val.

23 COMMISSIONER CAMPBELL: Well, we had a lot of discussion
24 about the hospital discharge data and the holes in it and all
25 that sort of thing because our different disparate systems.

1 And is there a way that we could encourage the non-
2 participants to come onboard with that data because you're
3 only as good as your data? And I realize we've got, you know,
4 a couple of federal systems here, but we've also got one or
5 two private hospitals that are not in the circle, and they
6 have -- at least one of them has got a fair chunk of numbers.
7 So -- and I don't know what -- you know, we're not in the
8 policing business, but somebody has got a lot of dollars in
9 this game that might have enough muscle to say thou shalt
10 submit your numbers, so that's just a suggestion, but I --
11 that was a major hole and a discussion in the Milliman thing.

12 COMMISSIONER ERICKSON: And my sense, from the
13 conversation at the end of this last year when we were
14 discussing that, was that the group wanted to give the Alaska
15 State Hospital and Nursing Home Association, who really has a
16 -- the new President/CEO/Executive Director this past year has
17 just been bringing a new team on and focusing and noting that
18 that was one of their priorities as an association was to try
19 to help fill those gaps that were giving the Hospital
20 Association an opportunity to make those improvements this
21 year, but we can continue tracking with them and continue the
22 conversation about that. Yes, Ward?

23 CHAIR HURLBURT: But that chunk, if we get all hospitals
24 in, like if Wasilla comes in, we'll get much better data, and
25 it'll be a lot of the real expensive data, but it's still just

1 a part of it. So the all-payer claims database is a much more
2 universal set of data, and a lot of states have that,
3 including a lot of states that are just as red as we are here
4 in Alaska. If we can just get to the point that we can get
5 that, it's very useful information. It gives you a much
6 better picture of what's being spent for health care.

7 COMMISSIONER CAMPBELL: Yes. Well, I say that because,
8 you know, we got a fair amount of (indiscernible - voice
9 lowered) about the Milliman study, and some of the criticism
10 was kind of unjustified because they weren't in the pool, and
11 you know, that bothers me personally, and as a consumer, it
12 really does bother me in representing consumers. If you're
13 going to have numbers, you ought to have as many and as solid
14 as you can get.

15 COMMISSIONER ERICKSON: Moving right along then, I wanted
16 to point out one little business item. All of our voting
17 members should have, in the front -- Ward, do you want to use
18 yours as a -- your envelope as a visual aid? And the folks
19 who are travelers should have two of those, one with their
20 travel receipt checklist form, but all voting members should
21 have a pre-addressed, pre-stamped envelope with your 2012
22 financial disclosures form. You didn't get one, Keith?

23 COMMISSIONER CAMPBELL: I had a spare from someone.

24 COMMISSIONER ERICKSON: Well, I had handed them out once
25 before at the very end of this last year, but it's for the new

1 year. I think I emailed them at one point, too. So we're
2 missing a couple. Colleen, we're missing a couple here. So
3 could you get Keith and -- no. That was the Memorandum of
4 Agreement. So we'll -- before this meeting is over, we'll
5 make sure that Keith and David get their 2012 financial
6 disclosures form with the envelope, and one for Emily as well.
7 Does everybody else have theirs?

8 CHAIR HURLBURT: Do you want to gather them.....

9 COMMISSIONER ERICKSON: If you're able to complete them,
10 Dr. Hurlburt is at the head of the class. He's already filled
11 his out.

12 CHAIR HURLBURT: It's five minutes, if you do it during a
13 break, so yeah (affirmative).

14 COMMISSIONER MORGAN: (Indiscernible - away from mic)

15 CHAIR HURLBURT: That's the other part of what you don't
16 know about yet, David.

17 COMMISSIONER ERICKSON: Well, we'll make sure that you
18 get those, and just a reminder, we need to get those in and on
19 file.

20 One other thing that I wanted to make, too, for all of
21 you about is that we had a considerable amount of media
22 coverage, and now with Colleen onboard, one of the things that
23 I started with Rich and we'll finish for this past year and
24 update for this year is a media log that I'll share with all
25 of you regularly.

1 A couple of fun things, Jeff and I were invited by the
2 public radio, Alaska Public Radio Network, to do a couple of
3 live radio programs, hour-long call-in shows, and it was fun.

4 One, they asked us to talk specifically about costs, and
5 we got to the end of the call -- this was the "Talk of
6 Alaska," the one-hour for those of you who listen to PBS. So
7 the first one was on health care costs, and at the end, it
8 really went well. We got some good questions and comments
9 from the public, and when it was over, the producer came in
10 and showed us the stack of calls that they hadn't been able to
11 get to, and I suggested that it was a little disappointing to
12 have time only to share the problems, and I said, you know,
13 the Commission has worked on solutions. We don't just talk
14 about problems, and she said, well, can you come back next
15 week? So we did. We came back and talked for an hour and
16 tried to keep it focused on the employer's role in improving
17 health and health care, which is something that's going to be
18 on our agenda next year.

19 But we've had some attention both in another series on
20 APRN, a whole series on APRN. I had sent links to all of you
21 to that. I hope, if you haven't yet, if you have a chance to
22 listen to those, they were very well done, I thought, a three-
23 part series on health care costs in the state. And she
24 continued -- the same reporter, Andy Feights (ph), continued
25 to do five-minute segments since then on solution areas as

1 well. So again, not just focusing on the problems.

2 And then we've also had some attention from the Alaska
3 Journal of Commerce, the *Fairbanks Daily News Miner*, and some
4 other print journals as well. Nome Radio picked up on some of
5 these, and they got -- took a recording and hosted their own
6 Nome-based call-in radio program as well.

7 So I mostly just wanted you all to know -- and
8 interestingly enough, actually, I, in the past, have reached
9 out to the press. I did not specifically, in any one of these
10 cases, make the first contact. They're starting to find us.
11 I specifically didn't want to bring too much attention and
12 make it look negative, our focus on the costs. So I wasn't
13 reaching out to the press because of that, but they found us
14 anyway. So I think, overall, it's gone well. So if any of
15 you have any questions or comments about that, I would welcome
16 them as well.

17 And then finally before -- I see we have our speakers for
18 2 o'clock here. So we'll go ahead and get started with that.
19 I just wanted to note, in our upcoming meetings and especially
20 these next two meetings, we're going to be trying to focus on
21 these top two issues related to the employer's role in health
22 and health care. I've started working with some of the
23 business community, and specifically, I'm trying to, for this
24 case, avoid the health care business industry. We have enough
25 interest and attention from them. We're interested in non-

1 health employers' engagement in our conversations this year
2 around the employer's role and are fortunate to have access to
3 folks with some national level expertise in this area, in
4 health program management. And so I'm working with the
5 Anchorage Economic Development Council, and we'll be calling
6 Rachel of the Alaska Chamber of Commerce and also the
7 Anchorage Chamber of Commerce and seeing if we can get as much
8 interest and involvement from our state business leaders as
9 possible when we start holding those learning and discussion
10 sessions.

11 And then on the end-of-life care sessions as well, we're
12 starting to think about the type of panel that we could put
13 together for that conversation to include some medical
14 ethicists, physicians, and other -- and hospice workers who
15 work with folks and with families at the end of life about
16 what the Commission might recommend to improve policies that
17 improve both care, quality of care, and patient choice and
18 family choice at the end-of-life.

19 So I'm excited about -- I'm not going to go in -- don't
20 have time to go into too much detail, but just wanted to let
21 you all know that, if you have any specific ideas that you
22 would want me to be looking into for how we approach planning
23 for those sessions, let me know because we already are working
24 on getting those planned for later in the year.

25 Any questions or comments about Commission business

1 before we move into our update? Now we're spending the
2 afternoon on tracking prior year recommendations. And so
3 first on the agenda, we have Kim Poppe-Smart, the Deputy
4 Commissioner from the Department of Health and Social
5 Services, and Kim is responsible for the state -- she's also
6 the State Medicaid Director, responsible for our Medicaid
7 agency, the Division of Health Care Services, as well as the
8 Division of Behavioral Health, and the Division of Senior and
9 Disability Services, but specifically, she's going to update
10 us on what the Department is doing related to patient-centered
11 medical homes.

12 And then Marilyn is here. Marilyn, do you want to just
13 come sit at the table with Kim? Marilyn Kasmar, the Executive
14 Director of Alaska Primary Care Association, is with us to
15 help update us on the good work that the Primary Care
16 Association is doing, and we also have a handout from the
17 Primary Care Association behind tab four for all of you.
18 That's an Executive Summary of kind of where they're at that
19 they put together for all of you.

20 CHAIR HURLBURT: And Kim and Marilyn, if you could talk
21 closer than you normally would, the folks on the line are
22 having a little hard time hearing us, and it seems to help to
23 get pretty close to the microphone. Thank you.

24 MS. POPPE-SMITH: Will do. That's probably a little
25 close because I hear echo. There it is. Just don't turn it

1 on, Marilyn. Thanks, Deb. It's nice to be back here again.

2 As Deb said, I'm Kimberly Poppe-Smart, Deputy
3 Commissioner for Health and Social Services. The only thing I
4 think you missed is I'm also the Olmstead Coordinator. So
5 yeah (affirmative); it's a long list of duties.

6 In any event, I have two projects related to patient-
7 centered medical homes that I want to report on today. I have
8 to confess the one I report on, although it originated under
9 my watch, it's now under Dr. Hurlburt's, so he may have
10 something to add to it when I start talking about TCHC (ph).

11 Our patient-centered medical home for Medicaid, which was
12 one of our legislative task force initiatives presented --
13 decided upon last year and presented to the Governor, and we
14 were given the nod to move forward; we are, indeed, doing
15 that. We have issued an RFP. We received responses, have
16 evaluated, and have accepted the services of PCG, Public
17 Consulting Group, to facilitate stakeholder meetings, help us
18 analyze various medical home models, and analyze those as they
19 compare to what Alaska needs because we know that service
20 delivery in Alaska is not the same across the state. One size
21 certainly does not fit all.

22 We are striving for an integrated model that has
23 behavioral health components to it. We realize full
24 integration is not reasonable or to be expected across the
25 state, but we'd like to strive to getting as close to an

1 integrated model of behavioral health as we can. We also
2 encourage reverse integration as far as that goes, so primary
3 care providers in the behavioral health setting for reverse
4 integration.

5 We hope, by the end of the summer, we will be able to
6 issue Request for Proposals, up to or exceeding, for pilot
7 projects. Our original vision of those four pilots included
8 an urban area, a rural area, a tribal provider, and a non-
9 tribal provider, so four different pilots. We may end up with
10 more than that. Providers are at various stages of readiness,
11 so we'll just see what we get when we start putting those
12 together, look for opportunities to participate in stakeholder
13 meetings that will be held over the next several months, and
14 never hesitate to write to us or call us or email us, if you
15 have good ideas, things that we should pursue or specific
16 questions we might want to ask of ourselves or of potential
17 providers as we're developing these pilot projects. We
18 certainly appreciate all of that. I know you guys have
19 studied it extensively. I've benefitted from that and
20 appreciate it. So your input is important to us.

21 The other project that we have going on in the state is
22 the Tri-State Child Health Improvement Consortium. There are
23 ten of these projects funded by CMS across the country. In
24 our particular project, there are three states working
25 together. Kind of hard to imagine when they are in West

1 Virginia, Oregon, and Alaska, but we are working together.

2 These projects are designed to look at electronic health
3 records and integration of data, quality measures, practice
4 configurations, and how those practices work. Patient
5 satisfaction surveys are an important element of this. It's a
6 five-year project, again entirely funded by the federal
7 government. It is not exclusive to Medicaid. So there are
8 benefits to all members who attend these practices. We have
9 three practice sites in Alaska. SouthCentral Foundation is
10 one. Ululuiak (ph) -- I can say it better than I can spell
11 it, believe it or not -- and Peninsula Community Health
12 Services were the two new ones added this year with
13 SouthCentral.

14 We are in the process of providing technical assistance
15 to them on quality assurance measures and reporting thereof
16 and establishing and integrating those electronic health
17 records. We are struggling to come to consensus on the
18 quality measures that are required for us to report. A bit of
19 a struggle there, but we hope, by the end of the month, we'll
20 have some consistency on those quality measures and we'll be
21 able to report the same quality data, so we can do a national
22 comparison as to the efficacy of these projects. I think
23 that's extremely important.

24 I wanted to be able to give you numbers of participants
25 in those programs, but at this stage of evolution, that's not

1 feasible. There's not really a way to track -- we can track
2 the number of individuals under age 21 who are participating
3 in care on those various sites, but not those have elected to
4 participate exclusively in a medical home model, so I don't
5 have that data. Perhaps over the years, we'll get it, but
6 that's something we will be watching for. That's a quick
7 update. I don't know, Dr. Hurlburt, perhaps you have
8 something to add to that.

9 CHAIR HURLBURT: Yeah (affirmative). Thank you, Kim. I
10 don't. We're still in the process of discussions with the
11 other two states. Strange constellation of states, but seem
12 pretty congenial and pretty collaborative in talking together,
13 but mostly talking at this point.

14 COMMISSIONER MORGAN: I guess I better declare a conflict
15 of interest. At the beginning -- the first year of the TCHC,
16 I was, along with Mr. Copez (ph) and a couple other people,
17 involved in that. I have found that the West Virginia
18 representatives, number one, didn't have an accent to me, and
19 I could communicate well with them, but actually, West
20 Virginians have a lot of similarities, especially in our
21 economies being based in energy and being very rural and
22 having transportation problems. So if you really know West
23 Virginia and the things they're doing, we actually have a lot
24 more in common than you would think. I think it's one of the
25 best -- to come up with the quality measures is the hardest

1 thing in the world, I think, and I think they're well underway
2 from the information and the little bit of information I'm
3 getting now. So it was a good job, and the State of Alaska
4 stepped up to the plate on that way before the Affordability
5 Act stuff. They were in this from the very beginning. So you
6 know, everyone beats up on you. I thought I'd be nice, for a
7 change.

8 MS. POPPE-SMART: I appreciate that, David. I would say
9 that this project has attracted a great deal of talent in the
10 arena of quality assurance and data mining and data
11 evaluation. Amongst the three states, they've got some
12 phenomenal talent there. So I'm real eager to see their
13 reports as they come out over the years.

14 COMMISSIONER ERICKSON: Other questions or comments for
15 Kim? Thank you for that update. Marilyn?

16 MS. KASMAR: Good afternoon. Am I little too close?
17 How's that? Good. I'm here to update you on the patient-
18 centered medical home initiative that the Alaska Primary Care
19 Association is working with. This is a -- for about two
20 years, we've been working with our community health centers in
21 educating and training them about the model. We kicked it off
22 two years with an intensive training where we brought some out
23 of state consultants in who had been working with the patient-
24 centered medical home for a few years to do a training on, you
25 know, what to look at and how to get started with

1 implementation and also just to train about the model in
2 general because, two years ago here, it was pretty new.

3 And so over time, since that time, we've continued to
4 offer training and education via webinars and via
5 presentations at our conferences.

6 Last year, we asked the Alaska State Legislature, along
7 with support from the Department of Health and Social
8 Services, to fund a project where we could actually provide
9 some -- or to directly fund a project to the health centers so
10 that they could have some funds to start working on some of
11 the elements of transportation -- transformation. Not
12 transportation. Transformation to start moving in the
13 direction of accreditation and certification.

14 Some of the health centers in the state are well along
15 that road, and others are not well along that road. So for
16 example, SouthCentral Foundation has already achieved Level
17 III certification, but even once you achieve that level, there
18 is still work to be done in terms of improving practices and
19 really getting there.

20 So what we did -- at the end of the day, the Legislature
21 funded \$400,000 and actually did that through a grant through
22 the PCA, and we will be then sub-recipient granting three
23 \$100,000 grants through a competitive process and retaining
24 about \$80,000 to use for consulting and technical assistance
25 and training for not just these three, but also all of the

1 health centers that want to partake of that training and
2 education. And we just actually closed the RFP for that
3 yesterday. We had seven applications. I haven't had a chance
4 to look at them yet. We got them yesterday afternoon, but in
5 scanning them, they looked like pretty strong applications,
6 all of them, and there was more interest on top of that.

7 We are, again, asking the Legislature this year for
8 additional funding because there is interest, there is
9 additional need, and we'd like to be able to see that
10 supported.

11 So our initiative includes funding through these three
12 direct \$100,000 grants to the sites and then the technical
13 assistance and training and also that they will be together
14 participating in this as kind of a learning team, learning
15 collaborative as they go through it, sharing best practices
16 and learning from others.

17 In this handout that you received is kind of a
18 description of that model. The goals of the project -- I
19 don't think I'll read this to you, but if you look on page
20 two, the project description for this initiative outlines the
21 goals, which are pretty much one glance of the triple aim,
22 pretty quality, contained or decreased costs, and an improved
23 patient and provider experience.

24 The objectives are in embracing the six elements of the
25 patient-centered medical home and achieving, at the end of the

1 day, Level III, or when I say that, I'm thinking the NCQA
2 model, but that is not prescribed. The health centers can
3 choose whichever model they would like, and actually, we want
4 to be -- I should stress that we're working very much in
5 partnership with the State and the State's PCMH work, and you
6 know, don't see any other way for success but to do that as
7 well. And so you know, in joining our efforts and working
8 alongside each other, I think that we will achieve much more
9 that way.

10 So the process is outlined here in this little graphic.
11 And then we have a stakeholder group that the participants
12 will be participating in, and this stakeholder group is also
13 addressed in the State's RFP, and we're thinking it's going to
14 be the same stakeholder groups, an example of working
15 together.

16 So in a nutshell, that's kind of where we're at. We
17 anticipate actually wrapping up the review of these grants
18 next week and making the award announcements by the end of the
19 next week. So we're moving it right along. The copies of the
20 materials, the RFP, scoring matrix, other resources and
21 materials can be found on our website, which is AlaskaPCA.org.
22 And I think that's about it, in a nutshell. I don't know if
23 there are additional questions. We're really excited about
24 this project. Our sites are really excited, and we think this
25 is going to be that launch that kind of gets them past some of

1 the barriers that they've had due to (indiscernible - voice
2 trailed off).

3 COMMISSIONER ERICKSON: A question from Keith?

4 COMMISSIONER CAMPBELL: Marilyn, how quickly do you think
5 you'll have some -- enough valid information to start
6 disseminating the results of your studies?

7 MS. KASMAR: Thank you for that question. This is a 16-
8 month project period, and one of the items that we're working
9 on is the collection of data, and you know, the consolidation
10 of that data to prove results, and the results that we are
11 interested in knowing about are the three related to the
12 triple aim. So I would say in 16 months we should have a good
13 set of data. We're still though outlining what the metrics
14 are, and we need our project participants to help us with
15 that. And I should also say we're working closely with AHN.

16 One of the other things that we would like to do is --
17 the AHN has a clinical data repository as part of its model,
18 but it doesn't plan to collect other information in terms of
19 financial or practice management or population. So we would
20 like to work with AHN to augment that, so that, when all the
21 information is coming in through the (indiscernible - voice
22 lowered) network, that it's really telling the whole story.

23 COMMISSIONER ERICKSON: Other questions or comments from
24 the group? I have one for Kim, I think. I just want to
25 clarify -- check and make sure that I didn't misinform

1 somebody, but I had a phone call from an administrator of a
2 large private practice just a couple of weeks ago, and he was
3 expressing frustration a little bit, but was calling me to ask
4 if I knew if he was going to have an opportunity. His
5 frustration was both the TCHC project -- could you go check
6 that out? They're scraping ice, but maybe you could go ask
7 them to wait until our meeting is over. Thank you. Thanks,
8 Colleen.

9 He was frustrated, and I explained to him why it rolled
10 out this way, that the clinics that were invited to apply to
11 participate in both TCHC initially -- and then I think he had
12 looked into the Primary Care Association's RFP as well. So
13 this is a large private practice clinic that was interested in
14 seeing what they could do to participate in getting some
15 resources to support their transition to a medical home model,
16 but since they weren't or aren't a non-profit, they weren't
17 able to participate in either of those two projects. So it
18 had to be, well, a non-profit to participate in the TCHC
19 program and I think a federally-funded community health
20 center, which his clinic is not, to participate in the Primary
21 Care Association's. And so he wondered if there was anyway he
22 would ever get a chance to participate in some initiative that
23 the State is putting forward to test and support development
24 of this model, and I told him that I believed that the
25 Medicaid pilot program, once that's rolled out a few months

1 from now, would support pilot demonstration projects in the
2 private sector that would not be limited to just non-profit
3 clinics, but I probably should have confirmed before I went
4 out with that. I can call him back and correct, if I was
5 wrong.

6 MS. POPPE-SMART: I don't think you need to correct. I
7 think the important thing, to us, is that they are a Medicaid-
8 enrolled provider.

9 MS. KASMAR: I actually have a couple of additional
10 comments that I would like to make. One is that we have
11 already held a meeting of our stakeholder group, and there was
12 great interest in that, and one of the things that we're
13 seeing is there is so much stuff going on in the arena of
14 patient-centered medical home, and it's all kind of swirling
15 out here in the universe, and it's, at this point, I think
16 really important to talk coordinating, collaborating, making
17 sure that we all know what each other is doing and working
18 together in a common direction and talking about that on a
19 regular basis. So that was something that we talked about.

20 The other thing that we're actively working on is some of
21 the policy aspects of this, and this is something that our
22 participants in our project and the stakeholder group will
23 help with as well is, you know, informing favorable public
24 policy that is compatible and supports the patient-centered
25 medical home.

1 And then the third thing -- I had three things. It just
2 flew out of my brain. Okay. I think those two are very
3 important to note though. Thanks.

4 COMMISSIONER ERICKSON: Well, and I had one other thing I
5 was going to point out to the Commission that I included in
6 their packet that nobody else has. So if you think of the
7 third thing, Marilyn, before I finish, but behind tab four, I
8 had actually included just the scope of work from the
9 Department's RFP for the patient-centered medical home
10 consultant, just so you could have a sense of what background
11 the Department was considering and the scope of work that they
12 were asking for from the consultant, but behind then the
13 Primary Care Association's paper -- and this was just
14 informational, again, but a very recent edition of the *Nome*
15 *Nugget* had an article on the front page about Norton Sound
16 Health Corporation's approach to moving towards a patient-
17 centered medical home. It's just informational, but we're
18 hearing -- I mean, the fact that we're hearing from this large
19 private sector clinic in Fairbanks with a question and we know
20 that other clinics that have shown early interest are already
21 moving to Level III certification, SouthCentral Foundation,
22 Providence, Family Medicine Clinic, and some others, one of
23 the things, with the help of the Primary Care Association,
24 their new stakeholder group, I want to start inventorying
25 where all of these different clinics -- because we don't have

1 that many in the state. We can keep track of where they are
2 and what their interest is and who has actually attained
3 certification, but there is a lot of interest and activity
4 moving forward, not just through a couple of government
5 initiatives, but in the practice and service delivery world as
6 well. Yes, Marilyn?

7 MS. KASMAR: Just one more thing. What I also wanted to
8 mention and make note of was we have a strategies paper that
9 we have produced that outlines, at the local level, the health
10 center level, the PCA level, the statewide level, our vision
11 for the way that this could move forward in a really
12 coordinated way. So that is available on our website, and if
13 you have further interest -- and I know I've provided it to
14 you. So you may have already seen it, but I think that that
15 could be a useful document for you, too. Thanks. And that is
16 it for me.

17 COMMISSIONER ERICKSON: Larry and then Dave?

18 COMMISSIONER STINSON: Kim, when does that Medicaid
19 program start or when can people try to become part of that?

20 MS. POPPE-SMART: Dr. Stinson, we're looking at mid to
21 late summer, issuing whatever mechanism it is, whether it be
22 an RFP or a Letter of Interest or whatever mechanism we're
23 going to use to attract interest. We will have a bit of a
24 marketing campaign before that, so we get some interest going,
25 but later in the summer.

1 COMMISSIONER STINSON: Thank you.

2 MS. POPPE-SMART: You're welcome.

3 COMMISSIONER MORGAN: Yeah (affirmative). That was one
4 of the best presentations that I've ever -- no -- Marilyn.
5 The question I have is -- and it's -- since I've tried to
6 document it myself, how will -- have you got an idea yet or a
7 concept of how you're going to track the units and costs
8 outside of the primary care system for your medical homes
9 because it's a savings to the system, not necessarily a
10 savings inside the primary care center or the community health
11 center or whatever? Have you guys kind of got a strategy on
12 how you're going to track that or be able to report it?

13 MS. KASMAR: Well, at this point in time, we've done some
14 research, but this is one of the questions that we would be
15 looking to the consulting folks to help us with, as well as
16 the talent that you've got with your project. And you know, I
17 see a group working together on this. So to answer your
18 question, kind of/sort of, but not really. At this point, we
19 know how it's being done in other places. We have some ideas,
20 but we haven't put that to any kind of a formulated strategy
21 yet.

22 COMMISSIONER ERICKSON: Any other questions or comments?
23 Well, thank you both very much for taking the time out of the
24 middle of your busy afternoon to come update. Appreciate it.

25 We just have other updates for the rest of the afternoon.

1 That was one thing about not having all of our new members
2 onboard. I tried to focus this meeting more on update and
3 learning and less on those areas where, later in the year,
4 we're going to spend time actually developing, working on
5 developing specific solutions. I'm going to follow the agenda
6 here, and if we get done early, we might just break early, if
7 there's a possibility. I shouldn't promise that before we're
8 done.

9 Just quickly related to our recommendations -- so again,
10 we're tracking prior year recommendations in the areas of
11 evidence-based medicine and payment reform both, certainly,
12 the patient-centered medical home initiatives, to the extent
13 that they're incorporating naturally some sort of payment
14 reform approach with the addition of per member, per month
15 payments to support the delivery of their new model. But I
16 wanted to share with you all -- this is, hopefully, not too
17 premature, but there is an RFP out on the streets right now,
18 and I have talked with the Commissioner's office, the
19 Department of Administration -- and we'll be inviting them to
20 come to a meeting a little bit later this year to share their
21 vision, probably with employer's role in health discussions,
22 have Commissioner Hultberg come back and meet with us on this,
23 but I think it's really significant and I wanted you to see
24 it. I included, in your packet behind tab four, the scope of
25 work for this RFP that's currently out on the streets from the

1 Department of Administration, and they have actually worked
2 with Commissioner Streur and are looking for a consultant for
3 health management and health plan design, and they're looking
4 at developing an employee wellness program as well as looking
5 at opportunities and options for redesigning the health
6 benefits plans for not just the employee health program, but
7 they're looking for someone to consult with them on aligning
8 strategies for -- across Medicaid and Worker's Comp and
9 Corrections purchased for health care services.

10 So just a reminder for the folks in the room that one of
11 your recommendations related to payment reform was that the
12 State could take the first step in aligning strategies and
13 working together to leverage some positive change in this area
14 across the different payers within state government, and this
15 is evidence of moving forward in that. And if you look
16 carefully at that RFP, they are making an effort to address
17 bringing in some evidence-based management principles as well
18 -- evidence-based medicine principles -- sorry -- as well.

19 So we will be getting updates later in the year directly
20 from Commissioner Hultberg on not only their vision, but where
21 they're at in moving forward with this initiative later.

22 COMMISSIONER CAMPBELL: That seems like a monumental
23 task. Has it ever been done before? Are we going to find out
24 or is somebody learning on our nickel this whole process?

25 COMMISSIONER ERICKSON: Has it been done before in other

1 states?

2 COMMISSIONER CAMPBELL: Yeah (affirmative).

3 COMMISSIONER ERICKSON: Yes; it has. There are actually
4 models in other states where they have reorganized state
5 government around all of the programs that are responsible for
6 purchasing. Now that's not something that's been discussed
7 and is not suggested in any way in this RFP, but I think there
8 are a few states that have gone as far as completely
9 reorganizing state government programs, not just talking
10 together and aligning strategies.

11 CHAIR HURLBURT: Including our nearest neighbor.

12 COMMISSIONER ERICKSON: Washington State. Washington
13 State and Oregon now, too, and there are a number of states.

14 CHAIR HURLBURT: Both of them, but they brought --
15 (indiscernible - voice lowered) kept separate departments, but
16 basically, they've brought the purchasers together in
17 Washington State. They bring them all together. Every year,
18 they have a seminar, a two-day seminar on evidence-based
19 medicine for whether it's (indiscernible - voice lowered) or
20 Workman's Comp or the state employees or Medicaid, but you
21 know, I think Oregon has done some more structural change.
22 Washington is more collaborative, although they have done some
23 structural change there, but there are others that are doing
24 it.

25 COMMISSIONER ERICKSON: Any other questions? As far as

1 transparency, you all had created a task for us for this year
2 with your recommendation last year, which was related to the
3 All-Payer Claims Database and the recommendation that the
4 Commission actually conduct a needs assessment and feasibility
5 study for an All-Payer Claims Database for the State. And
6 Keith, specifically, this was a recommendation that was
7 accompanied by the second recommendation related to
8 encouraging participation by all hospitals in the Hospital
9 Discharge Database.

10 So that's how those are related, and we're standing by to
11 recommend -- holding off on recommending anything more
12 directly related to the Hospital Discharge Database for now,
13 but in the meantime, we'll be working on getting a contract in
14 place, and I'm shooting for the end of this month to release
15 an RFP, but I wanted to just share with all my intention to be
16 working closely with the State Health Information Technology
17 Director who is responsible for the Health Information
18 Exchange development at the state department level. He's the
19 Program Manager and provides oversight and is the connection
20 to the Department for the Alaska e-Health Network, the AHN.
21 And to make sure that all of these different pieces related to
22 meaningful use requirements, the Health Information Exchange
23 requirements and capabilities -- understanding the data that
24 we receive now from the Hospital Discharge Database might not
25 be complete because we don't have all players. And also

1 understanding what -- we want to link in and make sure we're
2 understanding what the Health Insurance Exchange capabilities
3 will be as opposed to the Health Information Exchange, but
4 both of those -- and so I think it's really important that
5 we're coordinating and not working separately and in silos,
6 since all of these data pieces need to come together
7 eventually, to the extent we're trying to line up in early
8 planning stages and research and discovery. But also planning
9 on asking this consultant not just to do a needs assessment
10 and a feasibility for an All-Payer Claims Database, but up
11 front stating what our goals are and that those goals aren't
12 just about price and quality transparency for public reporting
13 purposes, which is our main area that we were studying here,
14 but across all of the different strategies we've been
15 discussing, the importance of having good data available for
16 population health management, for providing data to providers
17 and to payers, for clinical quality improvement, for
18 performance reporting for payers, information that
19 policymakers need, information that hospital and community
20 health improvement planners need, when we've identified that
21 whole infrastructure to the extent that we might -- we just
22 want this consultant to understand what all of the health
23 information needs of the state might be and to also ask the
24 question, if there are other systems other than an All-Payer
25 Claims Database that they might advise would better serve

1 those needs than an All-Payer Claims Database -- I didn't want
2 to go too far down the path of just assuming that that --
3 well, we believe, from what we've learned, that that might be
4 the ideal model, to not make that assumption. And then also
5 since we do have a specific interest in price and quality
6 transparency for the public, as part of this RFP, we'll ask if
7 they can do a little bit of an assessment for us of existing
8 laws in other states and data systems for supporting public
9 reporting of price and quality transparency in other states.

10 So that's, again, just an update for you, if you have any
11 questions or suggestions as we move forward with getting that
12 consultant onboard. Val?

13 COMMISSIONER DAVIDSON: Are they going to also provide an
14 estimate of how much providing that information is going to
15 cost?

16 COMMISSIONER ERICKSON: Yes. That will be part of the
17 feasibility side of that.

18 COMMISSIONER DAVIDSON: Thanks.

19 COMMISSIONER ERICKSON: Any other questions or comments?
20 Dr. Hurlburt, do you want to update us on the status of new
21 initiatives related to obesity prevention and also
22 immunizations?

23 CHAIR HURLBURT: Yes. The five priorities in public
24 health that we have as a public health division, and probably
25 in the order of priority, would be obesity and overweight,

1 number one; number two, tobacco, immunizations; three,
2 unintentional injury; and then fluoridation of public water
3 systems, and probably our biggest challenges are in one,
4 three, and five there. We're seeing some success in several
5 of the areas, although not all of them.

6 So let me talk about one and three there. Related to
7 obesity and overweight, what is the good news? A couple of
8 pieces of good news actually. One of the surveys that we do
9 of parents' perception of the leading health challenges for
10 their children resulted in 75% of the parents responding that
11 their perception of the leading health challenge related to
12 their kids were one of three things: overweight and obesity,
13 poor nutritional habits, or inadequate physical activity.
14 That's pretty good to get 75% of parents to do that. My hope
15 is that this is an area, when we see things, like that, that
16 the public will lead the political sector in identifying this
17 as a major problem that we have.

18 A second piece of good news related to that has to do
19 with the MatSu Valley. I think I've mentioned this before,
20 but the school board there in MatSu took on the challenge
21 related to overweight and obesity to try to get their kids to
22 be more active, more PE classes, more physical activity during
23 recess, improved school diets for breakfasts and lunches,
24 getting sugar-sweetened beverages out of the schools and so
25 on, and what we have seen is that, going back to the early

1 part of this past decade and through last fall, there has
2 actually been a decrease in the average BMI for the kids
3 there. That's the only place we've seen it. Anchorage has
4 had some leveling. Anchorage has been committed to it. Carol
5 Comeau has been a real champion. I hope her successor will
6 pick that up as well. But MatSu has been a real star in that
7 area. The rest of the state, the curve still goes up for kids
8 of increasing percentages of being overweight or obese, but
9 that shows it can be done, and the Borough Council out there,
10 the school board got behind it, the principals, the schools,
11 and parents, obviously, of course. And so that's the good
12 news.

13 Well, what's the bad news? The bad news is two-thirds of
14 American adults are overweight or obese and that number keeps
15 going up year-by-year-by-year. Poor self-perception. Most
16 people, meaning like 60% to 70%, of those who are overweight
17 think they're of normal weight. Similar percentages of those
18 who are obese think they're a little bit overweight. So the
19 perception is not good there. So what does that mean? I'll
20 say it again, but it's got to be imprinted in our DNA. CDC
21 projects, of American kids being born in the last decade, 38%
22 of girl babies are at risk of becoming diabetic as adults, 34%
23 of boy babies. That's huge. Historically, we've had about
24 6%. We're up about 8% now of American adults are diabetic.
25 If that number gets up to those kinds of numbers, the economic

1 impact on the American economy will be devastating. What does
2 it also mean? It means, if you're a woman and you're 40 years
3 old and you're diabetic, your average life expectancy is 14
4 years less than if you're a 40-year old woman who is not
5 diabetic. That's big time. That's not what our plans are for
6 our lives there. What does it mean? It means, as it was
7 pointed out in the First Lady's report, Michelle Obama's
8 report from the White House, that the generation of American
9 kids being born now may be the first ones since the beginning
10 of our country to not live as long as their parents, and as I
11 say, that keeps getting worse and worse. The numbers of
12 deaths are still greater related to tobacco, but the
13 complications for overweight and obesity are approaching it,
14 and the direct medical costs related to the complications of
15 overweight and obesity have now surpassed those related to
16 tobacco. What does that mean for Alaska? Close to half-a-
17 billion dollars a year now on the medical costs directly
18 related to that.

19 There is not good general acceptance yet that it's a
20 public health problem. To be honest, our Governor's office
21 does not yet recognize this as a major public health
22 challenge, and I don't have any great-grandchildren yet, but
23 I'm convinced that, for my great-grandchildren's lives, it
24 will be the dominant public health challenge for their entire
25 lifetime. It's going to be a bigger challenge than tobacco

1 has been and will be. We're seeing more of the folks in the
2 Legislature, folks from both parties, who are recognizing this
3 and understanding that it's a problem, that it's a health
4 problem, but it's also an economic problem.

5 Representative Mike Hawker expressed to me that he
6 believes, probably on a national basis, it's our number one
7 national challenge. That's in a world with Iran. It's in a
8 world with Somalia. It's in a world with Obama Care. It's in
9 a world with a lot of other things, but what it's doing to our
10 health, what it's potentially doing to our economy is
11 absolutely huge, and it is a public health issue, just as
12 water and sanitation are, as immunizations are, as a lot of
13 things are. And so I'm heartened that we see 75% of parents
14 recognizing that it's a problem for their kids because I
15 think, you know, sometimes it's a role of government and
16 government leaders to lead the public. Sometimes, the public
17 leads us. And hopefully, this is going to be an area where
18 we're going to see that happening.

19 There are some initiatives in the Legislature to provide
20 some funding. The funding that we have is very modest now.
21 Representative Holmes, a couple years ago, was instrumental in
22 getting some money into our base budget to replace the loss of
23 federal money that we've seen there. Public health money from
24 the Feds is in a fairly dramatic downward curve. If you look
25 at the curve of federal public health funding starting about

1 2001 -- and a lot of it was, quite frankly, related to 9/11
2 and to the Anthrax scare, but base public health funding went
3 like this until about 2009, and it's been going down ever
4 since. I said, to one of my colleagues, that I wonder how
5 many public health types ever thought they would look fondly
6 back on the days of George W. Bush. But the support that
7 we've had in public health areas is kind of on a downward
8 curve now because of the all the pressures that we see in
9 government and so we're looking for some areas where the state
10 will step in, in areas that they haven't before.

11 So kind of a mixed bag, but mostly negative, mostly
12 discouraging. My own self-perception is I failed, that I have
13 not been able to convince folks this is our dominant public
14 health challenge, and public health is a valid governmental
15 function. Under our constitution in our state, it is a state
16 government function, the way we operate in Alaska here. And
17 so the news, mostly not good enough, but a few hopeful areas,
18 and hopefully, we'll see that.

19 Immunizations is the other one I want to mention. We
20 have seen improvement in that we look at immunizations at
21 various age levels. It involves kids right from birth on up
22 to the oldest adults who need immunizing. We measure --
23 around the country, one of the common measurements is for two-
24 year olds. It's usually 19 to 35 months old. How are they
25 doing in the recommended immunizations? The number of shots,

1 the number of immunizations has gone up a lot. So there are
2 now 15 shots that a kid has to have by the time they're two-
3 years old to be up-to-date. Because we have more vaccines, we
4 have more protection to offer. The costs have gone up. The
5 vaccines cost about \$1,800 now, if you got all of the
6 recommended vaccines. So it's pretty costly. We were number
7 49 among the states. We have moved up to 42. So we've made
8 some progress. It's not -- in percentages, it's not a big
9 progress.

10 One of the challenges that we have is what's called
11 parental hesitancy. That means parents who don't want their
12 kids to get immunized, and our parental hesitancy rate,
13 according to one report anyway from CDC, is 9%. That's the
14 highest, in my mind, the worst in the country and that's
15 because parents are concerned there are so many shots for
16 their kids. They're concerned they're not safe. They're
17 concerned for other reasons, and much of that is just plain,
18 flat out ill-funded. For many years, and today, tens of
19 millions of people around the world think that the shots for
20 measles, mumps, and German measles, rubella caused Autism.
21 There was a widely-read, widely-accepted study that came from
22 a British medical scientist that showed that that caused
23 Autism, and this was widely believed. It turned out, a number
24 of years later, and just a couple of years ago now, that it
25 was not a misinterpretation of data; it was a deliberate

1 falsification of data by an individual who had a bias. He has
2 since lost his medical license. He has been discredited, but
3 many people still believe that, and there are some other, I
4 think, ill-advised things. So we really need to work on
5 educating people.

6 When I started in practice, there was no measles vaccine.
7 There was no mumps vaccine. There was no chicken pox vaccine.
8 We had small pox. We had tetanus. We had typhoid. We had a
9 few things. Polio was just barely getting started with an
10 older vaccine, but I saw kids die every year from measles in
11 Alaska, particularly in western Alaska. The infant mortality
12 rate, which means the number of kids who died -- you measure
13 it per 1,000 live births. The number of babies who died in
14 their first year of life due to the complications of measles
15 was 25 per 1,000 live births every year. Do you know what the
16 total mortality rate, the infant mortality rate is now from
17 all causes per 1,000 live births? It's around six. It's less
18 than a quarter of what it was from measles alone. That's a
19 preventable disease. We shouldn't see it there.

20 Alaska was blessed in many ways by Senator Stevens,
21 Senator Ted Stevens, and one of the ways where he used his
22 clout was to get us significantly more than our share of
23 federal funding for immunizations. We were totally funded for
24 kids, for all kids, whether Premera insured them, whether they
25 had no insurance, whether they were Alaska Native, whether

1 they were Medicaid. We were funded federally for all of those
2 kids. When Senator Stevens lost the election, starting in
3 2009, CDC has been cutting us down to the point where we're
4 now treated like other states. They're not treating us
5 unfairly, but we lost that favored treatment. And so we have
6 a lot of kids. There is \$700,000 in the Governor's budget to
7 buy vaccines there. And so if that passes the Legislature, I
8 think -- you know, hopefully, expectedly, he would sign it,
9 since it was in his budget request.

10 And then in addition, the Legislature -- and Senator
11 Cathy Giessel started out as the initial sponsor in the
12 Senate, and Representative Herron is on the House side. They
13 have sponsored a bill that would provide additional money for
14 vaccines. This is a major change, a major new thing. If the
15 State of Alaska is going to provide that, what that would
16 provide is vaccine money for the 25% of kids that neither have
17 good health insurance that would cover the vaccines or the 50%
18 of kids who are either Alaska Native or on Medicaid because
19 the Feds still provide the money for those vaccines. We
20 didn't look at providing all vaccines because, as I started
21 out, they're quite costly.

22 The initial bill that Senator Giessel came up with -- and
23 it's in Representative Herron's bill -- was about \$2.9
24 million. What that will buy -- now that will buy all the
25 vaccines for kids and the ones for adults in which the cost is

1 for what we call QALY, Quality Adjusted Life Year. It's where
2 the cost per Quality Adjusted Life Year is below \$25,000.
3 That means, for a dollar spent for an immunization, you save -
4 - some of them are actually positive numbers. You save more
5 than the dollar, but it goes on up to \$25,000.

6 For those that are not included -- and there are several
7 that are recommended that are not included -- the cost per
8 Quality Adjusted Life Year was \$50,000 or more and that goes
9 up to \$250,000 or more. So it was a reasonable and a
10 defensible kind of thing, trying to get the kind of money
11 that, potentially, we could receive. That's working its way
12 through the Legislature. I don't know what will happen, but
13 we have some -- there are some good champions in there. We,
14 likewise, don't know what would happen in the Governor's
15 office on that, but if we get a reasonable bill there,
16 hopefully, we could see that supported, and as I say, that
17 would be something really new and really dramatic, and in my
18 bias, showing concern for our kids there.

19 In the meantime, the VacTrAK system, which is the
20 computerized data system for vaccine, we're trying to get all
21 the providers in the state that we can on that, which gives
22 good information about who is getting the vaccines, and
23 pushing to try to continue to improve our immunization rates.
24 So far, we have dodged the bullet, but two years ago,
25 California had ten infants die from mumps, from the

1 complications of that, and they were -- one of them had had --
2 I think two of them had had one shot, not the series; the
3 other eight had had none. They had between 2,000 and 3,000
4 cases of mumps there in the state, and virtually all had not
5 been immunized. That state put on a big push, and their
6 immunization numbers went up. From the ten deaths they had in
7 2010, there were zero for mumps in 2011 with the immunization.
8 So it paid off, and it saved the lives of kids. So that's
9 basically where we are on that.

10 COMMISSIONER ERICKSON: Does anybody have questions for
11 Dr. Hurlburt? Moving along, thank you, Ward. I had asked
12 Paul Cartland, our State Health Information Technology
13 Director, if he could come give us a little more thorough
14 update on the status of a variety of health information
15 initiatives, but he had to be out of state this week.

16 So I just put a few statistics, and these are very recent
17 -- I'm on slide 12 of our Discussion Guide -- just through
18 February, through the end of this past month, the numbers of
19 health care providers who have signed up and the number who
20 have been paid already under the Electronic Health Record
21 incentive payment program. So far, we have 348 professionals
22 registered with CMS and 17 hospitals registered with CMS and a
23 little bit fewer registered with the State in both of those
24 categories, but to date, over \$7.5 million has been paid out
25 under those incentive programs for professionals and

1 hospitals.

2 And we also have -- this is relatively new in the past
3 year, and I don't remember if you all had an opportunity to
4 learn about it. I think the last we had a real thorough
5 overview and update on the Health Information Technology was a
6 year ago, and since that time, we have two programs, one
7 statewide and then a separate specific to the tribal health
8 system, federally-funded programs that are called RECs,
9 Regional Extension Centers, and those are extension centers
10 that provide technical assistance to health care providers to
11 help them with the adoption of Electronic Health Records. And
12 so far, in just a few months, the tribal REC has signed up 933
13 providers in the tribal health system, and the Alaska e-Health
14 Network has signed up 390 providers. So we have folks coming
15 onboard, joining the RECs, and receiving assistance in
16 accessing services for help with establishing Electronic
17 Health Records.

18 There are -- so far -- we need to give you a much more
19 thorough overview and update on the Health Information
20 Exchange, but I just wanted to note, for you, that, so far,
21 there are 34 organizations, health care organizations signed
22 up through Data Use Agreements for that, and I know they've
23 been doing some limited pilot testing, but we'll have Paul
24 come to a future meeting to give us an update on the status of
25 the development and implementation of the Health Information

1 Exchange.

2 Related to Workforce Development, the Alaska Health
3 Workforce Coalition continues to meet monthly and are working
4 on implementing their Action Plan. I wanted to highlight, for
5 you, a couple of -- well, one is a piece of legislation, and
6 one is a legislative funding request for -- that are directly
7 related to recommendations from our 2009 report, the Workforce
8 Development recommendations that we made.

9 One of those was for the establishment of a loan
10 repayment and employment incentive program for recruiting and
11 retaining health care providers. There is legislation pending
12 right now, House Bill 78, in House Finance. Assuming it makes
13 it through the House, it has, what, a couple of months, at the
14 most, to make it through the Senate side. So if that state
15 policy, that new program -- it is probably a little bit
16 tenuous, at this point, but there is legislation pending that
17 would establish that program.

18 Also related to one of our recommendations from 2009 was
19 the importance of establishing and maintaining residency
20 programs for primary care physicians, specifically, in this
21 state. There has been a lot of activity around development of
22 a psychiatric residency program, and currently, there is not
23 funding in the budget request for the new fiscal year, state
24 fiscal year '13, but I know there are efforts afoot to try to
25 get an amendment added to the budget that would support

1 funding. That's an initiative that has lots of support
2 already from private provider organizations, I think, the
3 Mental Health Trust Authority as well, hospitals, and the
4 Hospital Association. They're just looking for some state
5 support for that. So those are two issues pending in the
6 Legislature directly related to past, but still current,
7 recommendations of the Commission.

8 Also related to residency programs, I didn't note on here
9 the ongoing work to get the pediatric residency program
10 established, but that's still moving forward, but there are
11 relatively new efforts in both Fairbanks and in MatSu. In
12 Fairbanks, I think, hospitals, at least one of the leaders in
13 this initiative and in MatSu, private practice physicians are
14 working on initiatives to establish new family medicine
15 residency programs in those two communities. And so I wanted
16 to just mention that for you. We'll do -- at some point later
17 this year, we'll have the Health Workforce Coalition come back
18 and do a complete overview and update, but since they had
19 come, what, three or four or five months ago, we thought we'd
20 wait a little more time. I mostly wanted to bring to your
21 attention some of the things pending in the Legislature
22 related to our recommendations.

23 And with that, we will be ready for next year, or
24 tomorrow. We are ready for a break. If you want to take just
25 a ten-minute break right now, and we'll do -- I wanted to

1 bring something related to state health planning to your
2 attention and then we'll do our federal reform update and be
3 ready to recess for the day.

4 3:05:03

5 (Off record)

6 (On record)

7 3:22:33

8 COMMISSIONER ERICKSON: Are we about ready to reconvene?
9 Everybody is back at the table. I had -- Colleen and I had
10 noted, when we were talking about the 2012 financial
11 disclosure forms, that Keith, Emily, and David were missing
12 them from their notebooks, and you should now all have them.
13 The three of you should have them. Was there anybody else who
14 was missing one? I know several folks have already filled
15 theirs out and turned them in to Colleen; thank you. We have
16 a couple extras here, in case you didn't have one.

17 So we have just a couple of quick agenda items for the
18 rest of the day, and one, I wanted to share with you some
19 activities that are really just getting underway related to
20 statewide health planning, but first start with a reminder
21 that our statute -- the bill that established the Commission
22 in statute added to a section in state law that describes the
23 duties of the Department. So it's the part of the statute
24 that directly establishes the Commission. It's a different
25 area of statute that that bill addressed, and included in --

1 as a new -- it's not really a duty because there is a "may"
2 statement with it, "the Department may," and the new language
3 was that "the Department may develop a statewide health plan
4 based on the recommendations of the Commission." So there
5 isn't a duty, but there is an authority, I guess, for the
6 Department to do that, and we've started some preliminary
7 conversations about what that might mean, and we'll be
8 treading slowly and lightly, moving in that direction.

9 In the meantime, something that we had started doing --
10 another provision in the statute assigned, as a duty to the
11 Commission, responsibility for coordinating all health
12 planning for the State. And since there are so many bodies --
13 I don't know that that those of you who were on the Commission
14 in 2009 remember the inventory that I put together of all of
15 the state government bodies, not just all of the groups in the
16 state that do health planning, but those that are designated,
17 in some way in state statute, for having some sort of
18 responsibility for some aspect of health planning and thought
19 that, if nothing else, we could, at least, have -- keep track
20 of and have a list and understand all of the different groups
21 that are responsible. And at the same time, we had put
22 together an inventory of all of the plans, health -- statewide
23 plans related to health that had been developed by any sort of
24 group, but with a statewide purview, and it was a long list.
25 We listed everything that -- every plan that had been

1 developed in the past ten years. And so I'm going to be
2 taking a stab at updating those, and Tom is in the back of the
3 room from the Alaska Mental Health and Substance Abuse Board,
4 so I'm going to ask you to help with the behavioral health
5 section of that, but I'm going to update those two inventories
6 for all of you, for us.

7 At the same time now, there are a couple of new things
8 going on. One, there is a new national body that will be
9 accrediting -- there has been a project going on for five
10 years now, but it's just launching a new accreditation for
11 board for governmental public health agencies. Specifically,
12 state and local governmental agencies now have an accrediting
13 board, and they've just now -- it started at the beginning of
14 this calendar year. They've gone through the beta testing and
15 everything, and they've just launched the actual initiative
16 where government agencies can start the application process to
17 become accredited.

18 And Dr. Hurlburt, I don't want to -- if I say anything
19 off-base a little bit related to your responsibility as the
20 State Public Health Director, make sure you correct me, but my
21 understanding right now is that our state public health agency
22 isn't ready to just jump onboard the accreditation wagon, but
23 they also have a grant from the federal government right now
24 to support public health system improvement in the state, and
25 at the same time, the Alaska Native Tribal Health Consortium

1 has the same grant from the same federal agency to support
2 public health system improvement planning in the tribal health
3 system. And these are interrelated because a prerequisite or
4 a precondition of starting to work towards accreditation as an
5 accredited public health agency is the development of a
6 statewide health improvement plan.

7 And so the fact that there is this new board and this new
8 activity and that our state government public health agency
9 might be interested, at some point, in moving in that
10 direction, a first step would be for them to develop a state
11 health improvement plan. Under a separate initiative, they
12 have funds to develop a state health improvement plan and have
13 been partnering closely. The project leads for the state
14 public health agency have been working closely with the tribal
15 health system project lead, and they approached me,
16 understanding that we have a charge related to state health
17 planning, and we're assuming that we would -- that they would
18 do their work and provide it to us two years from now, and I
19 pointed out to them that we, this body, sunsets in two years,
20 which doesn't mean we'll be gone, but that, at least in my
21 mind, I am acting as if we'll be gone in two years and kind of
22 trying to focus our work so that we have a comprehensive
23 report and plan that adds some value, in case we don't exist
24 after two years. And if we do, good, but if not, we want to
25 have added some value at the end.

1 So we've started coordinating efforts, and as part of
2 their work to start development of a state health improvement
3 plan, a parallel effort will be to update -- to do the new
4 Healthy Alaskans 2020, and it was probably a year or more ago
5 when I shared with all of you copies of Healthy Alaskans 2010.

6 Every ten years, the federal government put out Healthy
7 People targets, health improvement targets for the decade. So
8 there was a Healthy People. I think the first one might have
9 been 1990. In 2000, we had Healthy Alaskans. And then states
10 can choose to adopt the framework and work on developing a
11 resource document, plan document, based on the federal
12 national document.

13 So in Alaska, we did a Healthy Alaskans 2000 and a
14 Healthy Alaskans 2010 initiative, and if you're interested,
15 it's across multiple focus areas, everything from infectious
16 disease to food safety to water quality, family planning.
17 There were 26 different focus areas in Healthy Alaskans 2010,
18 and I think, more than 300 different indicators. They're
19 trying to do something a little more targeted and focused for
20 Healthy Alaskans 2010, but they are starting the -- and when I
21 say they, Dr. Hurlburt and his staff in partnership with the
22 tribal health system and other agencies within the Department
23 of Health and Social Services are beginning to plan to plan
24 for Healthy Alaskans 2020.

25 And so I mostly wanted to just note that for all of you,

1 that one of the first things I offered them, actually, as a
2 resource is these inventories that we could update quickly and
3 easily, from a couple years ago, as they move forward, but
4 we're going to be meeting monthly in short meetings to make
5 sure we're coordinating and sharing resources and information
6 and not duplicating efforts, and to the extent we can combine
7 and consolidate -- and may or may not conquer -- we're going
8 to be doing that.

9 One other thing I would note about that, you're going to
10 see here in this presentation on an update on the Affordable
11 Care Act, new IRS requirements for tax-exempt hospitals that
12 are taking effect this year include a requirement for
13 hospitals to conduct a community health needs assessment and
14 to develop a strategic plan based on that needs assessment.
15 And so some of the larger hospitals in MatSu and Anchorage,
16 we're talking with them and inviting them to participate as
17 well, so we don't have to duplicate the data gathering
18 efforts. So we're supporting each other at that, as a
19 minimum, and then just understanding, communicating, and
20 coordinating what we're doing between those local initiatives
21 at the statewide level.

22 So that's just more of an FYI for you, but I thought it
23 was important enough to just highlight that quickly for you.
24 Does anybody have any questions about that, before we go on to
25 the Affordable Care Act? Yes?

1 CHAIR HURLBURT: Just one comment, and you did say we'd
2 be more focused. That's a pretty big book for 2010. For
3 2020, the Feds have 600-and-some different objectives, which
4 kind of means, like, nothing to me. So we will intentionally
5 try to come up with a number of high priority areas because it
6 is important to think about these major public health
7 measurements and where we are and where we should be trying to
8 go, so we've got something to measure ourselves against, but
9 it will be a more meaningful number rather than the 600-and-
10 some that we're doing as a nation, which, to me, doesn't seem
11 very practical or reasonable.

12 COMMISSIONER ERICKSON: So let's move on to our Federal
13 Health Care Reform update status report. What I have done is
14 I took the PowerPoint presentation that I've put together for
15 you at the -- for our last meeting last year and have included
16 additional updated information in orange font.

17 And so what I'm going to do is move through this
18 presentation quickly, and I'm not going to go -- I'm not going
19 to revisit all of the points on all of the slides. I'm only
20 going to stop on the slides that have an update in orange font
21 and tell you a little bit about those, and we'll turn to Linda
22 for support on any of the updates related to insurance market
23 reform specifically and insurance programs. And you all have
24 this in your notebook at the back behind tab four, and there
25 is also a copy of this in hard copy in the back of the room

1 for folks in the audience, and it's also posted online on the
2 Commission's March 2012 meeting page as well.

3 Just a quick note about the Supreme Court challenge, a
4 couple of things I wanted to note for you about that. The
5 question had been about the individual mandate and also the
6 Medicaid expansion were the two major areas that were being
7 challenged in the court cases.

8 One of the court cases that was brought and that was
9 ruled on at one of the Circuit Court levels was the Anti-
10 Injunction Act and that is a question regarding whether --
11 since these provisions have not taken effect yet so the harm
12 hasn't been incurred yet directly, there is no jurisdiction to
13 bring a case to court, at this point. And so -- and this is
14 something that the Supreme Court decided to rule on. The
15 significance of that is, if they decide to uphold the question
16 about the Anti-Injunction Act, they, essentially, will be
17 saying nobody can bring a case against the federal government
18 related to these provisions that don't take effect until 2014
19 until after 2014, so they can demonstrate the harm that
20 they've experienced from those provisions. So that's going to
21 be real significant. It's a possible outcome, not just yes or
22 no; we find the Medicaid expansion and/or the individual
23 mandate to be constitutional. They might, instead, say there
24 is no grounds for these cases to be brought before us because
25 they have not taken effect yet. So there is a chance that we

1 could be hanging in limbo for a while.

2 The Supreme Court will be hearing oral arguments on all
3 of these points on March 26th, 27th, and 28th, in just a
4 couple of weeks here, and they'll issue their ruling in June
5 of this year.

6 Just a point about all of the regulation packages. I did
7 not have a chance to go back and count, since the last time I
8 updated this presentation, the 34. There were probably -- I'm
9 imagining it's up to 50 or so regulation packages that have
10 been released so far, but I had stumbled across a website last
11 week that somebody who was keeping track of just the word
12 count of all of the regulation packages, they pointed out that
13 the total number of words in the regulation packages released
14 under the Affordable Care Act, to date, exceeds three times --
15 about three-and-a-half times the number of words in *War and*
16 *Peace*. So this is the Health Attorneys' Full Employment Act
17 maybe is what they should have called it.

18 You know, one of my thoughts though about that is just
19 imagining looking at all of those -- that laundry list of all
20 the laws that impact the health industry -- I asked a friend
21 who is a hospital administrator, a couple of weeks ago, how
22 they can manage to actually deliver any care when they have to
23 spend all of their time complying with all of these federal
24 requirements, and he told me the story of having had, within a
25 90-day period at one point, nine different governmental

1 agencies come in and do some sort of inspection or audit or
2 survey, and I think it is pretty overwhelming, not just for
3 the hospitals, but especially for private practice providers
4 in dealing with all of that. So these are just some new
5 layers in that effort.

6 On slide 11, the New Insurance Plan Options, the
7 temporary high-risk health insurance pool -- and Jeff, you
8 might know even more than Linda, since you're on the board for
9 ACHIA. We had mentioned earlier today that, with the number
10 of Alaskans enrolling in the Affordable Care Act Federal Pre-
11 Existing Conditions Plan that ACHIA administers, there have
12 been somewhere between usually about 45. And Linda, did you
13 say you saw there up to 47 now?

14 COMMISSIONER HALL: I think yesterday's update was 47.

15 COMMISSIONER ERICKSON: So yesterday's update, 47. As of
16 the end -- during December, there were 44 Alaskans enrolled in
17 that plan, but significantly, the amount of money that had
18 been allocated to Alaska for this program that was supposed to
19 last until 2014 was \$13 million, and we've -- the initial
20 estimate was that we would be able to cover 200 Alaskans with
21 that, is what I'm remembering. Wasn't it? 250?

22 COMMISSIONER HALL: 110.

23 COMMISSIONER ERICKSON: Oh, 110? Well, maybe it was
24 less. So there have been not the same 45 Alaskans, but at any
25 given time, approximately 45 Alaskans, but we've run out of

1 that \$13 million at this point and have requested --
2 anticipate spending \$10 million just during 2012, and if
3 requested, additional funding from the Feds. Jeff, do you
4 know what the status of that request is?

5 COMMISSIONER DAVIS: What I was told by Cecil Bykerk, the
6 Executive Director of ACHIA, a couple of days ago is that that
7 additional funding has been committed by the Feds because the
8 position of the board, I think, consistent with our direction
9 from the Governor and from the Division of Insurance is that,
10 if federal funds fail, the pool will be shut down. So we will
11 continue to monitor it and project the run out, and if there
12 is not money signed up for from the federal government, the
13 pool will be shut down.

14 COMMISSIONER ERICKSON: Does anybody have any questions
15 for Jeff or Linda about that pool specifically before we move
16 on?

17 Another recent activity has been the release of some
18 federal grants and loans under the Health Care Cooperatives
19 program, and this is the program that will establish a non-
20 profit member-operated health insurance company. It's
21 supposed to establish, at least, one in every state is my
22 understanding. And those are to take effect in 2013, but the
23 Feds have already started awarding grants. They started
24 accepting applications last fall and have had two rounds of
25 applications so far. They're accepting applications quarterly

1 is my understanding. So based on the ones they've receive to
2 date, they have awarded \$638.7 million total to seven non-
3 profits who will be providing coverage in eight states. One
4 of those seven non-profits is covering two states.

5 I've had folks ask me questions about whether I've heard
6 if there were any entities or individuals in Alaska who have
7 been expressing interest in this program, and I have heard of
8 none. And Linda, I'm assuming that anybody who was interested
9 in setting up a health insurance company in Alaska would need
10 to go through you to do so, at some point?

11 COMMISSIONER HALL: (Indiscernible - away from mic)

12 COMMISSIONER ERICKSON: And you have not heard? For the
13 record, she is shaking her head no; nobody's expressed
14 interest to the State Insurance Commissioner in establishing a
15 Health Care Cooperative here. Yes, Allen?

16 COMMISSIONER HIPPLER: If a Health Care Cooperative was
17 established, would it be paying -- would it have to pay taxes
18 on top line revenues as opposed to bottom line net profits or
19 contribution capital, Linda?

20 COMMISSIONER HALL: Most of our insurance companies pay
21 premium tax. They don't pay on revenues at all. The
22 exception, our hospital medical service corporations who pay
23 on a different basis -- it's premium minus claims and then
24 they pay 6% of that difference. So I can't tell you how they
25 would be organized, but I'm assuming, as a traditional

1 insurer, they would pay premium tax. So they don't pay, like,
2 an income tax type.

3 COMMISSIONER HIPPLER: So some insurers get to deduct the
4 cost of claims before they pay taxes and some do not?

5 COMMISSIONER HALL: Well, it's a totally different basis,
6 but yes; hospital medical service corporations take premiums,
7 minus claims, and they pay a higher rate of tax on that basis.

8 COMMISSIONER ERICKSON: We've already had an update from
9 Linda this morning on the review of Health Plan Premiums, so I
10 don't think there is anything new here on slide 12 to share
11 with you from this morning anyway. I'll skip over that.

12 Tax credits, I haven't had a chance to do any
13 investigation to see if there is some way for me to be able to
14 figure out if any small businesses in Alaska have been able to
15 take advantage of that during 2010 and 2011, but I was at a
16 meeting last week of Alaska Association of Health
17 Underwriters, and they said that they had been sharing with
18 Alaska's congressional delegation that they had surveyed their
19 members and there are over 100 Alaskans carriers and brokers
20 in their membership, and based on that survey, they had found
21 one who had one client who had taken advantage of the tax
22 credit. So I don't know how reliable that survey was, but
23 that's as far as I've been able to get in that research.

24 Another program that was set up as meant to be a bridge
25 to 2014 when all of the major provisions are to take effect

1 was the Temporary Early Retiree Reinsurance Program, and this
2 was a program that was providing some reimbursement to some
3 proportion of claims for employers for early retirees for
4 folks in their retirement plans who were over the age of 55,
5 but below Medicare eligibility at 65, and the intent was to
6 encourage companies to keep those retirement plan options in
7 place for folks during the kind of gap years between when they
8 might retire and when they were eligible for Medicare.

9 The Affordable Care Act appropriated \$5 billion for that
10 program, and it was meant to last from when it started in June
11 2010 through -- until 2014, but they just ran out of money.
12 So it lasted a year-and-a-half. They've used up the \$5
13 billion. And so we had eight employers enrolled in that
14 program from Alaska, and as far as I could tell, only seven of
15 the eight enrolled took advantage of it, but there were, over
16 the course of the past year-and-a-half, \$30.3 million received
17 by those seven companies through this program. And the HHS
18 has discontinued the program now because of the lack of
19 funding to continue it.

20 Health Insurance Exchange, and we talked about this
21 briefly this morning. I had asked Josh if he could come
22 update this group on the status of the consultant contract,
23 and I don't know that he would have had a whole lot to share
24 with you, but he could have helped answer questions, too, but
25 he had another obligation that he could not break this

1 afternoon, unfortunately, but he will be joining us at a
2 future meeting. And for those of you who don't know who Josh
3 is, I shouldn't make an assumption. He's the Health Policy
4 person in Commissioner Streur's office who is responsible for
5 the Health Insurance Exchange project. And so that contract
6 was awarded to Public Consulting Group. It's the same group
7 now that has received the consultant contract from the
8 Department for the patient-centered medical homes, which will
9 be interesting to see how that learning plays out.

10 The contract was awarded in January, and I expect a
11 report well before this, but no later than June of this year.
12 I know the Department is anticipating receiving a report from
13 them. And I had, in your last notebook of the last calendar
14 year, included a copy of the scope of work and the RFP for
15 that project. So you could see the sorts of questions that
16 the State was asking if you wanted to look back at that, at
17 some point, and we will have Josh come update us a little bit
18 later in the year on that project.

19 Moving on to slide 20, different payment reform
20 initiatives, and these are all under Medicare. They're not
21 directly under the purview, any of them, of state government
22 at all, but I thought they were significant enough I wanted to
23 mention them to you.

24 One of the things we actually probably need to get on the
25 radar with the Primary Care Association stakeholder group,

1 just for the purposes of keeping track of all the pieces --
2 actually, this doesn't need to be on their radar. It's
3 already on their radar because it's one of their members, but
4 the Anchorage Neighborhood Health Center was awarded a
5 demonstration project grant under the FQHC Advance Primary
6 Care Provider demonstration project, and essentially what that
7 is, FQHC, for the non-health folks in the room, is Federally
8 Qualified Health Center, and this is a demonstration project.
9 It's basically demonstrating the patient-centered medical home
10 in federally-funded community health centers or their look-a-
11 likes of some sort and is paying a \$6 per member, per month
12 payment on top of their regular payment. So that's why it's -
13 - I've put it in the payment reform provisions for medical
14 home services for their Medicare enrollees. And so Anchorage
15 Neighborhood Health Center is now participating in that
16 project.

17 We initially -- you know, since it's meant to be a
18 demonstration project, we initially had, I think, seven
19 different community health centers apply for that program, and
20 none of them received a grant initially under it because what
21 I had heard was that none of them had a large enough patient
22 base that the evaluators felt would support a good evaluation
23 project. So it would just be speculating as to why Anchorage
24 received one, but our largest community health center in the
25 state now has one of these demonstration project grants.

1 Two other new Medicare programs taking effect this year
2 that are effecting hospitals specifically are the hospital
3 readmission reduction program and the hospital value-based
4 purchasing programs. And the hospital readmission reduction
5 program will actually start implementing a Medicare payment
6 reduction starting in federal fiscal year '13, which starts
7 this October, and it's going to increase to 3% in federal
8 fiscal year '15 and beyond, will be capped at a 3% payment
9 reduction, but it's a new policy that's going to apply to
10 certain conditions. And I won't go into all of the details,
11 and if you're interested in learning more about this, we could
12 invite -- I'm sure, if Pat were here, he could -- and Pat
13 couldn't join us today because he had board meeting. So we
14 can ask Pat in the future to share a little bit more. We
15 could invite the State Hospital and Nursing Home Association
16 to share more of the details around those programs, but I
17 think these are real significant changes for our hospitals
18 that we might want to learn a little bit more about.

19 And the value-based purchasing program. Where the
20 hospital readmission reduction program is going to be a
21 disincentive, a pay cut, the value-based purchasing program is
22 a pay-for-performance program that is going to provide an
23 incentive program to hospitals for achieving performance on
24 certain quality measures. And so I know hospitals are working
25 hard to get those -- get all of their ducks-in-a-row for the

1 measures of those certain quality indicators. And there are
2 clinical quality measures, and there are also patient
3 satisfaction measures included in those sets as well.

4 One of the things about that, too, is that that program
5 is supposed to be budget neutral. So while it's going to be
6 an increased payment, my understanding is there are other ways
7 that the law reduces Medicare payments for hospitals to offset
8 and to provide funding for the pool to pay the incentive. So
9 payment reforms in the Medicare world that are taking effect
10 this year.

11 Just a note about CLASS Act. I don't remember where we
12 were at when we discussed this last October, but Secretary
13 Sebelius had reported -- just for those of you who don't know
14 what the CLASS Act is, this was the provision in the
15 Affordable Care Act that would establish a new long-term care
16 insurance program for the nation. It's a voluntary program,
17 and the U.S. Department of Health and Human Services evaluated
18 it and determined and reported to Congress this past October
19 that, because of the way the statute was worded, the program
20 could not be -- the statute required that the plan be
21 actuarially sound, and because of the voluntarily nature of
22 the program, the federal actuaries determined that it could
23 not be actuarially sound. So I'm sure I'm way oversimplifying
24 that, but Secretary Sebelius did report to Congress in October
25 that the Department could not implement that program as

1 designed. The House voted -- the U.S. House voted to repeal
2 the CLASS Act just this past month, the beginning of February,
3 and I'm not sure where that will go, but I don't think there
4 is going to be any activity to actually establish that program
5 unless it's changed in some way.

6 I think that's about it. I just updated a few details
7 about the Medicare "Donut Hole" Closure, and I did mention
8 earlier the new IRS requirements for tax-exempt hospitals.
9 Those are taking effect. I think some of these took effect a
10 year or two ago, but the one related to -- there are four new
11 major points related to tax-exempt hospitals.

12 In order for them to keep their tax-exempt status, they
13 have to report to the federal government, to the IRS that they
14 have adopted and implemented written financial assistance and
15 emergency medical care policies. They are having to document
16 how they limit charges for emergency or other medically
17 necessary care. They're going to have new billing and
18 collection restrictions. And then they will be required to,
19 at least, every three years conduct a community health needs
20 assessment and then to develop a facility base, and these are
21 facility base, so those hospitals that are part of a larger
22 hospital network. These are by facility requirements. Each
23 facility will be required to do this. This community health
24 needs assessment requirement includes a requirement that they
25 also conduct -- establish a strategic plan for making some --

1 implementing some strategies related to what they find from
2 the community needs assessment, specifically in their
3 facility.

4 But that is it for the Affordable Care update for this
5 meeting. Do you have any questions still about anything that
6 I just covered, and do you have questions about anything that
7 I didn't cover, and suggestions or requests for how we update
8 -- make updates to you related to the Affordable Care Act in
9 the future?

10 Good. That is helpful. And we would have had Josh here
11 on the Insurance Exchange, but his wife just was one of the --
12 received one of the "40 Under 40" awards, and they were having
13 a big luncheon and bunch of activities today. I said, you do
14 not have to come to the Health Care Commission and miss that.
15 He was that worried. We want Josh to be happy.

16 So that's it for our agenda for today. Does anybody have
17 -- we're wrapping up an hour early, but I think that's -- I
18 don't think anybody seems too upset. If you're really upset,
19 I will stay here for the next hour. We have -- there is
20 something I'll mention that Dr. Hurlburt had suggested we
21 might do today, but we don't have a good enough Internet link,
22 and you might not have had the patience at the very end of the
23 day for this, but there is a brand-new PBS documentary that
24 just aired last week that's available online, and Dr. Hurlburt
25 and I both watched it online. It's the reporter T.R. Reid who

1 has written a couple of books on improving health care, and
2 this one is called -- I know it has good news -- *Good News*
3 *Related to Medical Care in Alaska* or something like that.
4 Well, and he is profiling a bunch of -- a number of health
5 care organizations and a couple that Dr. Hurlburt is
6 intimately familiar with down south and some communities and
7 also the *Dartmouth Atlas of Care* and their findings and
8 directions.

9 Some health care organizations are going towards making
10 improvement. A lot of the strategies that they discuss in
11 this documentary are very related to a lot of the
12 recommendations that we've been addressing and so we thought
13 it would be interesting for this group to watch, at some
14 point, together -- it's about 50 minutes long -- and then have
15 a conversation. So we might do that at some point in the
16 future, if you think that would be interesting.

17 But I also wanted to mention that, because of that, T.R.
18 Reid is going to be here in Anchorage on March 22nd giving a
19 presentation -- a speech at the Wendy Williamson Center, and
20 the title of the speech is specific to the Affordable Care
21 Act. That's why -- the documentary that was -- that just
22 aired wasn't about the Affordable Care Act. So I don't know
23 exactly what his speech is going to be about, but he's going
24 to be here in town. It's -- the World Affairs Council brought
25 him and so on March 22nd, if you're interested.

1 Does anybody have any final questions or comments at all
2 for the good of the group before we recess for the day? Very
3 good. Well, I am assuming we can leave our stuff in the room.
4 I wouldn't leave anything valuable, but they do lock up
5 overnight, and we'll be back in this room tomorrow morning.
6 Thank you all very much.

7 3:58:03

8 (Off record)

9 **SESSION RECESSED**

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