ALASKA HEALTH CARE COMMISSION

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P R O C E E D I N G S

8:02

(On record)

CHAIR HURLBURT: Let's go ahead and get started. I appreciate everybody who is here. As we normally do when we start, we'll have the members of the Commission introduce themselves, and then for the public members that are here, we'll ask you to do the same thing here. We have one new Commissioner, and we'll start with him and then we'll just go around the table.

Jim Puckett is here representing the Administration as the new third non-voting member on the Commission appointed by the Governor. Jim is the Director of the Benefits Program for the State Employees, very much involved with the kind of issues that we talk about here. And I would say that one of the heartening things about a lot of our discussions that we've had here with the Health Care Commission is (indiscernible - background noise) Commissioner Becky Hultberg and Department of Health & Social Services' Bill Streur have embraced a lot of the things and have become really good public ambassadors, and those two have partnered in a lot of ways where the State is really a huge buyer of health care services in the state. That's been a really good thing for Alaskans and Alaska as a state.

So I've asked Jim if he would introduce himself -- he has

a long Alaskan history -- tell you a little bit about his background and a little bit about his hopes, at this point, for joining the Commission. Jim, welcome.

COMMISSIONER PUCKETT: Thank you. I'm an Army brat. Some folks would take offense to that, but I'm grateful that the military brought my dad up to fight for the battle (indiscernible - voice lowered) up in Fairbanks, and I stayed. When we got here, I fell in love with Alaska, and I stayed. So from 1969 until now, I've been in the state. I'm very heartened also with the conversations that (indiscernible - voice lowered) engaged in on the health care arena, and I'm looking forward to being part of that conversation here on the Commission as we all work toward the goal of improving health care systems in the state. Thank you.

COMMISSIONER CAMPBELL: I'm Keith Campbell. I reside in Seward. I'm the consumer rep on the Commission, and I find it very stimulating.

COMMISSIONER URATA: I'm Bob Urata of Denali Physicians from Juneau, Alaska. I've been in Alaska all my life. I was born in Wrangell, and I represent primary care.

COMMISSIONER KELLER: I'm representative Wes Keller, District 7, and I've been appointed by the House, a non-voting member.

COMMISSIONER STINSON: I'm Larry Stinson. I'm a Pain Management physician, also originally from Fairbanks. I'm

representing physicians.

COMMISSIONER DAVIDSON: My name is (indiscernible - speaking Native tongue) Valerie Davidson, and I represent tribal health.

COMMISSIONER BRANCO: Short-cut to me. I'm Pat Branco. I'm the CEO of Ketchikan Medical Center, and I'm representing the Alaska State Hospital and Nursing Home Association.

COMMISSIONER DAVIS: I'm Jeff Davis, and I'm President of Premera Blue Cross Blue Shield of Alaska. I live here in Anchorage, and I'm here working on behalf of all Alaskans for a sustainable health care system.

COMMISSIONER ENNIS: Good morning, I'm Emily Ennis. I'm director of a program in Fairbanks that serves children and adults with disabilities, and I'm here representing the Alaska Mental Health Trust.

COMMISSIONER HIPPLER: Allen Hippler, the CFO for (indiscernible - voice lowered), and I represent the Chamber of Commerce.

COMMISSIONER HARRELL: Good morning, I'm Dr. Tom Harrell. I'm a cardiologist, and I represent DOD VA here as the Commander of the Joint Base Elmendorf Richardson Hospital.

COMMISSIONER ERICKSON: Deb Erickson, staff to the Health Care Commission.

CHAIR HURLBURT: And I'm Ward Hurlburt. I'm the Chief Medical Officer of the Department of Health and Social

Services and the designated Chair for this.

For the visitors here, I just want to say that we've come to expect that there is a flourish from heaven whenever Allen introduces himself, so we're all impressed and duly respectful.

I think you'll find this will be another excellent meeting. The last meeting that we had in July with the session on End-of-Life Care that Deb put together for us, in my experience, was the best seminar that I've seen on that, and I think that you will this is a very exciting meeting with a lot of opportunity to learn over the next day-and-a-half here. And so we welcome everybody here.

As you know, we have partnered with CommonWealth North and several other organizations that are listed on your program for the luncheon meeting, which will be across the hall, and we're expecting 200 or 300 business people from the Anchorage area to come and to hear that program.

In a sense, that program will be the second program. CommonWealth North sponsored a program in July that a few of us in the room attended with representatives from four businesses in this area talking about challenges that the payers, that the business people are having in providing health coverage for their employees, which they want to do. And so that will be a part of our focus that we have here.

The first topic that we have this morning, one of the

tasks for this calendar year for 2012 for the Health Care Commission has been to look at what's called an All-Payer Claims Database, and this is something that a number of states around the country have adopted and have found that this tool has been very useful to them in looking at their health care system and its costs and what the alternatives are, what some of the differences are, and it's been widely popular.

As the Commissioners know, we had an RFP and picked the selected group to work with to look into that to help educate us and provide information on what's involved with an All-Payer Claims Database and what the feasibility is. They also are folks who are knowledgeable about that and will be sharing information about what some other states have done and what their experience has been. And so we'll move into that.

We have two folks who are here from Boston. Linda Green, who got a Master of Public Administration from NYU, has been a Project Director with 30 years of experience in state and local governments, and was former Director of Health Data for the Massachusetts Division of Health Care Finance and Policy. Here, she is the Director of Managed Care Reimbursement for the CommonWealth Office of Acute and Ambulatory Care, so very much engaged with issues that have been of interest and of concern to the Commission here.

The other individual who came is Amy Lischko, who has a Doctorate in Science and Health Services Research from Boston

University, and is a Senior Consultant, and is with the Freedman Company, and is a former Commissioner of Health Care Finance and Policy and a Director of Health Care Policy for the state of Massachusetts at the time Governor Romney was governor there in Massachusetts.

So they have come here. They are, as I mentioned, with the Freedman Company. That is the company that we've selected to provide this help for us. They've been doing some analysis, and I think that -- Linda and Amy, if you could just come forward here now to the head table, we'll welcome you.

MS. GREEN: Good morning, everyone. I am Linda Green, and with me, is Amy Lischko. I'm absolutely delighted to be here this morning. This is my first visit to Alaska, and I had a beautiful view of the mountains as we came in last night. The sun was starting to set. The jagged edges were just amazing. I've spent some time in Denver, and of course, there are no mountains in Massachusetts that are, at all, like this.

So this morning, I thought we would introduce ourselves a little bit, tell you a little bit about the project, what we've learned so far, give you our preliminary recommendations of where we think we're going to go, and give you next steps. Then we'd like to get your questions and see what else we can help you learn about APCDs.

So let me go back to introductions. There is no slide

for that. So you heard Amy and my credentials. Let me tell you a little bit about Freedman Healthcare. We're a small firm based just outside Boston. We're unaffiliated with any technology vendors or other providers of services. Our independence is important in that regard.

We were founded in 2006 by John Freedman, who is an M.D., M.B.A. with experience practicing in Tennessee, Colorado, and Massachusetts, and later, as the Medical Director of Quality at a larger commercial health plan. He founded the firm to focus on measurement to improve health care value and efficiency.

We came together in 2010 to begin working with other states on All-Payer Claims Databases, based on our experience in Massachusetts. There, we developed an APCD that was specifically for the purpose of populating a public-facing, consumer-friendly website on cost and quality of major health care services around the state.

Now we've built out our APCD efforts. We are working with five other states and have worked with them in a variety of capacities from initiating an APCD all the way through to implementing it, and now, we're working with ones that are actually using the data. Very, very exciting to see these data sets grow and actually deliver information.

So the project here. So the Health Care Commission is looking at solutions for cost containment and quality

improvement, ensuring that the best available evidence is used for decision-making, enhancing quality and efficiency. Price and quality transparency is important. Paying for value, building the foundation of a sustainable health care system, and focusing on prevention.

The goals of this particular project are to look at the health care delivery and reporting environment in Alaska and understand where the gaps exist. What do we wish that we could measure? What can we do to use that information to help deliver better care? We also want to understand how an APCD or other solutions will integrate with other data initiatives. There is a lot on the data development table in Alaska right now. There is e-Health Network. There is the potential for Health Insurance Exchange, and there is the new MMIS system coming onboard. How do we fit these all together with an APCD? And we want to explore whether there are options other than an APCD for meeting these data reporting goals. How can we close the information gaps?

We're going to talk about stakeholder readiness, and we're going to provide recommendations for moving forward.

Our project methods. So far, we have conducted stakeholder focus groups and interviews with some of you here in the room. We have had, and will continue to have, in-depth conversations with experts in your state in the area of information technology, legal questions, and other areas of

expertise. We're reviewing written materials, and we're going to review other states' data collection models that specifically address the questions for the data gaps that you have.

Our timeline for the project. We began in August launching the project, developing a list of stakeholders, creating an interview guide, reviewing more materials. We're currently - we currently are looking at synthesizing our findings from the interviews, some of which you'll hear today as we go through this presentation.

Today, we're reporting back to you and getting your feedback on our preliminary recommendations. Further conversations with state staff will follow. In November, we will create our initial draft of a report, which includes reviewing other states' models, developing options for Alaska, writing the report, and getting your feedback on it.

So I'm going to turn this over to Amy to tell you a little more about the work that we did.

MS. LISCHKO: Good morning, everyone. So this is a list of the folks that we spoke to, both in focus groups or one-on-one interviews either in person -- we were here in Alaska just three weeks ago, so I was lucky enough to come twice -- and the others we spoke to either on the phone or in larger group settings. So we did talk to some providers, to the major health insurers here in the state, to the e-Health Network, to

the State Hospital and Nursing Home Association. There were a few consumer users at our meetings. The State Commissioners we talked to and their staff, to hear about their needs for the data and where their gaps are. When they look to measure something, you know, what do they wish they had? The Alaska Native Tribal Health Consortium and then researchers.

I'm just going to briefly tell you just some things that you already know, but just to give you the feedback of what we heard, really unanimously, from everybody about what makes Alaska different, just the environment here, not regarding health necessarily, but just the environment.

What makes Alaska different from the Lower 48? Your small rural population. We heard from everyone that that is a unique population, that privacy and autonomy are very important here across the board, not just in health, but in other spheres as well, that your work environment is mostly composed of small businesses. You don't have a lot of large businesses that can lead efforts towards improved quality or reduction in costs, that there is just a lot of small employers. It's a rich state. We heard that from everyone, a rich state with very generous health benefits. That's an expectation that people have, that employees have, and that individuals have in the state, that they'll have generous benefits, and the diverse population makeup of your state, which, really, everyone is proud of and feels that that has

both advantages but also challenges in managing population health.

What we heard about health care in Alaska from the people we spoke to that is perhaps different than in other states -- although we hear this from every state, I have to say -- that it's more expensive. It really is true in Alaska that you are more expensive, but we hear that from every state, that they're more expensive.

What does make you somewhat unique is that there is no private sector managed care here. There is managed care in some of the public programs, in the tribal health program, in the VA system, but there isn't any private sector managed care, and along with that, comes issues that there hasn't been a lot of measurement that there would have been had you had a lot of managed care and some of the measurement that came out of the managed care efforts in the mid-'90s.

We also heard that there is little provider choice in many areas. While that may not be true in Anchorage, it's certainly true in some of the rural areas where there is just very little provider choice. There is maybe a single provider or two providers and so that creates this next issue, which is that there is little competition. If there isn't a lot of choice for people and there is only one facility that they can go to or one specialist that they can go to, there is very little competition around price or quality and that's very

unique and that's very different than what we see in other states.

There is no private sector systems of care yet, so a number of people that we spoke to mentioned -- you know, we discussed the Affordable Care Act and what it's impact might be on Alaska, and a lot of the people we spoke to said we're not sure how these Accountable Care Organizations are going to work in Alaska. There aren't these systems of care that there are in other places to build from. How is that really going to fit with the environment here in Alaska?

We heard that there is a lack of data, both on quality and costs across the board. While there are little pockets of data on quality within perhaps a system of care, like the VA or the tribal health, across all providers, there is very little quality or cost measurement across different provider sectors.

And there is a unique mix of payers here in Alaska that, compared to other states that we've worked with, is not necessarily the case. In particular, the Indian Health Service makes up a large proportion of the insured population. The military is a large portion of your population, and we can feel this even anecdotally when we fly here. You know, half the airplane are people who are involved in the military in some capacity. Every trip I've taken back and forth, the people sitting next to me, it's a mother visiting a son or a

young man going back to the military. It is a very heavy military presence here, which is not the same in other states. And this mix of payers is important when we start talking about an All-Payer Claims Database because we get the data from the payers. That's where the data comes from to fill into this database. And so this unique mix is something that's unique for Linda and I to think about, how do we get that data, you know, how do we integrate all that data into the system, and we heard from a lot of you that it's really important that we have this whole pie, that we don't just look at focusing on one piece of the pie.

COMMISSIONER DAVIDSON: So can I stop you there?

MS. LISCHKO: Sure.

COMMISSIONER DAVIDSON: So I'm having trouble distinguishing between those various shades of blue, so can you.....

MS. LISCHKO: The colors are not -- yeah. So if you start with the self-insured being that largest pie and then go clock.....

UNIDENTIFIED MALE: (Indiscernible - away from mic)

MS. LISCHKO: Thirty-four percent. And then go around and the list goes in order. Thank you, Valerie, because, when I first looked at this, too, I said that those shades are not distinct enough. They look pretty though.

So now I'm going to talk a little bit about what we heard

was important to the stakeholders we spoke to, and clearly, when you do something like this, we may be missing important pieces because we only spoke to certain stakeholders. We didn't speak with everyone. And so we would like to take some time at the end of the session to see what did we get right, what did we miss, maybe what did we -- maybe we only heard it from one person, and it wasn't enough to really have a flavor here. So we want to hear from all of you about if there are things we got wrong, but this is what we heard was important to the stakeholders.

All the stakeholders could agree that the data system that is going to result from this effort, if there is going to be a data system, it's needed to help better understand population health and patient care. That was unanimous.

When we started talking about cost transparency or quality improvement, or you know, information for consumers, it wasn't unanimous, across the stakeholders, that that data should be used for that, that we need data for that. So what was true for all stakeholders is that we needed the data to understand population health and patient care. Everyone that we spoke to said that those were important goals that they felt the data would need.

Almost everybody had some nervousness around the cost of the system. We had that question a lot, how much does something like this cost to start, to establish, and also to

maintain, and that the benefits of the system needed to outweigh those costs. So tell us what you're really going to be able to do with this data set. Tell us what it's really going to cost us to do that data set, and let's make sure that the benefits are going to outweigh those costs.

Privacy, as I mentioned earlier, an important issue here in Alaska. So how do we ensure the privacy is maintained both in the collection of the data and then who we release that data to? There has to be protections in place, and we can speak to you later about some of those protections that have been put in place in other states. And certainly, this is an issue across every state, but states handle it differently. Some states have different features in both their release and their collection of the data, depending on their state statutes for data privacy and also based on just the environment, the political and the other environment constraints.

Inclusivity was really important. So when we go back to that pie chart, most states have begun these efforts with their privately-covered health insurance population and their Medicaid population and have built, from there, to go and look to get Medicare data and other data from other pieces of this pie. Almost everyone we spoke to felt that it had to be -- the data system that was developed here had to include everyone, that, if it had big gaps, if there were big pieces

of that pie that we couldn't get, then it wouldn't be as valuable for looking at population health and public health issues, that they didn't want to start with not knowing whether they could get those pieces of the pie, that we really wanted to make sure that, if we moved down this road, we could get all those pieces of the pie in there, not that they all had to be in there right away, but that we could ensure that there wouldn't be huge gaps.

And then we also heard about the necessity for it to be a collaborative approach, that the stakeholders be engaged along the way, at every step of the way, they know what's coming, they're involved in the decision-making around what's collected, how it's collected, how it's released, that it's a partnership and it's not just the state that's moving forward with doing this without collaborating with the various stakeholders.

We did our little SWAT analysis here to look at the strengths and the weaknesses and the opportunities and the threats of doing an APCD or a similar data collection in Alaska. So I'm going to talk to you briefly about how the stakeholders interviews fed into this analysis.

The strengths that we heard in Alaska to support a more robust data collection system were that you have generous public programs in place and a strong safety net and that, because a number of people are covered by your public programs

and safety net, those efforts could really lead -- data collection in those efforts could really lead to quality improvement and best practices that could be taken up by the private sectors.

You have a strong tribal health system. We heard that from a number of people that that system already does a lot of managed care and has some experience in measurement and managing care and so that's something that we could look to and say, how is health care/managed care delivered in that setting and could we learn something from that to spread to other parts of the system.

There are a small number of insurance carriers here, which is really a good thing when you're looking at an All-Payer Claims Database. If you have a lot of small insurance carriers, then, when you move down the path of implementing an All-Payer Claims Database, it's very difficult to get all those systems aligned so that all of them can contribute the data in the same format with the same specifications. When you have only a small number of large carriers that are predominant in the marketplace, it's much easier to facilitate an All-Payer Claims Database, at least in the private marketplace.

And your two primary carriers are actually national carriers that are active in other states. They're familiar with All-Payer Claims Databases. They know what's it like to

submit data in other states, so that's a big advantage as well. It's not something new. When we spoke to AETNA and Premera, they were very familiar with the issues that have come up in other states. They can help think through how the issues here are different than in other states and that's really a valuable asset, compared to having homegrown insurance companies that maybe never experienced this before and it would be, really, a much slower process.

You have some new efforts that are being initiated in the Medicaid department, the new MMIS, which is, you know, going to be leaps and bounds ahead of the old Cobalt system that was there before. And so the ability to contribute and analyze data will be much better, and this is a good time maybe to be introducing a new data collection system because this other system is going to be in place already.

Similarly, the patient-centered medical home will be one of the first attempts at really looking at managing care in that population and some lessons can be learned from that, that will contribute as you move forward.

There is a number, as Linda mentioned, of current data collection efforts underway and so this is both a strength and also a challenge in thinking about how to integrate these different data systems. So there is the voluntary hospital discharge data set. There is the Health Information Exchange. So there is already some experience here in Alaska for

collecting data. You haven't done a lot of analysis of the HTD data, but there certainly is some experience in collecting and cleaning data and some experience in how that data can be used. And we did hear that the hospitals are beginning to embrace transparency. Well, that's not necessarily true across other providers. The hospitals have begun to move down the path to transparency, which is important when thinking about an All-Payer Claims Database.

Some of the challenges that we've heard about -- and this refers back to the last bullet, which, you know, even though the hospitals are moving towards greater transparency, it's still in the early stages of establishment, and the physicians that we spoke to, the provider groups, have not moved down that path towards transparency yet. And in other states, they're much further ahead in efforts to measure provider groups, provide information on the web for consumers, for improvement efforts, both internal and also external for use by consumers and insurers and others. So the transparency is really just starting here in Alaska. It's probably behind by five years or so from where other states are with providing cost and quality data to consumers.

The business case among important stakeholders, I think, hasn't quite been made yet. I think states -- Linda has been working with states for a number of years now, and they're really just starting, I would say, the past year or two to

really start using this data in a more robust way. And so that business case hasn't quite been made for some stakeholders here that this All-Payer Claims Database is really going to give us information that can really be used to transform our health care system, and I think that case will have to continually be made, and as other states use these data, we can see how they're using that data and really help shape some of the analytic capacity moving forward.

We heard about there being little health care analytic capacity within the state government, that, once this database is established, people were nervous about the state having the ability to actually analyze it and produce reports and get data out, that there would probably need to be, at least initially, some consulting or some contractors brought in to actually help work with the data and provide some templates and some data analysis of the data.

We also heard that there was a little bit of some trust -- and this was not just across -- just for health, but there is a little bit of distrust of government efforts in these kinds of areas to really be able to carry this out, to carry a data collection plan out and be able to have a plan for the next five to ten years and really be able to sustain that plan moving forward.

There were a lot of opportunities that we see in thinking about a data system, like an All-Payer Claims Database in

Alaska. One is just the opportunity to align these various different health care data efforts that are going on right now and to really think about how they fit together and be able to make the business case that they do fit together and that they're all needed to get to where you want to get with being able to analyze your health care data and have an improved health care system.

I think any improvements -- because you don't have a lot of data now, that any improvements in this area, those small successes that you can get early on in producing some of the public health reports or reports on the state of the health system in Alaska would be viewed as success because you're working with a baseline where you don't have a lot of information on how all these different mini-systems within Alaska perform and how they all fit together to provide health services to the population.

It's a small state, and you have compact population centers. So there could be an effort to maybe look at the data by geographic in, say, Anchorage, for instance, where there are multiple providers. Because you have these compact population centers, that might be an advantage and an opportunity to be able to do some extensive data reports for those particular population areas.

And I think there is an opportunity for collaboration on public health and health care quality issues among and across

the payers. We've heard that from a number of payers. The willingness and the desire to really look across payers, to understand your population when they go outside of your system, what are they receiving outside of your system that you don't know about, and there is some opportunity with an All-Payer Claims Database to really be able to manage all those health care services that your population is using.

Some of the considerations that we heard from stakeholders are that this may be a lot of work for what may be seen as small gains initially and that's certainly been true in other states. So the newer states that we're working with that have just come onboard are really trying to move more quickly on the analysis phase than the earlier-adopter states where they sat on these large databases for a couple years, for five years even in some cases, before they produced a lot of reports. The states that are coming online now are really looking at that analytic piece and trying to move forward with that more quickly so that you can see some of the rewards sooner, not that you're working with data that are -- I mean, you also have to think about the quality of the data, but they know that, in order to sustain the efforts moving forward, they need to start producing data reports and using the data early on instead of sitting on the data for a long time.

There are a number of competing efforts here, and we need

to communicate to the stakeholders, if we are to move forward, how these fit together. Like I mentioned earlier, the HTD, the HIE, how do all those pieces fit together? Where are those gaps, and why do we need this new data system? We need to be able to communicate that.

I think education and outreach to providers is really an important issue here in Alaska because there hasn't been a lot of transparency efforts among providers and so that's a little difficult when you have a population center, but then you have a lot of rural providers outside of Anchorage, outside of the city center, making communication to those providers and engagement of those providers more difficult. So that, I think, is a challenge that can be met with our new technologies, but it's something that we have to be aware of moving forward. It's not like you can have a meeting here in Anchorage and expect everybody to come. So there will have to be a lot of outreach.

We're exploring the issues of getting federal data. This is something fairly unique to Alaska where that federal data, both the Federal Employee Health Benefits Program and the military data are a higher proportion than they are in other states, and where those data would be really important to get included in the system, that's a challenge. It's also an opportunity. I think Alaska has more of a desire to get those data into their system, so they could perhaps lead the way in

showing other states how to work with those federal organizations to get that data. States have been successful in getting Medicare data. There are a number of states that have been able to implement and integrate the Medicare data into their data sets, but no state has gone after and actually worked with the federal government to get the Employee Benefit Program data or the military data into their data set yet. So that's something that we're exploring, and hopefully, we'll be able to get some feedback to you soon.

The state regulatory environment here is also different. It's different in every state that we work with, so that's always something that we have to consider when we're thinking about an All-Payer Claims Database, what kind of regulations are possible, how are those going to be perceived by the Legislature, et cetera.

So now I'm going to turn it back over to Linda for a discussion of what some of our preliminary recommendations are and our next steps and then to facilitate a discussion among all of you.

MS. GREEN: So what have we seen so far, and how could this get shaped into some recommendations? Here's what we're thinking. So clearly, we've got a strong message. Build upon data efforts currently underway. Don't reinvent the wheel. Use what you have. Draw on that expertise. Draw on the information that can be derived from those sources as much as

possible.

Next, let's look at ways to integrate or link with other existing data sources. Amy mentioned the voluntary HTD. There are also other public health data collection systems that can be, I'm going to say, aligned with one another. I'm not going to say linkage because that has a connotation in the research community, but let's say aligned with one another so that we can understand more fully what the portrait of population health and how care is being delivered.

We want to take a further look at emphasizing the need for communication and continued engagement with stakeholders. We know, from our work in Massachusetts and in the other states where I'm helping develop APCDs, that both the payers and the providers need to be engaged early on, and you mentioned this, but the response is much more welcoming if there is an early conversation. The payers in Colorado, for example, were involved at the start of developing a set of data specifications for data intake, and the national payers in that group have told other states do what was done in Colorado. Folks in Colorado are also out talking to the medical society, the hospital association, and other large systems of care in order to engage them early and often.

We look at other partners or champions who might also be interested in greater transparency. When we think about that, it's people and organizations that have an interest and have a

need to help folks make better decisions about health care across the board. We'll be looking into that as well.

So our next steps. We're going to discuss our findings with the Health Care Commission today. We're going to continue our information gathering and synthesis. We have a lot of ideas out there, and as Amy was talking this morning, I was trying to put them into, like, a four-square grid, what's easy, what's hard, what's costly, what's not costly, and it's still -- these things are still filtering together, and we're looking forward to hearing more about that this morning.

Our draft report will include options with the benefits and challenges, some discussion about how we're going to align with the other initiatives and existing data. We're going to talk about sustainability. How can an APCD be continued over time? Where can the funding come from? Who has to be involved? What kinds of structures need to be in place in order for it to continue to exist?

We're going to set out a potential timeline for a selected option, and we will give you comprehensive examples of quality and price transparency from other states that have done APCDs and other transparency efforts.

So having heard all that, now we'd like to ask you, what have we missed? Did we misunderstand or mischaracterize anything? Is there anyone else that you'd like us to talk to who has an opinion or a perspective on health care data and

data utilization in Alaska? What else would you like us to consider? Do you have any specific concerns that need a different kind of emphasis? What would you like to know about APCDs in other states that we can help you understand? So I'm going to turn it over to you. Yes?

COMMISSIONER ERICKSON: Keith?

COMMISSIONER CAMPBELL: (Indiscernible - away from mic)

COMMISSIONER ERICKSON: Microphone, and pull it close to your mouth.

COMMISSIONER CAMPBELL: I seem to recall that we had a discussion in another context about data and data sets in the state. Are we sure that we've got a complete inventory of everything that might be available, no matter where it's housed in the state?

COMMISSIONER ERICKSON: So Keith, this group hasn't seen one, except in a PowerPoint slide I presented at one point probably a year-and-a-half ago, and it hasn't been shared with these consultants yet, and we could do that, but the state staff and the consultants to them working on the Health Information Exchange on the state side, overseeing the Alaska e-Health Network, has put together a real comprehensive list of the data systems with a description of those. And so I don't think it's been finalized for public sharing yet, but they're really close, and we can make sure that the Freedman consultants have that, and you all will see it eventually.

COMMISSIONER BRANCO: I have a great number of questions and areas of concern, but as you stated in the beginning, the hospitals are trying to move along this continuum and trying to be more transparent, aware of the public scrutiny of costs of health care.

My -- and I don't want to occupy all the question time, but I want to start with the definition of data, and it's really important to me and it comes from 100,000 years ago in college when they told me data by itself does not answer questions. Moving data into an information format is key. And then transforming information into knowledge is the step you need before you can make decisions. Data, by itself, does not do anything because it's open to interpretation by readers.

So I'm a bit -- I just get -- my skin gets crawly when I hear just data being used as a phrase for making decisions based on raw numbers. I know that's not the intent, and I'll give up the microphone in just a minute.

I have to wax philosophic on data one more moment, and it comes from my Boy Scout days, and what they told me was a dull knife is a dangerous knife, and I couldn't quite figure that out until you've worked really hard with a dull knife to cut a piece of wood and taken off a piece of your finger. In my view, dull data is dangerous information. And so we have to be cautious how we use it and what we're going to use it for

and not take it as the broad spectrum hope.

And so one of the key things that we're talking about here through an All-Payer Claims Database is payer information and translating that or gleaning quality information off of that, that may not be readily apparent, it's simply through the payer -- what claims have been filed. For example -- and then I'll get off my soapbox for just a moment.

It's one thing to say there are 125 diabetics in Ketchikan. It doesn't mean anything because those are -- and if it comes from a payer claim, that's only the ones who have sought care. It doesn't translate to the whole population. So until we get to the point where we're doing all of that and even outside of our payer claims, it only addresses the pieces toward quality of how many of those have had their Hemoglobin A1c under seven. We might be able to get at that, but we're really not talking about quality or transformation of care until we start to turn that data into knowledge and can take definitive actions and make decisions that are wise for the populations.

And the final piece is, if we don't have everybody, all the payers in this, we only have a fraction of the data we need to make these decisions. All right.

MS. LISCHKO: So thank you. That's -- I, and Linda, completely agree with that perspective, that data isn't everything, but the way towards getting to the information and

getting to the knowledge is to begin with the data and having everybody, this Commission and others, participate in those discussions. What is a good quality measure? What data can we get from this data set, knowing that it's not going to be everything, that the HIE is going to contribute information that's going to be really important? But you need to begin somewhere, and you don't not do it because of that, but you do it cautiously and you make sure that access to the data, you know, is protected in certain ways, that the information doesn't just go to anybody who wants to do a crazy report, that there is maybe an advisory group or someone to approve of data requests and that the level of the data that they get is the appropriate level of data and so you would have all those protections in place, but we absolutely -- you know, that's right on. I completely agree with you.

MS. GREEN: I'd like to add to that. So when states are setting up an APCD, Amy mentioned that they collect all this information and then don't do anything with it, and I think that's a failure of planning on the part of the states. And before -- I actually see this as the preliminary step in an APCD is creating a vision, a reporting plan. What are you going to do with this data when you have it? What do we think that we can get from it first, second, third? What are the expectations that we have for that first round of reporting? What are our basic principles? The measures we select could

be -- they have to be actionable. They have to be consistent with the identified data. No providers will be identified until there has been a thorough preview of the results, a "no surprises" mantra. And so by having these principles articulated beforehand, the way can be paved for a collaborative understanding of what we're going to get.

COMMISSIONER BRANCO: I'll just add really quickly -- and I agree with that list -- one of the key things we need to identify early on is, what questions are we actually trying to answer?

COMMISSIONER DAVIS: Thank you. Thank you, Linda and Amy. So you practically answered my question before, or my comment. I was going to join in with my colleague down the table here.

So a famous health care analyst, Yogi Berra, once said, "If you don't know where you're going, you're liable to end up someplace else." And I think, to me, that's the holy grail in this, and in next steps, you identified that. Other states have been at this for a long time, so I just am not seeing what we're going to get out of this effort. And so if I can see the destination -- cost, quality, transparency and how it works -- then okay, you know, let's join in this effort. So that's point number one. I think it's consistent with what you just said, Linda.

Point number two, piling on with Pat again, is that,

unless we can get pretty much everybody all in, we don't gain anything from this. Just speaking, just as an example for our company, we already use this with our data to get to cost, quality, and transparency. So if it's just our data and AETNA's data in the database, that doesn't do any good. It doesn't change anything in the real world because we're already using it to change things in the real world. So I think those are the two things that stand out most, to me, as concerns. Thank you.

MS. LISCHKO: So I just want to comment on the "all-in," how important it is and to suggest that maybe the federal government is starting to have some considerations about the use of data. Typically, federally-owned data has been very carefully stewarded, but we're excited to see -- but CMS has recently, just this year, issued a new program for states to obtain Medicare care about every Medicaid enrollee at a very granular level for use in this kind of effort. So that would really fill in a nice piece of our pie chart here.

I think there is an opportunity for a state, like Alaska, to go to CMS and ask for help with the other federal agencies, to try to get some of this data to start to flow under carefully controlled conditions, a high degree of security, and with a clear statement of how the data will be used. I think that we're on the cusp of that. CMS, their mind set is changing. It's very exciting.

COMMISSIONER HARRELL: So you addressed the first that I was going to ask and that is, you know, on your pie chart there between the VA, the DOD, and the Tribal Consortium, which receives some Indian Health Service funding, that's 65% of the community up here now. The military community, of course, is transient. They're going to turn over almost 20,000 people every year-and-a-half. So the applicability of that to the state becomes a little bit questionable. However, I think you are right, and I want to know, one, can you expand any further on your comment because there are other folks trying to partner? We, certainly here, have the Alaska Federal Health Care Partnership between the VA, the DOD, and Indian Health Service, and Tribal Consortium to try to figure out how we can link those up, and it would be a very strong tool to try to move in that direction. Any other specifics that you can name, besides the one you just did, about being able to have access to federal data? We do mine an awful of information, and we have a captive audience in the DOD. You guys know that. I can extract anything I need to extract because our patients are required to use our health care system.

So I want to know, one, do you have any more specifics? And then, sir, with your permission, I have two follow-up questions that I think will be quick. Any additional input though on the other mechanisms of what you've seen in other

states, other than the example you mentioned?

MS. GREEN: Alaska would have the opportunity to be a leader.

COMMISSIONER HARRELL: So appeal to vanity; that always works. So two additional questions. A lot of what's going to be required here in Alaska, outside of the federal system, is going to require you to incentivize, private practitioners, private health systems to be able to provide that data, and a large part of that -- you mentioned linkage and alignment -- is really going to require this underpinning of an electronic record and systems that can communicate to each other. Otherwise, you're imposing an administrative burden on a small business to say you need to be part of this, but to be part of this, you're going to have to have this system, so you can dump this data into this repository.

I'd really like to know what you have learned from other states. I understand the uniqueness, in your first two slides, of Alaska and certainly "The Last Frontier" kind of mentality that you expect to move towards to incentivize small business practitioners, which is what most of the state is, to actually be a part of this. It's one thing to say it. Where are your thoughts going in terms of incentivizing it? And then I have one other question.

MS. GREEN: The source of data for an APCD is the payer community. So it would be the insurers, the state Medicaid

department, and you know, hopefully, the other federal agencies. Where there has to be a more concerted effort is in self-insured plans. There is usually -- the ERISA preemption is interpreted differently in various states. Some states, where I might live, feel that there is no preemption, that the requirement for self-insured plans to submit data to a state does not conflict with the prohibition on regulating a self-insured plan. Other states have not been able to cross that border, have not been able to find the political support to make that case. So I think that's where small business will need to be engaged, where those businesses say, look, we need better information for our decision-making for both us and our employees who are facing, perhaps, higher deductibles, higher co-pays, and they need to be able to understand how to find high value health care. This may be one opportunity to create that.

COMMISSIONER BRANCO: All right. So I was inarticulate because what I heard you focus on was the small businessman, who is now providing health care as insured workers. I'm actually thinking of the small business medical provider. How do you incentivize the small group to be willing to play and to give access to their data, their quality data in a system when it's going to, essentially, since there is no clear linkage at the moment, create an administrative burden on them to do so? Have you had thoughts in that direction?

MS. GREEN: So the link between the APCD and the small medical practice is through the claims payment, and there is no direct additional burden on the small medical practice.

COMMISSIONER HARRELL: I guess I would disagree because I have a managed care support contractor who provides for our health insurance through the DOD, and the amount of man hours devoted to the payer process for our patients to be seen by private practitioners who must now be able to work within that system to get the payer data is extraordinary, and in this particular market, more often than not, what I happen to hear, as someone who comes with their hat in hand, saying, please participate in this and please see our patients and use this system to be able to get our payer data, is, why do I need to do that? That's an additional burden on my staff that I have to pay my overhead for.

So I'm not trying to be confrontational. I'm simply saying, what thoughts are you suggesting or have you got that far as to what you're going to do because that is going to be an issue, in my opinion. I don't know if my -- I'm looking at other heads, north-south or east-west, that I'm out on a limb here.

COMMISSIONER URATA: That's my question, too, is, what impact will you have on my practice, if I join this program and have to give you data? Am I going to have hire another half FTE to collect my data and then pass it on to your

computer? And the majority of practitioners in my community don't have computer systems. They still do it by paper. So to mine that data is really expensive, but of course, we all fill out bills, paper or not. And so if all you need is the bills, then that's simple, or simpler.

MS. LISCHKO: So it is the bills, the bills that are already being submitted. I think where there could be issues, at some point, is if you decided you wanted to collect an element that wasn't on that bill, that, you know, some states have said, we want to get race ethnicity and that's not on a bill. And so then that might trickle down to a provider. There is potential there.

The other place where it could trickle down to a provider is the uninsured data. Because this is a claims database, the uninsured doesn't have a claim. No one is paying -- directly paying that bill. So if Alaska -- part of that pie chart is the uninsured. If Alaska wanted to say -- and we did hear from some stakeholders that they want the uninsured in there. That's not something states have moved towards implementing on day one, but the state of Maine has integrated claims or proxy claims for the uninsured into their database. The state of Massachusetts has a system where they have these proxy claims for the uninsured. So that could be an additional responsibility, if Alaska wanted to do that and include the uninsured and had large provider groups that saw, you know, a

high proportion of uninsured, that that could then come from the provider. But for the most part, these issues are not issues immediately because it's really the claim that you are already submitting to the insurer for payment that we pull the data from, and it's not a submission from you to the database.

COMMISSIONER URATA: So how do you connect that to quality then?

MS. GREEN: So there are a number of administrative quality measures that can be developed, as you are certainly aware. The real opportunity is when there is outcome data from e-Health Network. That's down the road, but first, you need to know what services were used and then we need to be able to understand the outcomes. So there is a meshing that has to happen, but we'll start with the population health, which we can get from claims.

COMMISSIONER HARRELL: If you can expand upon that?

COMMISSIONER ERICKSON: Well, I think one of the concerns that I'm hearing, too, if I understand correctly, is that there might be some providers who would choose not to serve patients who had certain coverage -- was I understanding that -- if they knew that data from their practice was going to go through the insurer into an All-Payer Claims Database.

COMMISSIONER HARRELL: I think that's part of it, and again, I apologize for being inarticulate. It's probably a lack of vocabulary, too, on my part. My point is that, when a

provider is going to provide data to an insurance company and they're going to submit their claim for their reimbursement, they need to respond to the kinds of data and administrative processes that that insurer is requiring. To create a system where you're going to pull specific data, you are then, I believe, by necessity, going to go to the payer and say, hey, you need to be collecting this kind of data. They, in turn, are going to go the provider and say, you need to be providing me this kind of data.

And I submit to you that, in the process of constructing this, you are going to have small medical offices who are going to say I've got to answer this master, this master, and this master, and you are now asking me to conform to this system. I'm not going to be a part of it. It's not that it's claims data. I've got that it's claims data. It's that the administrative burden to respond to that administrative request will be overly burdensome to a small business operation, and they will simply say no, which gets back to your point, because we have -- as a DOD/VA entity, we have providers in this town who say this is my main insurance company I work with; we don't really care about your managed care support contractor. I don't want to learn what you need me to learn to be able to submit claims, and therefore, we're not going to play. I think that may be a hurdle that you will face, given the unique environment here in Alaska, and

therefore, forethought needs to go into that or I think you will fail by virtue of the market that we have here.

And then I would follow that with one final thought and that is the easy information to get at is in-patient information because of hospitals and the other regulatory things that they must already follow, regardless of what state you're in. So you can get to that. I'm very curious as to your thoughts on how to get to the outpatient data because health care -- health -- we talked about this earlier when we were here. Moving from health care, episodic care, interventional care to health is going to necessitate prioritizing outpatient interactions, and what can we do to incentivize in the outpatient arena, which gets me back to the first point.

CHAIR HURLBURT: David?

COMMISSIONER MORGAN: This sort of touches on the outpatient side and the uninsured. I do know the primary care and community health centers do a lot of statistical information, mainly their requirements for their UBS reports. For those of you who are unfamiliar, it's everything they do and who they do it to, from sex to age to where they live.

I know that they treat or had over 80,000 visits last year. So I would suspect, with their sliding fee scales, which is what they're for, to provide serve to the uninsured that don't have Medicaid and Medicare, that, right there, is

another system that may and probably could be part of this, at least satisfy some of the information for the uninsured on the outpatient primary side. I think, when you start developing medical homes -- and I know the Primary Care Association spent three whole days and had several programs working with Medicaid to develop on that -- they'll start tracking that data right into the patient side, once you get the medical home part started. But I think you're right. I think the one big philosophical hurdle -- and I mentioned it at another forum a couple of weeks ago -- now we all have to remember, at one time, there were 40,000 Alaskans that didn't even want to belong to the United States. Government is not necessarily a happy medium of what they want to engage in, if you just listen to talk radio for an hour every morning driving in.

So yeah; I think this will be the big one. I think coming up with what it's going to be used for, where we're going, and how it's going to help the system be better -- most physicians and physician offices are not necessarily anti-government. It's just they need to have a reason why, and it has to be a good one. But if it's any consolation, between 23 programs and 142 community health center delivery sites, I don't see that being a problem providing that information.

I helped prepare two sites where I work at, and it's unbelievable how much information that we pull down to diabetes and what are they getting and did the mothers get

certain treatment, you know, following the HEDIS, did they get their visits, their -- you know, I mean, it's just reams of information. So it doesn't help your problem, but at least, on the uninsured, which, on the primary care side, I think a lot of that data is there. It probably -- I don't know if you -- I didn't -- I apologize. All our VPs are on retreat for planning, so some of us sometime get calls at 4:30 in the morning (indiscernible - voice lowered) where we work. So at least, that's one area. I don't know, did you talk or visit with our Primary Care Association leadership on this issue?

MS. LISCHKO: We talked to the largest community health center in Anchorage. We did talk to them.

COMMISSIONER MORGAN: So let me.....

COMMISSIONER ERICKSON: Dave, I could talk to you afterwards, and we can talk about how to best connect them with the Association, too, because of the transition in leadership there. Maybe there are a couple of key folks on the Board or someone they should talk to. So we can follow-up on that after.

COMMISSIONER BRANCO: The uninsured population is a key data point, which we have to begin to capture, and you know, it's odd for me to say it, but the hospitals end up being a payer. We define it as uncompensated care, the combination of charity care and bad debt. We, as part of our Medicare Cost Report published annually -- or audited annually, we may have

the sources of some of that information already in our data. It would require additional folks to mine it appropriately or perhaps it can become a state function or a government function to withdraw it from the Medicare Cost Reports. But adding disease-specific population health management data to those pieces, they're the payer -- the hospitals end up being "the payer" of record for those folks. There may have to be another mechanism developed in order to capture more depth of information on those folks.

CHAIR HURLBURT: Val and then Larry?

COMMISSIONER DAVIDSON: I think Larry was in front of me.

COMMISSIONER DAVIDSON: A couple questions. I know that you're taking a 10,000 foot look at a lot of this, but what if providers don't want to have their information sent on by the insurer, by the payer? One question.

Two, in Alaska, both locally but also in the rural areas, you have nurse practitioners, you have chiropractors, you have other P.A.'s, not M.D.'s, not D.O.'s, who are providing a lot of the care. Are they captured in this or is there data that's represented? I already know, for a fact, with lots of friends in primary care areas in the rural areas, they know they charge real high, but they also have very high costs. I know they would not really be all that interested in participating in something like this.

MS. GREEN: So you've raised a couple of different

questions here. So is there an opt-out for the provider? In other states, there has not been an opt-out. That may be something that, you know, needs to be discussed here. From a data perspective, I would not recommend that because it would create holes in the data. We really want to get as comprehensive of a picture as possible, but again, it deserves a robust conversation.

The second question was, why should providers in rural areas be interested in this at all? And I think that's another good point. When there is a very limited choice of providers, there may not be a need to talk about variation in cost, but there should be. Or again, many states have decided to take on a conversation about quality of care, and this can be used to have that conversation.

MS. LISCHKO: In a number of states, we've really seen that the providers have, in many cases, led these efforts. They actually wanted to have information on their patients across the spectrum of care. They wanted to improve quality. They wanted to have best practices and understand best practices better. In several states, they have been the champions, which is totally not the case here in Alaska. At least, we got that feeling here. Maybe we got that wrong, but I don't think so, and it felt very different talking to providers here than it did elsewhere, but I think that there still is a way we could engage providers in the use of the

data in how it can help in improving quality, but it's going to be a journey, I think, here.

CHAIR HURLBURT: Larry?

COMMISSIONER STINSON: Personally, I would love it. I have no problem with it, and I think it would be much more likely to get compliance in a more urban situation, but as soon as you get Bethel, Glennallen, Delta Junction, they're really not going -- I don't mean to be speaking for these people, although I've talked to a lot of them. I can't imagine that they would see any benefit, but potential harm, to what they're doing.

CHAIR HURLBURT: Val?

MR. PUCKETT: Among those that you talked to, did you talk to any representatives from the union health trust?

COMMISSIONER ERICKSON: We had union health trusts on the contact list. I don't think you had any private -- separate interviews with them, but there was some representation in focus groups.

COMMISSIONER DAVIDSON: So I want to go sort of unify a point that has been pretty subtly around the table, but I'm going to make it a lot more explicit. So I don't mean to offend anyone, but I accidentally may. You mentioned in your slide in your presentation that trust must built, and I think that is very true, regardless of what state you would be doing this in, but I think that is especially true in Alaska for a

lot of the reasons that people have articulated. I mean, we are very independent-minded spirits here in Alaska, and trust is something that is not built with platitudes. Trust is something that is built with action. And so saying to people, "Trust me" in an environment where we have, in my opinion -- well, obviously, I'm the one speaking. We have not necessarily used data necessarily responsibly or respectfully in the past and in the very recent past, and I think we should just be careful about -- and be honest and up front about what it is that we're going to be using the data for, not necessarily -- our past practice has been it's very sensationalized, conservative talk radio, and it has been one side of the story. And so I think we should just be especially careful about our responsibility with holding that information, how we share it, and how we do it in a way that honors the real information because data, like everything else, is subject to a whole lot of manipulation and interpretation. And so I just -- I want to just throw that out there. I think it has been carefully alluded to around the room, but I just want to be very explicit about it.

And the other is I still haven't heard the answer to the question of, what is it that we really want to do with this information? I mean, not say what we're going to use it for, but what do we really want to use it for? Is it really to answer the quality question or it is really yet another way to

identify how much more it costs to provide care in Alaska, because I think there is a difference?

And the other is I don't think we can identify the cost of what that's going to be, unless we've answered that question, and I haven't heard that answer. And then who is going to be paying for it? I think, philosophically, we're all going to be paying for it, but I guess the question I want to know is, who is going to be writing the check?

I think those are a couple of really loaded questions, but I think probably get to the heart of what a lot of folks are wondering, and as you mentioned in your conversations around Alaska, trust was really a predominant issue, and it's very real, and we're not going to be successful until we can overcome that.

MS. LISCHKO: I think those are really good comments, Val, and I think that some states have taken different approaches in creating regulations where, right in the regulation, it's, this is how the data will be used, these are who the data can be released to, and it takes a statutory change to -- or you know, I meant, not the regulations, in the legislation. So depending on the state, it can be, you know, at the statutory level where those decisions are made or it can be at a regulatory level and changed more easily or it can be at an advisory group level, you know, in states where there isn't that trust issue, and it can be a group, like this,

that, you know, makes those decisions. So it really varies depending on -- and I think that gets at your question, how is the data going to be used? That can be dictated, you know, more clearly at a higher level or at, you know, a more -- I can't quite find the words -- at a more participatory level.

COMMISSIONER DAVIDSON: And then how much does that cost?

MS. LISCHKO: The cost of creating the database, is that what you're speaking to or maintaining the database?

COMMISSIONER DAVIDSON: I'm a believer in full on costs. I want to know what the startup costs are going to be and what the costs of maintaining that are into the future. Give me a 20-year vision.

MS. LISCHKO: Do you want to take that one?

MS. GREEN: So there are some variables here. The variables include the size of the population that's included in the APCD. Alaska, with 650,000 residents, that's actually one of the smaller APCDs.

What we're seeing is that they cost, you know -- to contract with -- usually it's a contract with a software, as a service vendor. It's somewhere around a million dollars for a larger state. You know, how we (indiscernible - voice lowered) to a smaller population? Not sure exactly how that would work because there are certain sunk costs in setting up a platform for taking the data in, cleaning it, warehousing it, and then producing the analytics that concert to be the

information that we talked about.

I think that there -- with a smaller population, I think there are some opportunities that we're going to be thinking about, like, could another state serve as your platform? You know, is there another state that's aligned in a similar mind set? So we look at that. Can we look at shorter -- smaller ways to do this? That's really what we're thinking about for the next month.

COMMISSIONER DAVIDSON: So a million dollars to start and then how much to continue?

MS. GREEN: Somewhat less. A little bit less, but there are -- the size of the database is constantly growing because, every year, they're taking in more data and doing more analytics and reporting because now we can see what we've got.

COMMISSIONER DAVIDSON: So a little bit, by my definition, may be different than yours. So what I'm interpreting you to say is that it's a million dollars to start and $900,000 every year to continue.

MS. GREEN: Maybe 750, but again, I'm not an IT firm. This is just what I'm seeing in a couple of other states.

COMMISSIONER DAVIDSON: Thanks.

CHAIR HURLBURT: Representative Keller?

COMMISSIONER KELLER: Yeah. I'm probably going to ask a question and raise a point here clumsily, but the -- my interest in transparency is to try to ensure, for all of us as

consumers, health care consumers, all of us as people, that we're getting what we pay for and that there is value in what we're doing. So it's a market issue. And when I look at the consumers of health care, as we're looking at it, as you're looking at it, you know, a consumer, for example, your self-insured that is in the state, we have responsible people that look for the best deal they can get and for their employees. You know, they go out there, and they look, and they want to buy something of value out there for health care for their employees, and right now, it's very difficult and a very painful process -- as I observed the last round to the State pretty closely -- to determine, you know, where the good deals are.

And Pat, you defined uninsured as people that end up in the emergency room and never pay a dime, and I do have a question in this comment. The question is, do we have any information on the two or three people that are left in the state that are actually paying for their own health care? You know, I mean, I'm assuming they're in the uninsured also. And I happen to know some that do, and they're very small business people, and they're what they call medical tourists, you know. They look at Thailand, or whatever, to go look because they need health care, and they go look for the best deal, you know, and that's the element here that we're trying to get at in this transparency. So I get a little confused and

frustrated as I look at this, you know, and think about it because it seems like it's so far afield compared to that, you know.

COMMISSIONER BRANCO: Let me answer you quickly on that. It's a larger population than you imagine, the private pay individuals who are consuming health care at a cash basis. They're there. They're unsung. They're unrepresented. We don't gather much data on them. It's a really important point, and they're not just the two or three left. There are hundreds. There are probably a couple of thousand in the Anchorage basin. It's a big number.

COMMISSIONER KELLER: Yeah. I was tongue-in-cheek on my part. I realize that because I figure, if I know two or three, there's got to be more out there, you know.

MS. LISCHKO: The other thing you have is an increasing number of people with high deductible plans and so Alaska has doubled their percent. It's still a small percent, but it's, you know, a little more than 5%, and it's growing. Those people are looking for the best deal, too, because they have a deductible to pay.

COMMISSIONER BRANCO: Just on raw numbers, our uncompensated care, the ones that we don't -- will not collect a dime for, represent about 8% of our operating expenses, and we're at about 12% that are self-pay, but they're an awfully loyal self-pay population. We get about 50% of their billed

charges.

CHAIR HURLBURT: Tom and then Allen?

COMMISSIONER HARRELL: Right. So just a positive comment, Val, in terms of a data point for you. An incidentally, I didn't get a chance to chat with you ahead of time. These folks already know. A disclaimer for you: my neutral face position is one of constipation and consternation, and I accept that, but I'm actually a nice guy. So I don't mean to sound aggressive to you, but I have these questions that, I think, need to be answered.

So moving beyond that, just to get some of your points, the unique thing about the DOD is, you know, we're a closed health care system, and it's very hierarchical and very authoritative. So no matter what you want to do as a physician, necessarily, if, barely, the SG says you will do the following, then we do.

So one of the nice things is we've had a patient-centered medical home now, at this particular facility, for coming up on three years, and across the 75 treatment facilities we still have remaining in the Air Force, they all have some measure of patient-centered medical home employed at the moment.

So in terms of the data piece, the thing that we are seeing, with fits and starts guaranteed, is that, when we collect this information, particularly related to specific

disease states, we are able to take that data and go back to the individual provider. So it absolutely is a provider champion. If the provider is not onboard with it, forget about it, but what our providers have seen -- take diabetes, for instance, they pull the data. We know what the Hemoglobin A1c's are. The goal now is to take that data, feed it directly back to the provider, and say, hey look, you -- compared it to your colleagues, your Hemoglobin A1c of your panel is "X", and you're kind of behind. Done so in a blinded fashion, but folks know who they are and so it engenders competition. So that actually does work.

And then secondly, in terms of getting new information out, we're seeing that we're able to push through our system new data that currently takes five to seven years to get into clinical practice. We're pushing those reminders out to providers, going, hey, the most recent data shows that you should be doing the following for your patients. So there is the potential for significant benefit, done properly.

My concern, again, is, just, it's an administrative burden because you're not going to be working in a closed system where a rank on my collar allows me to say to you, you will do the following or there is the door; you can become a civilian. So we have some leverage within the DOD that you're not going to have in the private sector.

CHAIR HURLBURT: Allen?

COMMISSIONER HIPPLER: Thank you. Representative Keller was talking about market forces, and for me -- there was discussion about, are we talking -- is the point of the claims database to isolate quality or to talk about price or cost? For me, it was, I had thought, that the prime benefit was for cost isolation, not so much quality. But given that, I would -- I thought I'd throw out here, prices are a tool. The point of prices in a free market is to help allocate services and resources where they're most efficient and best used, but prices only are able to serve that function if the person making the choice has to bear the cost. If, for example, I'm one of the large percentage of people that bears no share of the burden of his own health care, then giving me access to some sort of information, saying that it's more costly here and less costly there to get a service, has no impact on me because I'm not affected. So prices are only useful if people are actually affected by it. So I just thought I'd throw that out there.

There was another point. This has already been talked about, but I just thought I'd throw it out there because several people, including Val, brought this up. The trust issue. I thought it was a little telling in one of your slides that one line was inclusivity, mandate everyone participate. And then the next line is trust. Trust. Thank you.

CHAIR HURLBURT: Deb, did you have something?

COMMISSIONER ERICKSON: Yeah.

CHAIR HURLBURT: Go ahead.

COMMISSIONER ERICKSON: Unless you.....

CHAIR HURLBURT: I was going to just say we've got a little less than 15 minutes left. We're going to need to keep on schedule. These are questions that our consultants brought as a check of where we are. The reason we're in this process is that we're looking at All-Payer Claims Databases that a number of states have used, that a number of states, I think, have found quite useful. So we're educating ourselves about it. We're looking at it in terms of Alaska. And the end point of this is not to go with an All-Payer Claims Database, but to make a decision of, do we want to recommend that we do this as a state?

So this is kind of midway through the process of our consultation. We have these questions. And then on slide six, you have the timeline that Linda went over, and it kind of shows what are the next steps there -- thank you -- on the right side. So maybe from your standpoint and from ours, where we have less than 15 minutes left, are we at a point moving us along so that, at the end point, we can make an enlightened decision and recommendation of what we want to do? Pat, did you want to add something to that?

COMMISSIONER BRANCO: No. I don't want to add to it. I

want to move us forward on this continuum. I have a specific question that I'd like you to, if you have knowledge in it, help share with me, too.

In your study of other states who have implemented these programs and are mature in the process, are there unintended consequences that you're aware of? Are there mistakes, trips, stumbles along the way that you could help share with us so that we're more informed in the beginning rather than reacting to those that may happen?

COMMISSIONER ERICKSON: Just before they answer that question -- you guys can hold onto that -- I wanted to respond to Allen and was also thinking that it might have been helpful if I had framed up front before your presentation, especially for our newest members on the group and anybody in the audience.

Last year, one of the solution areas we were studying was transparency, and our recommendations coming out of that were not the end point, but just looking at a couple of data sources related to increasing transparency for both price and quality. And we had made a recommendation last year that the hospital discharge database be strengthened in terms of full participation and utilization of the data, but also that -- I mean, there was a discussion whether we should just go ahead that an All-Payer Claims Database be developed in Alaska, and we stopped short of that and thought, well, we need to study

it some more and come up with some more refined recommendations regarding whether we should recommend it at all and then what should be addressed, but there were two issues driving it.

One was transparency for consumers, and the other was the discussion, the recommendations that we made around payment reform. And one of the things that we learned about payment reform -- there were four main issue areas that we identified needed to be addressed, but one of those that we heard from the provider community most strongly but also from the payer community was that there needed to be a source of data for developing information, for making decisions, for understanding better, in part, what the risk might be, financial risk to providers in taking on new payment that might require financial risk of some sort. And so we had a strong message, at that point in the discussion, about payment reform that the providers would need a source of data for understanding better what they were going to be engaging in, if they were working with payers to come up with new payment models, moving away from fee-for-service.

So as a reminder and to frame, those were the two main reasons that the Commission was interested initially in studying an All-Payer Claims Database, but we learned, along the way, that there are lots of other potential uses for an All-Payer Claims Database, population health and public

health, just as one example, so to Pat's question then.

MS. GREEN: So you're asking for lessons learned?

COMMISSIONER BRANCO: With the theme of trust.

MS. GREEN: Well, I have a lot of gray hair from the lessons that I learned. It is important to have a -- I mentioned this before -- "no surprises" approach. What are we going to measure? How are we going to measure it? Here are the preliminary results. Before we publish, before any public release, here are the comments that those being measured have about the measures, and two, at least in the initial phases, make sure those comments accompany any published information. So again, that's that trust-building collaborative piece.

What we found, over time, was that not so much on the comments anymore. Once everybody got over there, this is how you're doing it. This is how it looks. We did not have to update the voluminous comments every update.

COMMISSIONER BRANCO: Because you established trust?

MS. GREEN: Because we established trust. It is a multi-step, even baby step process, but it has to be an integral part of this planning.

CHAIR HURLBURT: Linda, from your standpoint, from that slide and from slide six, are you getting what you hoped or needed to get for going on to the next steps, so that we can meet this time schedule and come back with information and some recommendations from you all, based on this input?

MS. GREEN: I very much think we have. I think this morning has been very, very helpful, to me, to give me context and an understanding of what the important points really are. I sat in on two of the focus group sessions. I've reviewed the comments that Amy and (indiscernible - voice lowered) brought back from the interviews, but there is something about sitting around the table with you and really hearing what the issues are that you are concerned about. So I think we have a lot of questions to bring back and a lot of, really, pieces to knit together for you over the next few weeks, and I'm really excited about doing that.

CHAIR HURLBURT: So with the questions from some of the Commission members of what's in it for us, what's in it for Alaska, that will be a -- in slide six and looking at some other states' models, coming back, and in a more formal and a laid out way, the ability to respond to that question that, today, was more interchanged, of getting a sense of what are the issues and the concerns; is that valid?

MS. GREEN: That's entirely accurate. Thank you.

COMMISSIONER DAVIDSON: So Linda, you mentioned a strategy that has worked well in other states of -- and you outlined a number of key steps. So are you planning to include that in your recommendation? So for example, defining what it is that the data is going to be used for, in what format, how it can be shared acceptably, so that there are no

surprises as well as an opportunity for comments to accompany and et cetera. So is that -- since that has been successful in other states, are you planning to include that in your recommendations?

MS. GREEN: Absolutely.

COMMISSIONER KELLER: Would it be appropriate to talk to some of the very small business consumers? It goes back to my question. Maybe Allen has a feel for this better than I do, but it seems, to me, like, you know, there are a couple organizations in the state. The one that comes to mind, because I know about it in my district, is the MatSu Business Alliance, and I would assume there are a number of very small employers that might have one or two or three, whatever, and if you want, I can get, you know, a contact for information there. Maybe it's a dead end. Maybe there isn't enough there, you know, to incorporate, but to me, it seems like it's incredibly important because that's the segment. You know, if I'm hiring two or three people, I'm thinking, how am I going to compete with these bigger companies, you know, on the health care thing, you know? And so they're out there really looking, you know. They're actually interested in the price, you know. There are a few out there, you know. If it's okay, I'll do that.

MS. LISCHKO: That would be very helpful. We'd love to talk to some businesses. That's one of the stakeholder groups

we were missing from our interviews, and similar to how providers have been the champions in some states, business coalitions, small business leaders have actually been the champions in other states for precisely the reasons that you're talking about. So that would be very helpful to add that dimension to our thinking.

COMMISSIONER URATA: Can I ask who the champions are in this state? Is it the State?

MS. LISCHKO: I would say, from our interviews in general -- I hope this came across -- that everybody was pretty supportive of the effort. I think there was nervousness around it. When you put the champion, I would say the State is probably the champion. The insurers were pretty supportive here compared to other states where insurers maybe are less supportive and providers are more supportive. It sort of varies depending on the state. But I think it's important for us to identify, and I think some of that has to do with how the data is going to be used, and your champion for quality may be different than your champion for price transparency. They may be different champions.

CHAIR HURLBURT: David?

COMMISSIONER MORGAN: I just wanted to ask a question. I was -- invariably, I peruse websites, like New Hampshire's. And I was intrigued by -- I don't know if anybody -- did everybody kind of look at New Hampshire's website? When you

go to it, it has -- this will make Wes happy, and I think, our Chamber -- health costs by procedure and then it has two buttons. It has one if you're insured and one if you're uninsured, and I found that intriguing. When they pulled their information for the uninsured, how did they do it? Did they do it sort of like what I was thinking, getting it from different groupings and systems that provide health care to people that are not insured or what? I mean.....

MS. LISCHKO: Well, New Hampshire's website looks at a certain number of procedures and so they were able to get data for the uninsured on those particular procedures, what the charges are, what the hospitals or providers actually charge. So New Hampshire is the only state that I know of -- Linda, you may know of others -- that actually -- it's really a consumer website for them to be able to put in what kind of insurance they have, what their deductible is, where they live, and be able to get the price, the out-of-pocket price on average of what it's going to cost them to go to a particular provider for a particular procedure.

Most other states that have looked at and have transparency websites around cost don't have it specific to that consumer and that consumer's insurance policy. They have average aggregate costs across all insurers for that provider. So it's somewhat different. New Hampshire is the only state, I think, that has taken that approach where they really were

trying to get it to the, what is that individual going to pay out-of-pocket when they go to that provider? And it's a unique website. It doesn't, unfortunately, get used all that much, we hear from New Hampshire, but it is a really unique website.

CHAIR HURLBURT: I think we're right on time, and particularly this morning, it's important we stay right on time because we're tied into the noon time thing. Linda and Amy, are you going to be here a little bit, if anybody has individual issues or questions that they want to ask or discuss with you? That would be fine. We're going to take a 15-minute break now. So for those on the phone, we'll be taking a 15-minute break and coming back at 10 o'clock.

One of the things I didn't do this morning that those you who have been here in the audience before -- I didn't do it because I forgot -- was to have the folks, the public members introduce themselves, but I think what we'll do is do that at the start of the public comment period, which may be better, because usually the number grows, and that way, particularly, folks on the phone will get a sense of who is here at the time. So for those of you in the audience here, we'll be doing that. Thank you very much.

9:45:35

(Off record)

(On record)

10:02:11

CHAIR HURLBURT: If we could, let's go ahead and get started again with our next session. This is going to be under tab three in your books. As Commission members -- most Commission members who have been on the Commission remember we embarked on the process a couple of years ago looking at, what are the health care costs in Alaska, particularly for acute medical care?

We had a contract with Milliman last year and got the information on the physician and other providers' care and hospital-based care for acute medical care, and the third component on that has been the pharmaceutical information and that contract also was with Milliman, the large international consulting and actuarial firm. And they have been gathering data, in most respects, comparable to what we got on the hospital services and physician and other provider services there in terms of the various payers and compared it with the other states, the northwest states, Washington, Oregon, and Idaho, and then the two small population rural states of North Dakota and Wyoming. So that will be presented to us here now, and there will be a time for discussion. David Lewis with Milliman is on the phone. Are you, David, can you hear us?

MR. LEWIS: Yes. I am, Ward. Hi, everyone.

CHAIR HURLBURT: Great. Thank you. So let's go ahead. We have the slides on the screen, and I guess, Deb, are you

controlling the slides? So if you can just say, next slide, then we'll advance them here. Thank you.

MR. LEWIS: That sounds good. Great. Hi, everyone. As Ward indicated, we performed this pharmaceutical reimbursement analysis here, and last year, we had also done similar analyses for hospitals and physicians that looks both at reimbursement and cost. We are focusing on reimbursement here, but we get into the details of that in some of (indiscernible - voice lowered) we identify. And also, Ed, are you on the phone?

MR. JHU: Yes. I'm here.

MR. LEWIS: I also wanted to introduce Ed Jhu. He was also involved in the project. I've got him on the slide. So I'll be going through most of the details here, with Ed certainly supplementing any questions or other aspects we have here. So go ahead to the next slide.

Here about Milliman. Just for those of you that aren't aware of Milliman, just a couple of statistics here to put out in front of you, that, you know, we are an international consulting firm, 55 offices worldwide, consultants and actuaries, and we cover pretty much just about everything, I think. We're obviously talking to a group here that focuses on health, but we have all actuarial disciplines covered by the firm and a lot of consulting that's outside of even the actuarial area, but pretty well-established firm. And I'm

happy to have been with Milliman almost 18 years now, and we're pleased that we get to keep providing you guys services and doing these studies here. So anyway, let's just go ahead and jump right in, if you can go to the next slide showing the map.

COMMISSIONER ERICKSON: And David, could you hold on for just a second? We need to fix a slight technical problem here.

MR. LEWIS: No problem.

COMMISSIONER ERICKSON: This will just take a second. Our speakers are all turned up on our individual mics, and the reason it's so loud in the room is that the individual microphones have their -- they're coming through the individual microphones. So if I could ask all of the Commissioners around the table to look for your volume button, it's the dial on the right, and if you could dial it all the way down, then we'll have a little better control on the volume. Thank you. Sorry, David. Go ahead.

MR. LEWIS: No problem. So here, the slide we should be looking at is the map. As Ward indicated, we did a comparison here similar to the one that was done last year for hospital and physician, comparing to the five states that were requested by the Commission here. Go ahead and go to the next slide.

Now I'll give a brief overview of methodology here. This

is covered in considerably more detail in the report, but just at a high level, we are focusing in this analysis on allowed charges, and our definition of allowed charges is the full amount that is paid for pharmaceutical. So that will include the dispensing fees. It will be the, you know, estimated or negotiated ingredient costs and such. So this is the full amount that is paid for the pharmaceutical. And along with looking at reimbursement, we also focused on some of the drivers behind that, including dispensing fees and some other factors that we'll be showing you here in just a moment.

And finally, the analysis did focus on a subset of drugs. It used three lists of these. The first was a set of 20 specialty drugs provided by the Commission here. And then we determined the top 50 generic drugs and top 50 brand name drugs, and those were based upon looking at claims databases we have of data for Alaska and all of the other states. So those lists were generated and reviewed and approved by the group we have here on the phone. So everything that I'm going to speaking about, from this point forward, does represent the data for just these 120 drugs. We think it will be very representative of all results, but it is important to keep that in mind.

And the results, as Ward had mentioned as well, we did calculations for multiple different types of payers here, and the first two are the largest, as you'll see in some of the

data tables. The commercial payers and Medicare, we have claims data sets that we can access directly for both of these, and we had good data for all of the states individually. So these do represent actual amounts paid that -- we've got -- we have different time periods here, as indicated, and from the commercial data, we also calculated, along with the average charge, the mean here, we have percentiles at different levels as well.

For the other payers, for Medicaid, TRICARE, Veterans Administration, and Worker's Compensation, we didn't have live claims data for those, but we were able to access their fee schedules that were current as of the beginning of 2012. So those schedules are compared to the claims amounts we have for commercial and Medicare, but they are comparable, since they do represent the amounts to be paid under those schedules. In most of the comparisons you'll see here, as we get into the results, we'll be comparing between states within a specific payer and then we'll be comparing between payers within a specific state. So we'll have ways to kind of show these values normalized.

I'm not sure how these meetings -- how you prefer them to progress, but if anyone has any questions they'd like regarding clarifying what I'm saying so far, just to make sure it's clear before I keep moving on, I can address those. If we have discussion questions to consider the results or other

aspects, we probably should hold those until the end, but just for the group here, if anyone is unclear on something I've said so far, please let me know, and I can put in a little bit more to make sure that makes sense before we move on. If you would go to the next slide?

This slide -- and I want to be real clear what you're looking at here. What we've done is we compiled the results for each of the states and payers. This particular slide takes those results and it compares them between states, but it does it within each payer type. So as you look at the commercial payer line on top, we have the comparison states to the side. You see Idaho, North Dakota, Oregon, Washington, and Wyoming. Those states have been combined to a comparison state average and that is why we show the 100% to the side, the combined amount. Alaska, and each of the individual states, is then compared to that state average.

So we have the reimbursement amounts for all six of the states sitting here. For the comparison group of five, we did a straight average of those, bringing those together. That straight average is what everyone has been compared to here. So again, that's why you've got the 100% over to the side. So looking, for example, here at the commercial line, we're seeing, for Alaska, 101%. That means that the commercial reimbursement for Alaska for this set of drugs we're looking at is 101%, so 1% higher than the comparison state average.

And if you could -- let's do this -- we might go back and forth between the slides as we look, but if you could go ahead and jump to the next slide, and we'll describe some of the other key observations off of these results.

The first one here, as I mentioned, Alaska is showing up as 101% of -- excuse me -- that was all of payers combined. So let me get that back to here. Sorry. I've got the slides here in front of me I'm trying to get through. So far all states and all payers combined, Alaska is coming in 1% higher.

Now the second bullet focuses specifically on commercial and Medicare. We're seeing those with fairly similar results at 101% of 102% of the comparison state averages. Now we'll discuss this further later, but I did want to mention that this result was initially surprising to us because, you know, you might expect Alaska, due to different geography or different elements here, to have different comparison. However, looking at -- and you'll see, as we flesh that out with some of the drivers as well, a lot of the pharmacy contracts that are out there are on a multiple state basis, and competitive elements effect both commercial and Medicare. And let me explain real quick what I mean by that with Medicare.

Medicare prescription drugs fall under Part D, and those are typically administered by a commercial carrier in that state. So Medicare prescription drugs differ greatly from the

rest of Medicare services because commercial carriers are out there, and they've negotiated contracts with pharmacies to get the best deal they can. So these two results being similar, commercial and Medicare, we did expect that. So what you've got here are two independent data sets, claims data sets for commercial and Medicare, both impacted by competitive elements that are showing us the consistency that we've got for Alaska between the comparison states. So a big point there, and we'll discuss that more later.

The other items here to notice, Medicaid and Worker's Compensation, these do vary quite a bit between the states. The reason behind that is, well, first off, they are not impacted by compensation. The states pretty much set their own schedules. So you've got quite a bit more variation between those.

And then finally, looking at TRICARE and Veterans Administration, these two payers are unique in that they have nationwide schedules for reimbursement terms that they apply. So looking at that chart -- if you wouldn't mind, if you're not on the chart now, if you could jump back up to that chart? Deb, I think you're controlling that. You can, for TRICARE and VA, we've got 100% all the way along the line here. So those two, they're still good for comparison, as we look at the next table, because you can see how the amounts vary between payers, but between states, you can't really get much

out of that, since the amounts are the same between states.

The -- let me see. I think the last thing to point out here, if you're still on the table there, Deb, is we do have weights by the different payers, which are based upon some national drug expenditures that we got from CMS. You're going to see more variable values for the other payers, but I think it's important to note here just the distribution of weights that we have. Worker's compensation jumps around the most, but it is the smallest payer that's out there. We're certainly dominated by commercial and Medicare with Medicaid and then the two national payers, TRICARE and VA, following close behind. If you could, please, jump to slide eight, the relative payer Reimbursement within each state?

Similar looking results here in terms of the layout, but what we've done is the reimbursement is now compared within the columns. So we've taken the payer weights and the reimbursement for each payer in a state and averaged those together. So that's why you see, at the bottom, 100%. That applies to all the values within that column.

Now it's important to note that you can't really compare values between states here because they've all been provided relative to their own state, so their own state average here. So for example, looking at Alaska, you see the 95% commercial reimbursement for Alaska. That's relative to the average of all payers in the state of Alaska. If I step over then and

look at Washington commercial at 97%, I can't really compare the 95 for Alaska to the 97 for Washington because those are only relative within their own state. If you want to do a comparison between states for payers, you have to go back to that previous table. Go ahead and stay on this slide, and I'll go ahead and go through some of the observations here.

As you can see, Worker's Compensation is the highest payer in each state, except for North Dakota. And also Worker's Compensation varies the most between those states, with the second most variable payer being Medicaid. And as I mentioned earlier, Worker's Comp and Medicaid, those are defined by the states. So you know, each state can kind of do its own thing and that's why you see a lot more variability.

Now the thing that did jump out to us that's initially a little surprising is when you look at the VA numbers. For each state, the VA is coming in at almost half of the average reimbursement for the other payers. We did get the VA information from a publicly available national schedule. So we are confident in these amounts. So we did want to point that out to you, that it did stand out to us. We didn't realize that the VA's levels were going to be this much lower than the other payers'. All right. If you could go ahead to the slide ten, we'll start looking at some reimbursement drivers.

The first driver and one of the key ones, too, obviously,

is dispensing fees. So what you've got here, it's a similar layout as the other tables, but the dispensing fee, it's percent of total allowed is shown here for each of the states and each of the payers. So in this example, Alaska, for commercial, the 2.1%, that does mean that, of the total allowed amount for pharmaceuticals in Alaska, dispensing fees represent 2.1%. Now that can be compared between states and between payers because nothing is adjusted to make it relative to the different cells here. So these percentages are comparable across what you see.

So the first thing, again, that stands out is Alaska's commercial dispensing fees are -- excuse me. Their dispensing fees, as a percent of total -- this is not the dollar amount of dispensing fees. This is just the percent of the total allowed. Alaska's percentages are fairly comparable to the comparison states. They're all in a reasonably tight range there, and Alaska falls pretty close to in the middle there.

Now when you go to Medicaid and TRICARE -- excuse me -- Medicare and Medicaid, we're seeing that Alaska actually has higher dispensing fees than all of the other states for both of these payers. Now for Medicaid, it's more by quite a bit.

Now Alaska Medicaid. The reimbursement terms for Alaska Medicaid did change recently and to a fairly different structure, and this, again, is covered in more detail in our report, but Alaska, the ingredient costs that are paid were

dropped by quite a bit from what they were before, but the dispensing fees were pushed up. So the relationship, the percent relationship of dispensing fee to the total allowed amount for Alaska Medicaid has recently shifted, and as you can see from this table, the shift has produced a value for Alaska that is quite a bit higher. Idaho is the closest. Oregon is in the range of it. But then when you look at North Dakota, Washington, and Wyoming, you've got -- those states' percentages are quite a bit different.

And the only other thing to note on this is Worker's Compensation for Alaska and Idaho, that's not a misprint. Those schedules do not separately identify a dispensing fee. They have the entire amount rolled into a standard payment for the drug. So it has zero percent there, but again, keep that in mind that the dispensing fee is, I think, considered embedded in the reimbursement that's happening for those two payers -- for that one payer for those two states. If you could go to slide 12, please?

We'll look at a couple more reimbursement drivers here. So here, we wanted to start to try to poke around a little bit more to get some understanding of what is it about Alaska that may be behind some of these drivers and how that compares to other states. So what we've got are two reference tables here.

The first one is the number of pharmacies per 1,000

residents in the state, and as you can see here, Alaska -- these are sorted alphabetically, but Alaska does have the smallest number of pharmacies per capita in the state. We'll tie that together here in just a moment, but look at the next table to the side. Then we take a look at the percent population by states for urban areas, and we defined urban areas based upon the federal government's metropolitan statistical area, the MSA definition that they use. So we were able to look at the percent of population for the state that is in those MSAs versus the portion that is not. So that is how we defined what we call urban. And we've had these separately for populations that were under age 65 and over age 65.

Now some of the really interesting results here -- as we said, Alaska's pharmacies per capita are lower than all the comparison states. Oregon and Washington are the closest. Now North Dakota and Wyoming had the most pharmacies per capita, although they are the least populated states. They also have the lowest percent of their population in urban areas. So that was an interesting relationship there. But then when you compare Alaska's portion of its population in urban areas, it has more in those urban areas than three of the comparison states and that's for both of the age ranges, under 65 and 65 and over, and then obviously, the total. Alaska has a higher portion of its population in urban areas,

greater than Idaho, North Dakota, and Wyoming. So that was pretty interesting.

If you could go down now to slide 14, the key summary observations, I've already touched on some of these. And certainly, there is a lot more that you can glean from the study and when you see the report in greater detail, but we think the two biggest points to note out of this, first off, as I had mentioned, is the consistency between states for commercial and Medicare payers. The competitive elements there -- the way that pharmacy reimbursement is defined is considerably different than hospital and physician because, for those of you that recall last year's report that looked at reimbursement for hospital and physician, Alaska was typically shown to be higher.

So drugs are a different story though because most of the reimbursement is being done with retail pharmacies and using contracts that cover multiple states, and pharmacy benefit managers out there will frequently operate on a multiple state basis, and they'll pursue contracts that cover that. So that -- and this is reinforced to us because, even though both the commercial and Medicare data are based on claims, they're based on two completely different claims data sets. The commercial data is based upon a market scan or a Medstat database produced by Thompson Reuters that represents a vast amount of the commercial claims that are generated by year,

and the Medicare data is actually based upon an internal Milliman data set, based upon a lot of the Part D work that we do. So we're able to see reimburse by state, by drug, and we do so much Part D work, it was a very credible data set. We were able to get good values for each state. But the point is though, we do have two completely different sources there for that information, and they both are showing a similar relationship.

The next point here, as we mentioned, is the portion of Alaska that's in the urban areas. Again, you know, harkening back to the hospital and physician reports that showed Alaska at a higher level, we've got a different situation here, but what's kind of interesting about this is, even though Alaska is more remote geographically, it's got a higher percent of its population in urban areas than three of the comparison states. So initially, you might be led to thinking that that would not be the case, but it was a very interesting statistic here to note that this higher portion of the population in urban areas could indicate a higher use of these chain or retail pharmacies as well. Unfortunately, information was not available to get a breakdown of the portion of chain pharmacies that are used in each state, but we think it's a reasonable assumption that the distribution of population would lend itself to a greater use of those, since you do have a greater concentration of people in the urban areas.

So that is pretty much it. Ed, I don't know if you want to add anything to what I've said here.

MR. JHU: No. I think you've captured it, and again, just to reiterate what you had said, the primary conclusion really is, you know, when we were looking at the higher cost of health care in Alaska, you know, last year, what we found is that certainly the physician and the hospital studies had shown a significantly higher cost per service in Alaska than the comparison states. By comparison, you know, what we're finding with prescription drugs is that there really isn't much of a differential in terms of the level of costs of the drugs themselves relative to the comparison states.

CHAIR HURLBURT: Thank you. Open it up for any questions from the Commissioners. While we're.....

COMMISSIONER URATA: I was wondering if you studied the chemotherapy -- costs of chemotherapy to hospitals and to clinics, the intravenous chemotherapies? I noticed that you had some oral chemotherapies on your data sheet, but did you have any intravenous type chemotherapies, which are quite expensive?

MR. LEWIS: Let me see. Just a moment here. We're taking a look through our drug lists here. Are those drugs that you would expect to show up on the specialty list or in the brand or generic list?

COMMISSIONER URATA: It's mostly specialty lists.

MR. LEWIS: Ed, do you have that in front of you? I know you've got a little more (indiscernible - voice lowered) experience than I do.

MR. JHU: I've got it here. What I'm pulling up here is a brand and generic lists because I don't have the specialty list on hand.

MR. LEWIS: Hold on just a moment. Looking through the list, we've got the of 20 specialty drugs here, and these were actually defined for us in the scope of the project. So we just used these as-is. They weren't separately determined. Do you know -- I, unfortunately, don't have a lot of experience specifically with chemo. Do you know the particular drug name that would apply?

COMMISSIONER URATA: Avastin.

MR. LEWIS: No. That is not on the list.

(Pause - background discussion; indiscernible - away from mic)

COMMISSIONER URATA: That was just curiosity because those are in the thousands per drug.

MR. LEWIS: Did you say Simvastatin?

COMMISSIONER URATA: Avastin, A-v-a-s-t-i-n.

MR. LEWIS: Yeah. We don't have that on the list.

CHAIR HURLBURT: The list that we had, we basically got from our Medicaid pharmacist of the so-called specialty pharmaceuticals, the one where we were seeing the most use.

And I want to make a comment and then end up with a question and maybe, David and Ed, to get your response on that, but the purpose of what we were looking at was the relative cost, not whether high or low or whether (indiscernible - voice lowered), but relative between us and the other states, as we did with the others. If you look at overall U.S. health care costs, according to the *Washington Post* seven months ago, by the year 2033, if we continue to have our current, which is somewhat lower, delta or difference between the increase and the cost of living for all costs and for health care costs, by the year 2033 -- 21 years from now -- we will consume 100% of our gross domestic product for health care costs and that's why we talk about costs, even though we don't like to. That's the reality. That's for the country.

So we started out looking, well, what's the difference between Alaska? So in the overall cost area, when we looked hospitals and physicians and other providers last year, we saw, are there differences, and there were. And we looked at maybe some "whys." That then -- if we're concerned about the increasing costs for all payers, we need to look at some unique Alaska solutions as a part of the overall issue.

When you look at the overall costs of health care, as we all know, compared to all other industrialized countries, we're between 50% and 100% more costly than all other

industrialized countries. When you look at this information that we're getting from Milliman, it says, to me, we don't have a uniquely differential problem for pharmaceutical costs. Pharmaceutical costs are high.

In terms of the Avastin question, there was an article just a few weeks ago. It started out in the *Charlotte Observer*, but basically saying hospitals are charging -- are marking up by ten times what they're getting, and they talked to hospital administration, and they said, well, we have to make up for our losses on the 8% of the non-paid business that we have and that was a defense of doing that, but I think it was that the Avastin is high, wherever you go. If you look the international comparisons -- and I don't remember the numbers now, but overall, our pharmaceutical costs are significantly higher than in all other industrialized countries, but when you break it down, what's interesting is that the generic products are cheaper, like often half, of what they are in other industrialized countries in the U.S.

So the competitive marketplace is really working in terms of generics, but our brand names are so much more costly than brand names in other countries that the average of all pharmaceuticals is quite a bit higher. So in terms of what this is telling us, pharmaceuticals, whether it's the generics, the brand names, or the specialty pharmaceuticals, which are the ones that are costing you, you know, one, ten,

$100,000 a month, whatever -- it just blows your mind now -- that's a national issue. Our addressing it is -- I would see it as the conclusion of this, and I kind of would like to get David's and Ed's reaction to that, too. Our addressing it is no different than our neighbors and friends in Washington and North Dakota and New York, whereas we do have a unique situation for some of the other health care costs. At least, that's what I'm getting out of this.

COMMISSIONER URATA: Well, it would be nice to have the data.

CHAIR HURLBURT: And I think we could probably get that for you, ourselves. Yeah. Ed or David, do you think that what I just said makes sense?

MR. LEWIS: Yeah. For my part, I agree with that statement that; yes. Given what we've found as far as prescription drugs just being inline with the other states, yes. Presumably, I think we're all recognizing that there is a nationwide problem as far as the cost of prescription drugs, but as you pointed out, it's not like some of the other services where there were some unique issues for Alaska beyond that, that need to be addressed. So to the extent that Alaska can be part of the nationwide solution, that's great, but it means that, you know, in this case, you don't necessarily need to be leading any additional initiatives beyond what's happening nationwide.

The only other thing I'd put in there -- and something that was outside the scope of our report for now, so to be honest, I don't have a feel for it, and I'm not sure if anybody else there at the Commissioners' table does -- is, you know, one of the other issues, quite apart from the average cost of drugs, is just the level of the utilization of drugs. And so I don't know, at this point, if anybody has got a feel for, you know, whether or not the utilization rates for drugs in Alaska are particularly higher or lower than those elsewhere. I know we have some various metrics here and there at Milliman. I haven't looked at them lately for Alaska specifically, but that's the only other area I think you might concerned is, you know, not so much the cost per drug as whether or not the utilization rates themselves are inline with the rest of the nation or whether or not there are any concerns there as far as excessive, you know, overprescription of drugs, or potentially at the other end, issues as far as just compliance with maintenance drugs that are required to maintain ongoing good health.

CHAIR HURLBURT: Yeah. I think that's an important fact there. So far, everything else that we've looked at has not suggested that utilization differentially compared to the comparison states or compared to the country, that it's been excessive in Alaska.

MR. LEWIS: I did want to add, Ward, to your comment

about the enormous difference between brand name and generic drugs. The study here certainly fleshed that out. When we were looking at the amounts by individual drug, we brought down some standard amounts, you know, the AWP, the Average Wholesale Price, and the Wholesale Acquisition Cost, and you know, as we had discussed, the -- for a brand name drug, the relationship between the Average Wholesale Price or the Wholesale Acquisition cost is very consistently -- surprisingly so, actually, but consistently about 1.2 relationship. So the cost times 1.2 would equal the average wholesale price.

When you went over to the generic drugs, it was a dramatic difference. The cost drops, you know, in some cases, to a tenth, in some rare cases, to almost a 50th of what the AWP would be. So dramatic change moving over to generic. So you know, certainly, generic substitution is advocated there, but just echoing your sentiment about the difference between brand name and generic, we saw that quite a bit when comparing those amounts.

CHAIR HURLBURT: I take some Statin, and the monthly cost coming from the PBM that provides my drug is now 2% of what it used to be before some of the Statin went generic.

MR. LEWIS: Wow.

CHAIR HURLBURT: David?

COMMISSIONER MORGAN: Yeah. This is a question, and I

have to bite. Why is the VA -- does the VA have a special formulary or a way of negotiating, but why is it so much less? I was just -- we have somebody that works in the system. I have contract -- I did a contract with them for primary care, but that's an extraordinary percentage, I thought.

COMMISSIONER HARRELL: I'm not entirely proficient in that, but I will tell you they do have a different fee structure and a different formulary even more restrictive than what we have on the DOD side.

MR. LEWIS: And part of it also with VA is just purely just the volume that they have and some of the purchasing power that they can get out of that as a result.

CHAIR HURLBURT: Yeah. On the drugs, the VA is one of the federal fee schedules, and I believe it's probably still true -- Val, I don't know if you know -- that the tribal health system used to be able -- that was -- that could purchase on a GSA schedule or the VA or the DOD schedule. Medicaid cannot, and by legislation, Medicare is precluded. So even though it's a federally funded program, they're precluded from purchasing on those fee schedules, but it's an awesome difference in price.

COMMISSIONER HARRELL: Note that it's even different between the DOD TRICARE vehicle versus the VA.

CHAIR HURLBURT: Any other questions or comments on this? Any preliminary conclusions? Pat?

COMMISSIONER BRANCO: No conclusions. I was just curious, and the fact that David was curious about the urban nature of Alaska, I quickly looked up the metropolitan statistical areas definitions that were used, and I was so surprised to find out -- not surprised that Anchorage is considered one of the urban areas. Fairbanks is, but Kodiak, Ketchikan, Juneau are in a micropolitan area, and I had never heard the phrase and never thought I was so downtown.

MR. LEWIS: You're in the exciting part.

CHAIR HURLBURT: With some of the federal grants that have been available related to health care, the definition -- on some of them that we felt kind of badly about -- is that small communities were excluded, and the definition was less than half-a-million people. So that Washington D.C. definition.

CHAIR HURLBURT: Jeff?

COMMISSIONER DAVIS: So I'll speak of what I know nothing about. I just note the Worker's Comp result at 180% versus the State overall result of 101, and I just wonder, again, knowing very little about Worker's Comp, if there is an opportunity there?

MR. LEWIS: I would say that there is. If I could add to that, that Worker's Comp stood out more than all of the other payers, and you can actually see the reimbursement terms in detail in the report, but it stood out more compared to the

other payers, in that some states were still paying these really surprising amounts. You know, Alaska's are obviously pretty high here as well. I don't know. It's almost like a unregulated area. Comparing between states, if you were to -- I don't know if you can put that slide back up on page six, slide six. Let me know if you have that back up.

COMMISSIONER ERICKSON: Yeah. We have it, David.

MR. LEWIS: You can see, between states, Worker's Comp's here, and these percentages do compare between states. They're all within Worker's Comp, but you can see that it is all over the place. We've got, you know, not nearly that level, but Medicaid can vary quite a bit, but nothing like what you're seeing here on Worker's Comp. And it's the kind of thing, obviously, that made us initially nervous, and we went back in, checked, triple checked, you know, access/ reimbursement terms by the state and brought these in, but it's almost like it's an untouched area for many states, and the schedules, the way they define them, are based upon - a lot of them on terms that, you know, they aren't using. Like, very few of them had a maximum allowable schedule or charge schedule in place, one that would limit and another one. So it was unregulated.

To the comparison average, Alaska is higher. And then when you jump to, as you mentioned, the other results on slide eight compared to the rest of the state, for Alaska, Worker's

Comp is certainly very high. So it feels like you would be justified greatly in changing the reimbursement terms that you got for Worker's Comp, getting it more in line with the other payers.

MR. JHU: And the only kind of argument I put there -- and not so much that there isn't an opportunity, but just keep in mind what we have as the payer weights on either side, six or eight, that -- nationwide, Worker's Comp accounts for, you know, less than half-a-percent of drug expenditures. So as much as -- there might be an opportunity to lower it. It's certainly, unfortunately, not going to be a silver bullet as far as lowering costs. It's going to be a relatively small portion of what you're actually going to impact with that.

CHAIR HURLBURT: Those payer weights will be different in Alaska, we know, just because of the uniqueness of our population. I think that was a good comparator for you to use, but some of them, for example, VA or TRICARE, would be higher here because of the makeup of our population. Allen?

COMMISSIONER HIPPLER: Yes. I was going to bring up the payer weight of Worker's Compensation. Based on my experience and the costs that my business is incurring, 0.4% sounds very, very low. I -- so if you just look at my business, of course, you have to cancel out Medicare and Medicaid, TRICARE, VA. We don't directly subsidize that, but we pay for our own insurance, commercial, and we pay for Worker's Comp, and

Worker's Comp is, I'm going to guess, 30% to 40% or maybe 30% and 70% is our private insurance. So it's a big deal.

COMMISSIONER ERICKSON: Allen, can I ask how many employees, full-time equivalent employees your firm employs?

COMMISSIONER HIPPLER: Right now, about 30, but in the summer, a lot more.

MR. LEWIS: So the percentage, as you mentioned, for Worker's Comp, with a population like that, that might, I guess, a couple of people you've got. Are they atypical or do you think you've got some fairly standard cases there that are driving that amount of cost?

COMMISSIONER HIPPLER: I was talking about our premiums and our cost for Worker's Compensation, and of course, I don't know, of our premium, how much of that is spent on pharmaceuticals.

MR. LEWIS: I see.

CHAIR HURLBURT: We have -- when you look at what our economy is here, what the jobs base is, industries that are very high risk for employees, like commercial fishing, like hard rock mining and so on. On statewide basis, they're a really big part of our economy -- logging -- and so it wouldn't be unreasonable that our percent of business that's Workman's Comp would be higher because we do have a lot of people that put themselves at risk in earning their livelihood.

COMMISSIONER HIPPLER: I should mention one of my companies is a seafood processing company.

MR. LEWIS: Okay. Well, you know, we're looking at average reimbursement here, and we made a point to use a common set of utilization to keep everything on the same basis. So we don't have a different mix or something driving these results. So those situations, you know, could certainly increase the amount of drugs use and maybe even the type, but in this study, we've got all that normalized. So the high amount you're seeing in Alaska for Worker's Comp is solely based upon how much is being paid, you know, the average reimbursement for the drugs. So you know, considering that, I think it is still coming in at a high level.

CHAIR HURLBURT: Any other questions or comments? David and Ed, thank you very much. This was what we wanted to know and what we needed to know, and it's very helpful.

MR. JHU: Yes. Thanks a lot to all of you for your time and the opportunity.

MR. LEWIS: We really appreciate it. With that, I think we'll hang up from the Milliman end.

CHAIR HURLBURT: Thanks so much. Have a good day.

MR. LEWIS: All right. I hope your conference goes well. Bye-bye.

(Pause - background discussion)

CHAIR HURLBURT: We're about ten minutes ahead of

schedule, so why don't we go ahead and take about a ten-minute break and then we'll come back and we'll have our public comment period.

10:47:36

(Off record)

(On record)

10:59:51

CHAIR HURLBURT: We'll come back together, and what we'll do is initially have the folks here in the room introduce themselves. And then we have a couple of folks here and another opportunity for anybody online to make some comments or testify. So if we could start out? Maybe if the public members who are here, if you could introduce yourselves? Just say who you are and your name, and if you're representing somebody, you could say that. We'll start with you, please, sir?

MR. ADLER: Hi, Ron Adler, and I'm the CEO of API and am very interested in how behavioral health will be integrated into the transformation in the state of Alaska.

MS. STEPHENS: I'm Donna Stephens of Hospice of Anchorage, and I want to talk to you about End-of-Life Care.

MS. PEMBERTON: I'm Jocelyn Pemberton. I'm with the Alaska Hospital List group.

NICK (LAST NAME UNKNOWN): I'm Nick (indiscernible - away from mic). I'm (indiscernible - away from mic) Specialist

with Health Information Systems.

MS. MINARD: Hi, I'm Robin Minard. I'm from MatSu Health Foundation.

MS. BRADY: Hello, I'm Kennis Brady from the Primary Care Association.

MR. RICHARDSON: Bruce Richardson, Central Peninsula Hospital.

MS. OBERMEYER: Gwinn (ph) Obermeyer, private consultant.

MR. BRASSELL: John Brassell from Alaska Regional Hospital.

MS. FARMER: Kelly Farmer, Heathsmart.

MS. PERDUE: Karen Perdue, ASHNHA.

MS. CULPEPPER: Delisa Culpepper, the Trust.

TOM (LAST NAME UNKNOWN): Tom (indiscernible - away from mic). I'm a visiting Cheesehead.

MR. RAMSEY: I'm Dean Ramsey with (indiscernible - away from mic) Services.

MS. HERMAN: I'm Lori Herman (ph) with Providence.

MS. LOVE: I'm Jenny Love, Medical Director for Alaska Psychiatric Institute.

CHAIR HURLBURT: Thank you all for being here today. We appreciate that. Is there anybody online now who has a -- wants to make a comment or a question? We'll come back, and you'll have another opportunity at the end. We have just two folks signed up here in Anchorage at the Hilton. If we could

start out? Donna Stephens, if you could come, we would appreciate that.

MS. STEPHENS: I'd like to thank you very much for the work you've done End-of-Life Care, and I was thinking, on my way over, that your Preliminary Findings and Recommendations have really helped me to see the forest through the trees. I think sometimes we can get so immersed in the topic that it's hard to say where should we be focusing. And so that really helped me to focus my thoughts and comments that I'd like to share with you on that.

As you know, Hospice of Anchorage is a strong component of palliative care, but my comments primarily focus on the end-of-life for the seriously ill -- and by that, I mean people that we expect -- we wouldn't be surprised if they died in a year or two -- and the terminally ill.

I want to remind you that hospices and palliative care occur in a variety of settings, and I know you hospitals (indiscernible - voice lowered) ALS, but we also work with people in prison and with the homeless population. And you know, those are some of the populations that are often forgotten, but seeing 100% of us die, people die in prison and when they're homeless.

There are a variety of payers, as you've noticed. One is what I call true charity, like the volunteer hospices we have in Alaska where we're prohibited by law from charging for

care. We have the government programs, the Medicare, the Medicaid, and the VA, but we also have a very what we call the informal caregiving, which is stressful and financially burdensome, that families and friends provide to their loved ones, that, because they don't really get the support they need, it's an increased cost to the system from their loss of physical and mental health as well as their productivity at work.

I wanted to point out that it's important to note that the difference in hospice concepts that you find are primarily payer-driven. It's not best practice to start hospice care only when a physician is willing to sign that a patient is likely to die in the next six months. It's not best practice that you can't give hospice care concurrently with curative treatment. It's not best practice to require that a patient sign that they've known they're dying from health care. It's not best practice to provide hospice care only to people whose oxygen saturation levels fall below a certain level. Those are things that were put in place to control costs, not because they're best practices.

And so when we look at the complicated issue of cost savings for palliative, hospice care, I think we have to look at those issues as well the cost shifting that you talked about and the cost avoidance practices that happen in our system.

Good end-of-life care is the right thing to do, and providing it and doing it right is likely to save money, though it won't save the health care system. I'm naive enough to believe that, just as we solve this problem, they're going to solve health care.

Studies show that individuals and families who have discussions about their goals at end-of-life suffer less, are more capable and alert longer, and their families, after six months from the death, are less likely to suffer from major depression, but studies also show that only about a third of us ever have those conversations, even when death is imminent within four months.

Studies have also shown that individuals who receive hospice care lived better, as long, and in fact, often longer. We know that people are willing to choose hospice when they don't have to give up.

The discussions that need to happen are not medical, and they're not the death panels that some people worry about. Dr. Susan Blanc (ph) and Dr. Obogandi(ph) -- you may have read his articles and some of his work -- used these questions, and I wanted to share them with you because I think, if you haven't heard of them or used them, you're not sure what we mean when we say, death discussions. But they used these questions with both their dads and that's, how do you want to spend time as options in your life become limited? What

tradeoffs are you willing to make? What concerns do you have about what lies ahead? Do you know what your prognosis is? You know you're dealing with an incurable disease, but do you know what the timeline often is for people in your condition? Who do you want to make health care decisions when you've reached the point that you can't? Have you talked with them about what you want?

Those are the kinds of things, when I talk about having discussions and advanced directives at end-of-life, that we're really looking at. Those are the important things, that we begin to understand people's values. They're not necessarily the medical procedures that people might be faced with needing. If they can't talk for themselves, if someone doesn't know what they want, it's hard for them to make those decisions. So it really becomes a gift. These conversations are very hard. They take a lot of time. To be effective, they have to have an individual with their family, so it's not a 15-minute conversation that a physician has in their office. It can be a 15-minute conversation, if it starts early and continues with each visit, but it's building up to that.

And I wanted to share with you that Dr. Obogandi, in his (indiscernible - voice lowered) interview in July of '10, stated, "These conversations are the most beneficial thing we can do to make End-of-Life Care better and cope with the costliness of it."

So if, you know, this is one of your recommendations, then I think there is just such strong support for it that I really wanted to share this information with you.

So going into your Preliminary Draft Recommendations, you recommended education, and I'd like to make a comment that State of Alaska funding is required to make the cultural change needed to positively impact End-of-Life Care in this value equation. (Indiscernible - voice lowered) we shift away from just medical model, focused individual and family-centered system.

The provider education requirements that you recommended need to be much broader. They need to -- you mentioned palliative life care. I'd like to see you specifically mention end-of-life, and they should be for all health care providers, not just MDs. I got a little carried away last night making a list: RNs, LPNs, social workers, psychologists, nurses aides, care coordinators. And then I said, maybe even attorneys, hairstylists, and barbers. I think that's about (indiscernible - away from mic). Actually, as I get to the (indiscernible - away from mic), they might be the most effective in having these conversations.

I wanted to speak about the standardization and POLST and MOLST, and I think you know that the Palliative Care Committee of Anchorage has been looking at those, but we're an informal committee of people who are concerned and care about this, but

we don't have any formal standing. So I thought about it, and Comfort One's system is operated through the Division of Public Health. And so they don't have any money to do that, but they do it. So maybe with some funding, they could help to involve the stakeholders that really need to be involved with deciding a good MOLST or POLST system for Alaska. I think we're too early to recommend legislation at this time. It hasn't been studied, and we haven't collected all the input that needs to come from stakeholders.

I think a secure electronic registry would be practical, and it would bring peace of mind to many who worry that they're going to have aggressive treatments long after they want them.

I wasn't clear about the idea of a palliative care formulary, so I turned it into what I thought would be helpful, and I think it would be wonderful to have a website that was based somewhere in the state government, probably about best practices for End-of-Life Care.

I know we've had physicians visit hospice from Bethel this year. We've had a nurse visit from Seward. We've had a nurse practitioner visit from Kodiak, trying to learn how can we do hospice care in our community, and I think, with a good website, we could reach more people. There is a lot of great information that just needs to be pulled together. Some ideas I have for where that could be based are the ADRCs, the

Commission on Aging, or again, the Division of Public Health.

You talked about incentives in your findings.

CHAIR HURLBURT: Maybe another minute or two.

MS. STEPHENS: Almost done. Good. The incentives. A positive impact on the End-of-Life value equation could be made by the State by dropping the Medicare hospice requirement for Medicaid and health plans written in Alaska that require people to be promptly dying and allowing what AETNA Insurance, a pilot demonstration project, has called concurrent care, which is basically hospice care that allows and reimburses curative care until the person is ready to move into hospice care. The State could provide grants, increased grants, such as in the senior in-home care program and the family caregiver programs designed to help elders live independently at home as long as possible. They could be expanded to focus on education to prepare for end-of-life and to provide supportive care management, respite, (indiscernible - voice lowered), grief support.

Specific grant funding should be encouraged to allow and promote a vibrant and effective volunteer hospice program throughout Alaska. Because we're not able to charge for services, hospice struggles to care for neighbors and support dying and grieving. Approximately 20% of grieving people become a problem, a major -- causing major physical or health problems when they're grieving.

I looked at your (indiscernible - voice lowered) recommendations, and I thought telemedicine would be fantastic, but it also could be very useful in the urban areas when people can no longer get out of their homes.

Hospice houses, I believe, have pros and cons. Although every one I've been to looks wonderful, it tends to centralize expertise in one area and not have the whole community engaged in end-of-life.

You also mentioned that the "no one dies alone" programs. They're currently at the individual hospitals and agencies, and I think that would be a great program that could be highlighted on a web program, a web-based program so others could learn about it.

And again, I'd just like to thank you for the admirable job you've done in your Findings and Recommendations for this complex issue.

Given the fact that 100% of us die, approximately 80% from the frailty of old age and serious chronic illness, it's a major problem. And I'm hoping that you can also figure out how to keep this, what you've done, going. We need a statewide planning, education, advocacy program for implementing the best practice strategies and evaluating what happens at End-of-Life Care, so that we know we've made a positive difference in the (indiscernible - simultaneous speaking).

CHAIR HURLBURT: Thank you very much for that.

MS. STEPHENS: Thank you.

CHAIR HURLBURT: It's going to be helpful. The list that you have, basically, tried to capture some of the thoughts that came out from the seminar, really, that we had in July that worked so well. The next step will be for the Commission to consider those as we come to, what recommendations do we want to make to the Governor, to the Legislature in this year's report, which will go out on the 15th of January.

COMMISSIONER URATA: Can we have your comments?

MS. STEPHENS: I brought Deb a copy, and I'll give it to you.

CHAIR HURLBURT: Thank you very much. That was helpful.

MS. STEPHENS: Thank you.

COMMISSIONER ERICKSON: I'll try to get that copied before the end of the day, if I can, so you can have it. And then the Findings and Recommendations that she's referring to are what we produced in the last meeting, and you all have it in two different forms in your notebooks behind tab five, the Meeting Discussion Guide, the slides. And then right behind Meeting Discussion Guide, there is a two-page -- thank you.

(Pause - background discussion)

COMMISSIONER ERICKSON: There is a draft two-pager right behind the Meeting Discussion Guide specific to the End-of-Life Care, just a draft concept still for draft Findings and

Recommendations. So you can be looking at those overnight, tonight, for homework, and to refresh your memory, and I'll do my best to get -- pressure.

(Pause - background discussion)

COMMISSIONER ERICKSON: So I will get Donna's written testimony to you, and I think we have, at least, one more person in the room signed up.

CHAIR HURLBURT: Yes. Yeah. With that wonderful introduction, Karen Perdue, if you could come, thank you.

MS. PERDUE: Good morning, everyone. I wanted to comment today. My name is Karen Perdue. I'm the CEO of the Alaska State Hospital and Nursing Home Association. Pat is one of my bosses, and I enjoyed listening to the conversation this morning.

I wanted to comment on the All-Claims Payer Database project. ASHNHA has done a fair amount of thinking about this, probably not as much as we want to do at the (indiscernible - voice lowered) level, but we, and the staff, have done some research, including talking to our peers in other states, possible associations (indiscernible - background noise) systems, reading, and then also meeting with the consultants, the very knowledgeable consultants that you have and also provided some written comments. So we're probably going to be at the table along the way on this process.

I wanted to give you some of my thoughts after some of that research, in your thinking -- (indiscernible - voice lowered). I'm having a little trouble summarizing my comments because this is such a big idea, and I have struggled with that, and I wanted to just tell you that I was coming at this from a couple of different backgrounds.

One is as the Commissioner and the Deputy Commissioner in the Department of Health, I did set up quite a few or was involved setting up quite a few disease registries, including the HIV (indiscernible - voice lowered), which was a very credible process, a good process for a very controversial time. And EAFE does provide (indiscernible - voice lowered) in an unparalleled (indiscernible - voice lowered), both for public health investigations and surveillance. (Indiscernible - voice lowered.)

I've been involved implementing a new OIS system and also working to (indiscernible - voice lowered) serving NIH Institutional Review Board processes, looking at (indiscernible - voice lowered) research and that is a very process, and I believe that's relevant for the information that would come out of a claims payer database.

IRBs are not -- they are very powerful in NIH-funded research and in terms of human subjects research, and I think we've seen across the country, and even in Alaska, disproportionately unrepresented populations of (indiscernible

- voice lowered) research assert a fair amount of control in use of protocols to the IRBs. And so if an IRB feels that research is, in some way, not consistent with positive outcomes -- so good research practices -- they can prevent the research from going forward. They're non (indiscernible - voice lowered).

The reason I think this is such a big idea is that we're now putting pretty much all the information of the $7 billion industry into one bucket. You know, it's a private sector industry, and it does, of course, receive a lot of money from Medicare and Medicaid and other public sources, but in general, it's a private sector industry. And so I think, when we're talking about protocols about how to use the information, (indiscernible - voice lowered) use of information, we need to think about examples where governments have taken private sector data -- it may not be exactly the same, but -- and learned from that, too.

Let's take the oil industry and the use of tax information, property information, exploratory information in our state and how much the State should know, who should know it, how it should be governed, how confidential is that information.

Employer wage records for the Department of Labor, and I can only imagine the body of law that's involved with the use, the responsible use of that data at the Department of Labor.

So I think one of the things that my colleagues talk about when they talk about nervousness is that not only would this entity have public health information, for instance, it probably would be (indiscernible - voice lower), so it wouldn't be used for investigation services. But they would have price, (indiscernible - background noise), information all together in one place.

Some of the nervousness has come from the government's issue. You know, is this a state entity or a state chartered entity that manages this information? Some states have an arms-length relationship with those entities. Some states have the state managing that database.

Where the nervousness has come from is the conflicting uses of the data, and some of them have been highlighted by the state of data and using the State's role, for instance, as a payer, the State's role as an employer, the State's role as a regulator and having access to that data.

Right now, I think the State does a pretty good job of keeping, for instance, licensing investigations and public health reporting separate, but that's the kind of thing that you can think about when you're thinking about this (indiscernible - voice lowered).

So one example of a state egregious example is that the database was set up and then the Public Health Department determined that they wanted to mandate additional reporting

requirements, so they went into the database and they changed the form, which led the industry to go back to the Legislature and clearly define the scope of what was to be reported.

I'm sure that you can find positive examples of how it's being used, too, but the nervousness comes from lessons learned in other states, and it comes from other industries and what kind of restrictions and protocols they have put on these kinds of situations.

I do not -- I think there would need to be a statutory framework for this database. It needs to be very robust, and I think that the statutory framework would have to layout protocols, and I would strongly suggest that the Board or a governing group not be advisory in nature, but really have strong authority to assert themselves independently.

I think one of the things I took away from your conversation this morning is, who owns the claims data? Providers are not necessarily thinking that insurance companies own the claims data. I'm sure Jeff has a ton of expertise in this area, and you know, it governs their daily existence.

Medicare, you know, really has been a leader in using its data to shape provider behavior, and I think, in some ways, they've done a very responsible job of it, although it's been painful, and they put a ton of infrastructure and energy into doing it responsibly. We, in the hospital field, understand

that Medicare is driving the train of transparency for us. For PBS hospitals in particular, the reporting requirements, you know, are continuing, and they will only continue more. In January 2013, we'll see hospital (indiscernible - voice lowered), mandated reporting for PBS hospitals. Our critical access hospitals really have not seen -- which are half of our hospitals -- that kind of reporting. So they don't have necessarily the culture of using the data as robustly as our PBS hospitals have. The larger critical access hospitals, I think, do have that. If you only have one person who is in charge of quality, you know, (indiscernible - voice lowered) control, the newsletter, everything, is very difficult, you know, to have a lot of it. And I will say that reporting fatigue is very big factor right now in hospitals, in the hospital world because various funding sources are all requesting various different kinds of reporting. We're hoping to see some of that gel into a system of -- a streamlined system.

So I guess my question for you is -- to answer some of the questions you asked yourselves this morning -- do you, as Commissioners, understand this idea fully? Are you able to explain it to others because you're really required? And I am still -- I'm still really seeking information about how these very big systems fit together. Who governs them? What are those protocols? What are the principles for those protocols?

I also know that, when you're working with data, it seems simple, but -- and of course, people who love data can go and on. We all know that, too. It's just they put in the data in a hurry, and it'll just be -- it'll not be perfect, but it will be okay. But for instance, hospitals are being asked to report hospital required (indiscernible - voice lowered) through NHSM. There is not nationwide agreement on some of the definitions of that reporting (indiscernible - voice lowered) other things. I mean, these are complex areas where, you know, the definition of what you're tracking is as important as the data that comes out.

I don't think that ASHNHA -- I don't understand entirely the timeline for the report, but ASHNHA will take a serious look at the report, but I would just say that, to involve our board in this, we will need time. We cannot turn around a response to this report draft in a matter of a week or two or three.

So I would just ask you to think about, in the interest of trying to gain more understanding of what you're doing, to look at slowing a little bit because this is a very big idea, and maybe we bring in providers. I don't know what the next best would be, but however you get out of this phase of the process, you need to define a process that includes providers at the table that have the time and expertise to work on this. I mean, many of you are representing entire industries and

you're very busy, but there must be a sub-process that could be defined. So Mr. Chair, those are my comments, and I appreciate the time (indiscernible - voice trailed off).

CHAIR HURLBURT: So the takeaway is you want three-and-a-half weeks. I think that's very helpful. I think our intent to have this group of 15 or so become the most knowledgeable of any Alaskans about what an All-Payer Claims Database is and to look at it and to see what is the potential benefit to be gained and what would be the cost of getting that done and then I think I would absolutely agree that -- in the case of providers, in that whole process of looking at it will be important. So these are kind of the first steps that are going on, and I think, in terms of timing -- obviously, things can go on forever and nothing happens, but (indiscernible - voice lowered) there is no deadline on it and looking at it, and I think we have the time to try and do what is right as we can.

We hear a lot of good reports from other places, but this is a part of the process of educating all of us and others in getting there. In fact, I think your comments, Karen, were very helpful.

MS. PERDUE: Can I just make a couple additional comments? One is, I think we're all sort of understanding that, you know, when the EHR movement was first designed, I think people in charge of it thought, well, it's going to flip

right along and be done in five years. I think what we're now seeing is, you know, investments of millions and millions and millions of dollars by providers, and it's taken a lot longer than we hoped, but a commitment to the idea that this idea -- this big idea is going to improve clinical practice eventually and should impact costs. So I think that's the kind of effort that you're doing here. It's that big. Now it's not nationwide, the same everywhere, but it is big, and it takes a long time. So that's one thing I wanted to mention.

And I wanted to also mention that in -- when I talked to hospital colleagues, what they have said about the movement that CMS has imposed is that, at some point in the process of public reporting, it turned to a drive for the clinical leaders to get information to a group practice. That has been the success of the movement. It's not core measures that you can look up on the website. It's that medical staffs sit down with their boards and review, in a governance fashion, the quality that's going on in the facility. That is what you want the data for. That's what's going to drive the cost involved. So that's why it's important to take a big idea and spend the time to really invest in the knowledge and understanding of it and really ask the hard question from yourselves and providers, you know, is this going to be (indiscernible - voice lowered)?

California went through a huge process, and they

determined that they didn't want to be involved in (indiscernible - voice lowered) system, is my understanding. So there are different ways to get at it, but the quality movement has been, I think, embraced, for the most part, and that's going to make the difference.

CHAIR HURLBURT: Thank you. Any other comments on that from Commissioners? Deb, do you have something?

COMMISSIONER ERICKSON: Let's check on the phone.

CHAIR HURLBURT: Is there anybody on the phone that has a comment to make? Thank you, all.

COMMISSIONER ERICKSON: Well, we are ready to break for lunch, and for the Commissioners, so you know, we have three tables in the front of the room across the hall that are reserved for the Health Care Commission, and you don't have to sign in or register or buy a ticket. You can go straight in.

CHAIR HURLBURT: (Indiscernible - away from mic)

COMMISSIONER ERICKSON: They've already read it, right? They got it a couple meetings ago.

CHAIR HURLBURT: There are about 100 copies of the book that we purchased that will be available to the business people that come in (indiscernible - voice lowered). So if you have colleagues or friends who are coming who might want the book, there won't be enough for everybody, but there are about 100 copies.

COMMISSIONER ERICKSON: For those of you on the phone, I

apologize we won't be able to teleconference the newsfeed from a different place in the hotel, but we will be recording it and making it available.

CHAIR HURLBURT: John Torinus will be the speaker. He's been with us all morning. Probably most of you have seen that he has been very engaged in our discussions, and he and I have had the opportunity to chat a little at some of the breaks about some of his experience that would cause him to relate to some of the issues that we've been talking about. So we appreciate you being here. So we'll break for lunch now. Deb, what time?

COMMISSIONER ERICKSON: You've got about 20 minutes. And CommonWealth North does a very good job of starting right on time and ending right on time. So make sure you're in your seats across the hall well before the appointed time. Actually, there is buffet line set up, too, to get your food, I believe. I saw the room. So you might want to try and get over there really quickly to get through the line.

11:35:34

(Off record)

(On record)

1:13:05

CHAIR HURLBURT: Let's get started here. We're going to follow through this afternoon on the (indiscernible - background noise) lunch hour and look at some of the things

that employers are doing, and part of it is wellness. The Providence systems have been quite involved in that for a while. They try not to hire anybody who smokes and that's a big cost to folks who do that, not to discriminate against them, but they've been a real leader in looking at that. And then we're going to have a Reactor Panel later on with some other folks representing various employers, including the State, and talking about some of the things that are going on here.

As we heard over the lunch hour, Safeway has been a real leader in that nationally, and they've had some very dramatic impact on their -- they've got some sharing of costs, like we heard about, but they've done some balancing kinds of activities. And so we'll see (indiscernible - background noise) about that.

Tammy Green is here with us. She's the Director of Well-Being & Absence Management, which is an interesting title. She works with Providence Health & Services, and a Member of the Board of Director of the National Business Group on Health and the Integrated Benefits Institute. I've, from Deb, a lot of neat things, and others, and we welcome you here, Tammy.

MS. GREEN: Well, thank you. We're waiting for a microphone. All right. Welcome. It's so nice to be here. I know a lot of you are colleagues, and you know, friends. And so I'm waiting for a mic so I can stand up. I'm a much better

speaker when I can stand up. But in the interim, I'll start here at the table.

As Ward said, I'm Tammy Green. I work for Providence Health & Services. Recently, I think in June, I took a new role at our system office. Providence has about 30,000 employees across five states, about 40 hospitals, 500 clinics, a large health system, and I fully enrolled in June to oversee all the well-being activities our entire system and our Absence Management. And one of the exciting things was just having the title "Well-Being" instead of just wellness, and with that, we wanted to really try to create a whole new way of looking at health management from a really interactive way and the fact that we're having leaves of absence, which is (indiscernible - background noise) of all the kinds of things that go into managing (indiscernible - voice lowered), we're really trying to bridge that continuum of health management. So I'll tell you a little more about that as we go on.

Today, I wanted to talk to you about what we've been at Providence here in Alaska, kind of the case history. And John Torinus, who was just speaking, it was really exciting to see him here. I had called Deb, I don't know, about eight or nine months ago and said, you know, I read this really great book. I've talked to John. He's just an incredible guy. I think he's -- you know, he just resonated with my passion. And so that was really great to see him here and to share a lot of

the information that he shared. A lot of things that I'm going to talk about today that we've been doing and that we hope to continue to do into the future.

What I hope that kind of that you come away with today is a new perspective that you can look from, from an employer perspective, and then how does that look to you, as an employer, and your bottom line, and how can those two things kind of interact simultaneously.

At Providence, we always start with a reflection when we have meetings or any kind of gathering. And so I always like to level set with the audience to do the same thing, and this is a reflection or quote that I've been using for the last few years, at least, that we have been on this journey, and I think it really speaks to where we all are, whether we're a business or whether we're an organization or whether we're a government entity. "It's not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change." And that's really where we're at right now.

As John said, we're really in this revolutionary period where, you know, there is no option. We have to change, and we have to adapt. Those of you that know me, I've been in this business about 20 years or more, and I've waited my entire career to get to this point where health and well-being is no longer just seen as something that would be nice to

have, or you know, be a great thing, but it's really become part of an integrated business strategy, and I feel really lucky that I've the opportunity the last few years to really put that into play at Providence.

So really, what is the problem? And I don't mean to reiterate what that is, but really, John spoke very eloquently about the problem and the cost of rising health care. And I tell you, it's really interesting doing this work inside health care because, even though we're a large health system, we're also a large employer. And so as a large employer, our own health care costs are driving, you know, our costs in business. Then those get cascaded out to the work that we do in the community. So I think doing this work in health care is really not only an opportunity, I think it's an obligation for us in health care to really step out, set the pattern to show what is possible and what we should be doing.

So I came to Providence in 2007. And for those of you who might know Joe Gilbertson (ph), who was the Commissioner of Health for a while for the State of Alaska a few years back, he was at Providence, and I actually had worked with the Division of Public Health. And he said, you know, let's look at what we're doing over here to see if we can do some different things in terms of our employee health and well-being and look at what we might put together to actually put out into the community to offer to businesses.

So the first year I was there, I really kind of spent that year looking around, seeing what we were doing, and looking at some cost trends. And so we knew -- starting in 2008, we had gotten the information from our consulting firm saying, here's what the cost trend that you folks are on, and by 2013, this is where you're going to be. So when we started in 2008 looking at this, 2013 seemed a long way away. Now it's just right at our doorstep.

And so if you look at this, you can see that we were on a trajectory. We were on the poor performer's path, that, if we did nothing, by 2013, we were going to be spending close to $50 million on our employee health care on our Providence employees. So if you look at that line, we knew that we had to make some decisions to do things differently.

So what did we want to do? We really wanted to move from -- and I think John talked about this -- really a transactional mode to really transformation. And I'm not going to go through all of those, but you can see that it really is a very different paradigm.

When we look from the medical model approach, it is usually pretty reductionistic. It kind of tries to reduce everything down to the smallest part, fix that piece, and then not take into the account the broader comprehensive view that we had. And so we wanted to look at it from a much more broad perspective and look at it along a continuum and then

(indiscernible - voice lowered) didn't just operate in isolation from where we were starting.

So I'd love this slide. It's the current approach to health care. And so you can see the water just pouring down the sink. They've got one solution. The guy has got a towel. He's wiping water, but it's, you know, not helping very much. They've brought in another guy with a mop, maybe a little bit better technology, but the real answer is for somebody to go over and turn the water off. And that's really kind of where we need to kind of be backed up.

So if you look at this slide, it really helps you understand that not only do we have to kind of get upstream to turn the facet off, but we have to figure out what are those factors that are guiding them. And I came up with this slide a couple years ago because I was trying to explain what our current model is, where we're spending our dollars, and really where we should be doing it. And all of us know, intuitively, that this is the way that we should be looking at things, but a lot of our models are payer models, and how our system works doesn't really support this type of a model, but this is where we need to go, knowing that we're never going to eliminate illness care, obviously, but that we can certainly do a better job of getting upstream and really doing true prevention and promotion.

So I want to just go through quickly with a case study

and what happened for us in Alaska at Providence over the last four years.

So again, we started with this was our cost trend, and we said, what do we want to do? We can't sustain this kind of cost over the next several years. So we decided to look at what we were going to do and put a plan in place.

We wanted to look at what was really driving the cost, and when you look at the cost of (indiscernible - voice lowered) health organization, most of the time, we always focus on the medical spend, and it is really important and it's usually a huge budget line item, but what happens is underneath the iceberg are all of these other issues that really are also driven by poor health. And what happens is that the budget for the direct medical spend, that's always something that shows up in the budget line item. So people are very attentive to that. But we have to think about all these other issues, that they're just kind of like water running out underneath the door because nobody is really paying attention to them, and they're very siloed in most organizations. So people don't make those connections between the poor health of an individual and all these other issues.

So just to put a dollar figure on it, this -- if you look at the PFPY -- that's Per Member Per Year -- cost of about $5,300 for our organization, when you look at that and multiply it by three, which is really the true cost to the

organization for the poor health of an employee, you can see that it quickly adds up. And as we start to look at how we mitigate that, we have to look very holistically at the approach that we do.

So this was the vision statement/mission statement we came up with for Providence, and basically, it says that our employees are our most important asset, and if we don't value them in the way that we should, we're not going to be able to expect the kind of quality care and deliverables that we hope to have with our patients.

So when we started looking at all of these things, we wanted to have a very holistic approach, and we wanted to look at things not just from the physical health, as I said earlier, but looking at all the domains of well-being and trying to understand how all of these intersect and what we could do, as an employer, to really make a difference.

And our motto has always been that, "Health and well-being is not a destination; it's a journey, and each one of us is on it everyday." We have to make choices and decisions about our health and the health care choices that we make, so that we can influence what our costs are and also our outcomes.

So in 2008, we started to put this plan into place, and prior to 2008, we didn't really have a strategic plan or certain expectations for really specific deliverables. We had

limited kinds of things around chronic care management and lifestyle coaching, lots of different separate pieces working independently.

In 2008, we restructured, brought all of this under one umbrella called Health Management Services, and we also started looking at re-engineering our onsite health planning. We had a traditional health clinic that, you know, served our employees, but over the last few years, we have evolved that into a true onsite health clinic for our employees.

And it's really been a great experience, and John spoke about what are the benefits from an onsite clinic, and these are just some of things that I wanted to point out.

It really provides a hub to really put your services together and really keep the seamlessness, if you will, for all the services that your employees are experiencing, so that they're not going from one place to one place to the other. And in a hospital setting, we have a lot of interaction with our employees because we have immunizations, all kinds of things that require yearly or even every six months kind of testing. So we have an opportunity from folks who are coming into our clinic to have an interaction with them that can really move them from something that's either compliance-related, or if they come in for an illness, to, really, wellness and to show them all the resources that we have to offer them.

So in 2009, we launched a program called "I Choose Health" and that's been our brand. We decided that we wanted to focus on a culture of well-being so that we could really try to change how people in our organization looked at health and well-being and also what their part and their role was in that.

So when we started down the path, one of the things that I said, right from the beginning, is that we can do all these great programs and do different kinds of ideas, but if we don't have the right plan design that really is going to nudge or move people in the direction that you want them to go, you're just usually going to have an extra program that, obviously, the people are already doing the right things are just going to be -- you're going to be singing to the choir.

So we started with a plan design in 2009 that would really look at how we can motivate people to do something different and to get engaged in their own health care.

So as the previous slide said, we offer $600 in a premium credit at that time for employees and $600 for their spouse or adult benefit recipient, if they participate in biometric screening. And that first year, it was just participation, and these were -- the first year, they got the full $600. In year two, what we did -- and we talked to our employees during the first year, that we were going to be moving to an outcomes-base, which now we're calling an action-based

program, so that it wasn't just participation, but we wanted people to move to action.

So in the second year, we said you still have the opportunity to earn the $600, but it's going to be broken down a little bit differently, and now you would get $200 for doing the health assessment and the biometrics screening, and then each of the biometrics that we were choosing to track were then worth $100, meaning that, if you fell in the criteria of meeting the biometrics, then you got an additional $100 for each of those criteria. And again, the possible total was $600.

And this is a continuum that we use. So when you look at it, you can see that we weren't asking people to be all the way down here in the low risk. We were saying, if you are under the high risk category, you had earned the incentive. And part of what we were trying to do was to really engage people that, if their numbers were outside of that moderate risk category, we wanted them to be active. So people said, well, how do you that? If they, you know, they fall outside of this category, how can you legally do that? Well, all you have to do is to provide an alternative, and we had three alternatives. Actually the first year, we had four, but one was they could do health coaching onsite at our health center with one of our health coaches for a minimum of four sessions. They could do telephonic coaching with our vendor partner, and

same, four sessions. Or they could see their health care provider and provide a Statement of Treatment form saying that they were working with a provider on any of these issues.

And the first year, we also had -- to kind of ease into this, we the option that people could do an online program and complete it related to whatever one of the biometrics they were out of range on.

After that first year, I just felt like that was not really very attentive, and I really wanted -- the whole idea was to engage people. So we didn't that program, the online program, except the very first year.

(Pause - phone rang in background)

MS. GREEN: So this, I wanted to show you what's happened over the last three years from 2009, and granted, we have a lot more work to do and opportunity, but what I wanted to show you is that, when you put things in place and you have metrics that you're using and you really have the right kind of incentive and nudging for your employees, things can start to change. And our data is not research quality data, obviously. These are employees, and there is turnover. But we've had very consistently about a 70% participation in our biometrics screenings over the last four years.

So you can see, in 2009, we had 31% of our folks in the healthy weight category, and in 2011, we've now moved it up to 34%. So we've had all of measures moving in the right

direction. Now you can't say causal by all things that we've been doing, but I believe that you can certainly say corollary and that, if we had not been doing anything, I don't think this is what we would be seeing in our numbers.

This one, this is a little bit of graphic to show you, particularly for BMI. You know, I don't know if you know this, but health care workers are notoriously the least healthy of a demographic that they're comparable to. So we have a lot of opportunity to improve our own health. So you can see that we have this nice trend of increasing our low risk and decreasing our high risk and that the middle is staying about the same because you have people moving out of the high risk into the middle and then down into the low risk. So this is one of my favorite slides to show how this can make a difference.

So just to kind of wrap up some of the pieces, these are some of the programs that we have right now that, I think, have really been instrumental in helping people get engaged, and you know, it's not like we said, here's the deal; you've got to participate in biometrics and we want to you meet these criteria. Good luck. We really felt very strongly about the intention to make sure we have programs available, we had resources available, and we really tried to have a variety of things to really address what people needed.

We have onsite health coaching services, and our coaching

are trained in the well-coach model. It's a fantastic model about how you really engage people on their own health journey, but traditional medical models have always been -- nothing against the docs in the room or folks who are in the medical field -- but the traditional medical model is really didactic. It's death, you know, overweight, you smoke, you should eat better. Now go and do it. And then the patient goes, wow, thank you; I didn't know that. I'm going to leave, and my life will change. But as you guys all know, that's not it works. And so what we've found with our coaching model is that, if we really engage people in a way that resonates with them and it's something personal to them, they're going to change because, you know, at the end of the day, nobody wants to be overweight or be unhealthy or feel bad. We just have not done a really good job, I think, of incorporating the kind of services that really could make a difference for people.

We have a weight management program called Naturally Slim that's been very successful over the last year. We've been doing stress management workshops, working with our leadership development, and I'll show you something around that in a second. We've been working with our Diabetes and Nutrition Counseling Center to have active nutritional referrals. And then we have a gym onsite for our employees as well.

So some of the lessons that we've learned over the last few years, that we really have been thinking about, how do we

change our language so that, as we talk to our employees and our leadership, we can really make sure that we're engaging them and helping them to feel a part of something much bigger than just what they're doing, but a part of our culture at Providence.

So as we looked at this and we started out with an outcomes-based -- is that me?

(Pause - background noise)

MADAM COURT REPORTER: We don't know.

CHAIR HURLBURT: Is that something online? Somebody on the phone needs to mute their phone.

MADAM COURT REPORTER: Is that what it is?

MS. GREEN: Maybe it was that one that was on, too.

MADAM COURT REPORTER: It sounds okay.

MS. GREEN: I think that's better. So we changed our language, instead of outcome-based to really action-based because that's really what you're trying to do is to engage people (indiscernible - simultaneous speaking).....

MADAM COURT REPORTER: Do you know what I think it is? The conference call. We need to tell somebody on the conference to mute their phone.

(Pause - background discussion)

MS. GREEN: What we also knew was that we really needed an emphasis to change the culture of health care consumerism from one of entirely passive to engaged and partnered. John

spoke about this so eloquently, too, that, you know, we have really put this system in place that really helps people become enabled by utilizing health care in the most appropriate way. We haven't engaged our employees as partners, and we haven't done such a good job of helping them understand how much health care costs and what their role in not only just choosing the appropriate resources, but also how to use those resources appropriately, at the right time and the right place. So that's something we've been really working toward also.

And as we move into, I'll tell you, our next phase around moving to a consumer-driven plan, I think that that is, as John said, one of the best ways that you can really put into play the kind of mechanism that is really going to engage people to move in those directions that you're trying to do because, if you think about it -- and nothing against all the great health plans in here, but if you have a health plan that has a $250 deductible, a $500 deductible, the whole way you look at health care is very different because you say, I've done my $500 deductible. Great. Now I can go do this or I need to do that, and it's not that people, you know, consciously over-utilizing, but because it doesn't -- they're detached from the true cost of health care in the system that we've created. And so what we have to do is to help change that system so that our employees or partners are back in the

game and they're saying wow.

In the consumer-driven plan, you know, people will find out how much drugs actually cost. You know, they can online and my prescription is $10 a month. Wow. Yet, the first time they go to a consumer-driven plan, it's $250 for, you know, whatever the monthly prescription is. So once people start to become engaged as consumers, that starts to help them change their behavior.

And then we wanted to make sure that the incentives that we were providing were rewarding the right action and moving us in the right direction, and again, trying to move or just being transactional to really transformational. And so we've moved now to the next level of restructuring in terms of what we're doing with our plan design.

So now I'll kind of fast-forward to the next phase of where we're at. Providence, as a large system -- we're about 70,000 employees, like I said, from California to Alaska, and over the last 18 months, we've been moving to this really major restructure where no longer are all the regions operating as independents, but that they're becoming more in line as a corporate structure. So in that -- we call it the ones -- all of the different lines of business have been moving to this one structure.

(Pause - background discussion)

MS. GREEN: So as we've been going through this

restructuring, the whole area of HR has moved to one HR. So in the past, we had probably about 50 or 60 benefit plan designs across our system, literally, and you can imagine how disparate that is when you're looking at a large organization like that. If you're trying to get economy scale and buying power, you know, we were very fractured.

So over the last probably eight months, HR has been in this very rapid, accelerated restructuring phase, and I have to say being inside Providence in that health care organization, to move this quick has been pretty impressive to me, but we're moving in 2013, our entire system to a consumer-driven health plan with two different accounts, and I'll talk about that in a second. But if you can think about that from a cultural standpoint, it's major to move from the traditional kind of PPO deductible plans to a fully replaced consumer-driven plan. Now you layer on that we have lots of unions, as you can imagine, and so we've got lots of issues and lots of conversations and negotiations with our unions. And we have, right now, almost most of our unions are onboard with this. There are still probably about three to five percent that are still in the negotiation process to be fully brought on, but it's pretty impressive to see that an organization this large can move that quickly to something very substantially different.

So when we were looking at the whole plan design for this

new CVHP, we wanted to make sure that we had the plan design right because, if you don't have the right plan in place with the CVHP, really, all you're doing is shifting costs, and if your goal is just to shift costs to your employees, well, you can certainly do that, but if you don't take the time to really look at what you're putting in your plan, then you're not going to get the results that you want. And what we wanted to do in terms of looking at things is, when you look at really what drives health, the outcomes of health and you look at the determinants of health, it's really around lifestyle choices. And if you look at this slide, you can see that access to health care is only about 10% responsible for what true health outcomes are. So we wanted to design a program that we can start to engage and nudge our employees to become much more involved in their own health and to really focus on those issues that were driving a lot of the health care costs.

So for 2013, we have two new account-based plans, and I'm just going to talk about what's happening in Alaska because it's a little different than the rest of the system. We were really the forerunners here in Alaska to step outside the box and do the outcome-based incentives, the action-based, we're now, probably in the next couple years in regard to our system, to those incentives as well, but right now, Alaska is still leading the way on that. We also were leaders in our

system by instituting the first model of no hiring of tobacco users.

Last November on Great American Smoke-Out Day was when that became effective, and as a former public health nurse -- and that was one of my most crowning moments to do that because I think that had a really major impact in terms of our community and the messaging that goes out.

And I know, as John was saying, we don't really have a lot of experience here in Alaska with consumer-driven health plans. We just really haven't had to, but I think this is coming quickly here. And I think, as John had pointed out, these plans really offer employers the best opportunity to do the right thing for your employee see the programs the right way, but also to engage them as partners in your health care.

So we have -- and we are doing something that's pretty big as well. We're offering both accounts. We're offering a Health Reimbursement Account and a Health Savings Account, and for a lot of large organizations, they either go with one or the other because there is a lot of complexity in trying to manage both of these, but we wanted to try to make sure that we could offer, across our spectrum of employees, the right kind of options for them. And maybe some of you know, maybe not, but in health care, most people think of the nurses and the doctors, but we have a very diverse workforce from the folks who do the dietary, the folks that clean our rooms, so

we have a real range of not only folks that work for us, but also how much money people make and so we wanted to be very cognizant of that to make sure we have the right things in place for everyone.

So in Alaska, what happens now with this new plan -- we're right in the throes of it, too -- we have, over the last -- since August, middle of August, we have been doing biometrics screenings across our entire system. This is like -- I'm not a very logistics kind of person, but we've had to put in over 500 screenings with our vendors across all of our systems over the last two months, and screenings now continue to December to offer folks the opportunity to get their biometrics screenings. For everywhere else, except Alaska, what folks have to do this first year is to take the biometrics screen and then they have to go online to our vendor, Healthy Roads, and attest that they have a primary care provider and provide the name of that provider because we really want to nudge people into that primary care provider relationship. So that's what we're doing with the rest of the system.

For Alaska, we're staying with the action-based outcomes because our population has now kind of -- they've (indiscernible - voice lowered) that's what we're doing. So they can earn $700 for themselves as the employee and then $700 from their spouse for their ABR, adult benefit recipient.

And it's broken out by half. So they get $350 if they just participate in the biometrics and that's it, but if they meet the outcome or action-based criteria that we have provided, then they get another $350. And again, we said earlier that, if they don't meet that outright, there are multiple ways that they can meet that. And this year in kind of that fashion of looking at what you've done and changing what you are doing in terms of doing things differently, we changed from looking at every one of the biometrics as an individual $100 because, if we're really trying to look at health holistically, it doesn't make sense to kind of carve those out and silo them. And one of the things that are driving our outcomes is really obesity, and at the crux of a lot of the issues that we have, overweight and obesity are really driving blood pressure, cholesterol, some of those things. So now we're making that more collective approach. And so if somebody is out of range, they still do the same thing where they can work with a health coach onsite. They can work with a telephonic health coach or they can work with their health care provider to address those issues.

And this is just a sampling of some of the preventative coverage we've put into our plan. When we started down the road, I said I really want to make sure that we include some of the things that I felt had been left out of other plan, particularly here in Alaska. You know, so one of the ones is

we are asking people to be cognizant of their diabetes, make sure they are, you know, getting their A1c and all of that, but yet we weren't covering the IV education until you met your deductible and then it was only at 80%. Now if we really are saying we want people to manage their chronic conditions, we need to remove all the barriers so that they can actually do this without any kind of issue.

So in our new plan, we've done, I think, a really good job of covering all of those preventative services at no cost and not subject to deductible. And I was really excited to see that we got nutritional counseling in there, and we also have our diabetes counseling and education in there as well.

And the same with our drugs. So any drug that is -- and you know, we have a whole formulary, but all of our drugs that are related to managing chronic conditions are all 100% covered at no deductible.

So just to wrap that up, I just -- you can kind of see the evolution that we have been in, in this long journey, and now that we've made this big leap to our system, really overseeing all of the things that we're doing in terms of our benefit design, I think we have a really great opportunity to really impact the health of multiple people, our communities, and our organization, and we've worked really hard to try to provide all the resources, but I have to say it hasn't gone all smoothly.

Right now, we're in open enrollment, and you know, everything has moved so quickly that we're finding lots of things that have, you know, fallen through the cracks. So probably in about three months, I'll have a really good white paper to deliver on what not to do when you move this quickly into a new plan design.

So all of that is interesting, but you know, really, what's in it for you and how can you translate this into your organization? And so as I've been doing this for the last few years, I've kind of developed little models and ways that I really try to talk about the work that I do in a way that might be easy for people to understand. It might be put together in a way that people can take it away. They can talk about it. At the end of the day, my goal is that, when people leave wherever I'm talking, that they have some pieces of information that they're excited about and that they want to go and really translate to someone, or at least, cascade that information out.

So this is kind of my little easy way to think about, when you're looking at planning and when you're thinking about how you're going to do things differently, I call it I-squared plus E-squared equals "O." So "O" is outcomes. So when you're looking at this, to me, this is just the way, my philosophy of how I interact with our (indiscernible - voice lowered) when we're trying to do things new and different, and

it just is a way to help people kind of capsulize, in a real simple way, what we're doing. So the I-square is intention and integration, and E-squared is engagement and empowerment.

So intention. I think that's one of the most critical elements for success because it really sets you on that path, commits you to a focus, and one of the things that I've seen so consistently in this field and in this work is that we want everything to be a priority. So we have 14 priorities and then nothing is a priority. And I think it's really hard for people to say, we're going to have two priorities. We're going to look at two things that we're really going to focus on. We're going to keep all this other information that's important in the background, but we're really going to focus and put intention on our priorities.

I think it requires a very specific directional approach, and as John had mentioned earlier, too, if you don't have the (indiscernible - voice lowered) into the planning process and have your YM, it just makes it much more difficult. And again, I feel really fortunate that, you know, we have that buy in from our top leadership at our system level as well as what I have here in Alaska.

And then finally with intention, if you don't know where you're going or what you're trying to get to, you're never going to know if you get there. So it's really important to look at how you select the metrics and then you can use those

metrics to measure your progress.

This is our dashboard that we use in Alaska, and we're translating it to our system dashboard with some variation. But it's kind of busy, so I'm not expecting you to read everything, but I pulled out a few little pieces here that really show how you can use this kind of dashboard, and our dashboard has really evolved over the last four years. I was looking at the original dashboard we did, and it was, like, that was not very good. But as we go through, we start to see things that you go, yeah, I want to make sure that we're putting that at attention, that we're going to look at that.

This just shows you what happened over the last three years from 2009, and if you look at the risk factors, you can see that we've really moved in the right direction, both from a risk factor perspective as well as our biometric data.

This next one is just another way to look at kind of what you're doing in terms of -- this is for us on onsite health center services, and we looked at return on investment, very basic monetization of an ROI to figure out what the cost was to run our onsite center doing primary care, treating our folks onsite as opposed to if they went out to the community. So we were able to put a monetized amount to this and come up with a basic ROI. Yes?

COMMISSIONER ERICKSON: (Indiscernible - away from mic)

MS. GREEN: Yes.

COMMISSIONER ERICKSON: Can you just mention to that for folks around the table, but also for the folks on the phone, that they're not able to see this.....

MS. GREEN: Oh.....

COMMISSIONER ERICKSON: Maybe you can just, like, explain the ROI difference.

MS. GREEN: Oh, I'm sorry. That's true. Some of this is not in their packets. It's data I can't really release. So the ROI, basically, for our onsite center, what we do is we look at what the expenses are to run our onsite health center and then I take all of the coding of every condition everybody received in primary care, whatever we see in the clinic, and we know the value of those services related to the CPT codes. And then we can add that up and come up with a monetized value of the services and then really just run it up against what it costs. So it's very basic, but at least, it gives folks an understanding of the return on their investment, if they are looking at this. And you can see the return on investment is about $30. Then we get, you know, a dollar back. And if you add in work loss avoidance, which means that people can come to clinic while they're at work, not have to leave work and you add that cost in there, it really ups your ROI. I always separate those out because some folks because think that's kind of squishy-soft data, so I let them make their own decision around that. But we do know that that convenience

factor does make a difference. It not only makes a difference that are people are away from their job that much less time, but also that they're more likely to stay on the job after they've been to the doctor. A lot of times, people go to the doctor in the afternoon and they never come back. So by having that service there, it really does impact people's ability to stay on the job, and as you can imagine in health care, that's really important because of the work that we do 24/7, 365. Having people present at work is really important.

And then we just started tracking, a couple years ago, our absenteeism. I thought, well, it would be interesting to look at how much does absenteeism cost our organization, and nobody had really ever looked at that data before. And so we have a payroll system that we're able to extract all that data, you know, excluding everything from, you know, normal vacation or ETO time. But just looking at sick time, FMLA, anything that has to do with people being absent that from work, you can see that, for our organization, we had about 307,000 hours in 2010 that was related to absenteeism and that's just the direct costs. And then you multiply that by your average hourly wage. And when you look at that, you think, wow, that's almost $10 million that is going out the door, but that's just the direct cost. That doesn't take into account replacing nurses or replacing people on the floor. The presenteeism that that creates when Sally isn't there for

the third day in a row, and Joan is really unhappy because she's had to keep, you know, her workload as well as Sally's. So absenteeism has really become a major player in looking at keeping employees at work and also healthy.

And then finally, we measure ourselves on what we call RPMPY (ph) (indiscernible - voice lowered) cost, and since we've started this program, we've really been able to stay at our budget and even under our budget for the last three years.

And just real quickly -- so I will stop there for a second and see if anybody has any questions about those slides. There is a lot of data in that.

CHAIR HURLBURT: Go ahead.

UNIDENTIFIED MALE: No. You were first.

CHAIR HURLBURT: A couple questions. The provider, in-house provider, are you figuring your ROI and the number of business per day, do those seem pretty low? And as you have a higher number of business, that's a big chunk of your cost. Wouldn't that -- including your ROI -- in other words, do you have a hard time running a physician's office on number of charges per day?

The second question is, on the absenteeism, do you have a PTO system, and are you training unplanned absences or planned absences? So if they're not out sick, are they still getting a day's -- and it's easier to management to plan for an absence, but are you still paying for that vacation day

(indiscernible - voice lowered)?

MS. GREEN: We have two systems. We still have the sick time and PTO. So it's not clumped together. So what I ran is just strictly simply not PTO, anything like that. That was sick leave, excluding (indiscernible - voice lowered), anything like that.

CHAIR HURLBURT: And does sick leave, if it's not used, it just kind of stays with the company, it doesn't.....

MS. GREEN: Right. And I think, you know, when you look at that kind of system, that's another we want to look at is that, when you start to clump those two systems together and just have one PTO system, you find that people aren't out on sick leave as much because, in our organization -- and I don't think it's uncommon, but when you have a sick leave system, people also feel like they're entitled to that, so they -- a lot of people use whatever sick leave they have. You know, they make sure that they use that. So that's another systemic problem.

When you were asking about the business per day, you're right. Each provider sees around 12, somewhere of 12 to 15, maybe, but it goes back to that kind of much more intentional visit. It's not just coming in and seeing the patient, and you know, moving them through because we've already paid for that cost, and our goal is really have much more of an integrated visit with our patients so it's not, you know, a

ten-minute appointment, that sort of thing. So our practitioners spend a lot more time with our employees than they would if they were out in the community, but you're absolutely right. Any other questions about the.....

CHAIR HURLBURT: Allen?

COMMISSIONER HIPPLER: My question is very similar to Dr. Hurlburt's. Do you include the $10 million in direct costs -- or excuse me -- $9 million in direct costs for absenteeism in your ROI calculation?

MS. GREEN: No. It's not.

COMMISSIONER HIPPLER: Thank you.

MS. GREEN: Any other questions? All right. So the second "I" is integration, and as you start to look at all these different kinds of programs, what you'll find, whether you're a big business or a small business is that a lot of organizations have multiple kinds of things and efforts going on to manage employee health and also different aspects of employee health.

So as you start to look at this from a very systematic approach rather than each of these pieces being siloed, you really start to look at where the elements of leverage are and how you can really leverage those to make a difference in your organization. And we also want to point that if you have -- you know, people are always saying, how do I get more data? You have, probably, a lot of data that you don't even know you

have that you can access that you can start to utilize that really can drive some of your planning.

So it's important to think about all those elements and data, not just your medical spend, but looking at your absenteeism, looking at your use of STV or LTV, whatever kind of programs you have that might give you an indication of how people are utilizing those kind of leads.

This is a model that, when you look at really developing a true population health and well-being model in an organization, this what I kind of put together and say this is how you really build this model. And you can see, at the base of the model is what I think is really critical, integrated data and management systems. If you don't have comprehensive ability to look at how your data is gathered and to use those data, then you're going to have a really difficult time to ever get to the point to know whether you're making a difference.

On top of that and very close to that is plan design, and your plan design -- you can have all these great programs in the world, but if your plan design does not support the right kind of behavioral change that you're looking for, you're never going to get there. So I think that, as the world starts to shift, we're seeing an understanding that plan design is becoming much more important in terms of how you're going to change the culture and the spend in your

organization.

And then finally, making sure you have communication, change management strategies, and at the top of that is employee engagement. We, often times, hear about employee engagement mostly from kind of the other side of HR that, you know, they send out employee engagements surveys. How happy are people at their jobs? And we do that as well, but what I'm advocating for is that we start to look at that much more holistically and understand that an engaged employee is most likely healthier, and they're doing more of the right kind of things. And whether it's chicken or egg I'm not sure, but we need to think about those two things, I think, much more linked together than two siloed events when you're looking for the organizational perspective.

And then if you look at the three silos in the model you have, keeping the healthy people healthy, really reducing the lifestyle risks, and then really managing and optimizing care for chronic and catastrophic conditions. So in this little picture, it kind of helps you understand in kind of a snapshot what are all those important elements in terms of how do you get integration.

And then this is just my flower slide to show, again, that there are multiple things happening in your organization that, if you're really looking at total employee health and well-being, you need to be cognizant of and really look at in

terms of our a partnering strategy and not just that these are all one-offs in some other silo, but they all are connected to what you're trying to drive at, which is true employee health and engagement and productivity.

The first "E" is engagement. So we have I-squared. Now we're at E-squared. And we hear so much about engagement, and John was talking about it as well. I think that we need to really look at it from a different perspective. We, often times, think of organizations really around participation, and you know, people will ask questions in surveys and that's important, but often times, we miss the mark on engagement. What really does meaningful engagement look like? And often times, it's not always financial in nature, but as we start to create a culture in which employees feel valued and they feel part of something bigger than themselves, they start to feel engaged so that, when you're providing these kind of services and programs, they're much more likely to have stickiness, at least is what I say, and it's not just Teflon sliding off. They're going, yeah, there is another program. But if they're engaged and your using that lever of engagement with the programs that you're trying to do, you're going to get a much better outcome.

Now we think that it's really important that, every opportunity that you have with an employee, you use those levers and that you really look at how that organization can

really promote what we call, "Say, Stay, Strive." This not my quote. This is from Aon Hewitt. They're a consulting firm. But I love that saying because you want your employees to say great things about you. You want them to stay with your organization, and you want them to strive to do better than what they're just expected to do in their daily work.

And this is just an example of how I think you can, you know, layer engagement in some of the other things that you're doing. Again, in our organizations, we tend to be very siloed on how we deliver products and programs. And what I found is there are lots of opportunities to work with different pieces and parts of the organization that, traditionally, maybe you don't think about. I think it's really important to think about leadership development in an organization. If you're an organization that says I value health and productivity and health and well-being, well then, you should be making sure that's part of your leadership development strategy, that it's not just something you say at one level, but that you're not including it in your leadership development because, if it's a competency that you want to see cascaded out into your organization, then you should be nurturing that behind the scenes.

So we started, last year, a program to do some management training and leadership development with managers. So in our HR group, we were talking about this, and this was the model

that we were using. And I said, well, I think it would be really important if we take some of the work that we're doing and we layer it on top of that, so that we could impart on the managers our philosophy and the things that we think are important, and it has meaning. It's engagement. It's not just here's the leadership development and here's something about health and well-being.

So what we did is we took the model and then we layered on the important pieces that we could deliver in that leadership development model that could really make that program have more meaning in terms of the work that we do.

So we took it from a self-care approach. So we wanted to make sure that, if we were asking managers to do certain things, we wanted to make sure that they were able to take care of themselves. And in health care, particularly nurses, they have more of a tendency to take care of others than themselves. So if we're asking leaders to really provide this kind of leadership and promote the kind of things that we want them to do, then we have to teach them and help them understand how to take care of themselves.

It's kind of like on the airlines, you know, if you don your own air mask first before you assist others, and so that was the philosophy was to really try to help the managers and actually give them permission to take care of themselves, so that they could provide better leadership to their employees.

So that was just one example of how you can make engagement be part of something that is broader than just your health initiative.

The other great opportunity is at a new hire string. When you have new employees coming into your organization, that's the perfect time to engage them in whatever it is you're trying to do. Most of the time when people come to work for a company, they're excited. They're happy to be there. It's not like they've been there 20 years and they are unhappy or grouchy, but they're excited. So that's when you engage them. And that's one of the things that we've really able to do that I think has been real exciting is that, when people come on, they -- you know, we do a lot of drug screens and other kind of fit testing and things like that in a health care setting, but I wanted people to -- and we're the first people that I see at employee health. So I wanted people to leave there not feeling like, well, I passed my drug test. I peed in the cup, and I passed the test. I want them to leave there going, wow, this is a great place. I had my biometrics done. I have an appointment with health coach. I can see a primary care provider if I need one. But right from day one, we've engaged them in that culture that we want to transition them to, so that they are our mouthpiece going forward because that's the best way that we get marketing is through our employees who are happy and excited about the work we're

doing.

And the finally, you want to move to where all these things culminate to where employees are empowered because, at the end of the day, if people aren't empowered to do the right thing, we're going to be constantly either trying with a stick or a carrot to get them to move along. So the kind of strategies that you put in place go back to helping people feel like, yes, I'm part of something bigger than myself and that they have ownership in not only the work that they do, but the programs and things that you're trying to promote as organization.

Employees should really see themselves as a stakeholder and as a partner, and as John mentioned in his talk, he's really created that partnership with his employees, and I know we've been working on doing that as well.

And the final piece is that you really have to use both intrinsic and extrinsic. A lot of times, we'll use extrinsic motivators, like in our incentives design structure, but then we have to make sure we have those programs in place so that people can take that to the next level and move it to an intrinsic level of partnership with themselves, really.

And then these are just some of the quotes that we've seen over the last few years as we've worked with our employees, and it's really always very exciting, to me, to see things from the people who have felt like they haven't, you

know, been able to reach their goals or that they haven't had the right resources. And we see these things. And when you look at those kind of things, you go, we're making a difference. And it's not like you're going to go into an organization, like ours, and unwind that culture in two or five or even ten years. It didn't take -- you know, it took 34 years to get to that point. So you have to be willing to understand that it's going to take a while to change that, but the most important thing, if you don't do anything, it's just going to continue to move in that direction that you don't want to go. So you have to have what I call disruption. You have to disrupt what's happening and really try to embed a new way of looking at things, and you'll start to see the kind of things that we're seeing with some of our employees.

So again, just re-capsulating that I think these are four important key elements when you try to look at how you're going to design the program, what kind of things you're going to look at, and then you're really trying to reach these outcomes. And then just to bring it full circle back to what we talked about, the outcomes are really related to these different pieces and the different costs that you're seeing in your organization.

So finally, what does this mean to you and what I hope you that you leave here with today. I hope that you can leave here with a new way of thinking and really shifting the mind

set from the traditional medical model of reducing everything to its smallest part, but really looking at the right side of the slide here, to say that medical costs are managed and they can be controlled. Don't forget that 85% of the people that are healthy that are doing 100% of the work. We don't want to ignore the 15% that spend most of the money, but we certainly don't want to ignore the other folks who are healthy because they're going to just naturally trip to the other side of the continuum if we don't pay attention to them as well.

Looking at health care needs under workforce not only is a way to give an employer a choice, which has kind of been what we've always been talking about, but also to say it's a competitive edge, and in today's world, it really is. Not only are the employees healthier, offering you a competitive edge, but it also is a competitive edge in terms of bottom line.

And then finally, it really does make difference in your community because each of us in our organizations are not only -- we're not just in a little isolated area. We're part of a community. As we become healthier as an organization, it really does cascade out into our community.

So when you do really create that culture, you have a healthy employee, which creates healthy organizations and then that becomes a part of our healthy community.

And then finally, I just want to read this quote to you

because I would like to challenge all of us to get outside of our boxes, outside of our landscape, and this is a quote that the late Steve Jobs had, and I think it really applies to all of us, and I'd like all of us to think about how this can work.

"So here's to the crazy ones, the misfits, the rebels, the troublemakers, the round pegs in the square holes, the ones who see things differently. They're not fond of rules. You can quote them, disagree with them, glorify or vilify them, but the only thing you can't do is ignore them because they change things. They push the human race forward. And while some may see them as the crazy ones, we see genius because the ones who are crazy enough to think that they can change the world are the ones that do."

And all of us here, I think, have that opportunity to really challenge ourselves to say, what can we do to really make a difference in this state of health care? And I really applaud everyone for all of your efforts to be here and want to thank you very much.

CHAIR HURLBURT: We've got about a half-hour before we get to the break, so we can have discussion. (Indiscernible - voice lowered) then we'll have our Reactor Panel. Yes. John Torinus, can you come up?

MR. TORINUS: Sure.

CHAIR HURLBURT: While John's coming -- John talked about

being able to go for quite a number of years without seeing their health care costs increase for their company and now some modest increases in line with maybe (indiscernible - background noise). What has been your experience from Providence Health Care System in the five years now?

MS. GREEN: So we've had a couple things that have happened. You know, we've done some of the cost-shifting, I'll be honest, that has dropped our numbers a little bit. But in the last couple of years, we've seen the trend starting to definitely go down. We haven't been lucky, like John, to have no increase in our premiums, but I'm really expecting, in the next year or so, we're going to start to see some of those outcomes when we move now to the new consumer-driven health plans that we're going to start to see.

As an organization, as the whole Providence Health System, we spend almost $400 billion on health care. So we have to do, you know, something different, and I think we'll start to see it with this new approach with the consumer-driven plan. And we're seeding our wellness accounts, I think, with enough money that, you know, it's not like we're just moving to a consumer-driven high deductible plan without really helping our employees with that, but we're not just giving it to them for free. We're asking them to do something, and again, to have some skin in the game to partner with us.

MR. TORINUS: I'll be your consultant. I just want 5% of your savings.

CHAIR HURLBURT: Are you doing anything analogous to what John described, which is harder for you because you're a provider as well as being an employer, as far as quality, looking at quality in a differential way, to continue to have superior employees?

MS. GREEN: Yeah. So that was great when John was talking about the transparency move, and I've seen that really over the last three years. As John had mentioned, they're just coming on like gang busters. And we actually are about to, I think, hire Gaslight for our own employees, which I think is going to be really great because, as a health care system, we're saying we want the transparency so that we can drive our own employees to understand that better consumers and behavior. And so we're actually in negotiation with them right now. It's a fantastic system. We'll see how it goes.

CHAIR HURLBURT: On follow-up?

MR. TORINUS: What if somebody else has a better value?

MS. GREEN: Well, no. I think that's part of it, is that I think our CEO is really -- that's one of the drivers is to help our providers understand the whole transparency factor.

MR. TORINUS: Business. You know, you're in business. What if a customer said, gee, I think we're going to (indiscernible - voice lowered). When you move the business

is when the market starts to really.....

CHAIR HURLBURT: Don't know what your answer would be, but again, it's one where you're in a difficult position. Dr. X who does more knees than anybody else in Providence and helps the Providence System (indiscernible - voice lowered) run the numbers, and generally, what you said is absolutely true. You do more (indiscernible - voice lowered) surgical procedures you have better outcomes. But suppose your quality (indiscernible - voice lowered) don't show that. Obviously, those discussions will have occurred among management there, and I think I know what the answer is. (Indiscernible - background noise), but how could your system be (indiscernible - background noise)?

MS. GREEN: Well, I think they're in the process. This is a whole new world for health care systems. I think to have these different kinds of accountabilities and transparency things, you know, brought (indiscernible - background noise), but I think that's one of the things that was exciting to me to know that we were willing to bring in one of those transparency organizations on ourselves, knowing that most of where we drive, you know, our business in terms of where our employees go is with a lot of our own groups, not so much here in Alaska, but we do have the rest of the system. In Oregon, California, there is a lot of different models there, but -- so we'll kind of see what happens and what drives the

different conversation.

MR. TORINUS: Generally on the quality side, you've got to think the providers and doctors want you to (indiscernible - background noise), so you show them. (Indiscernible - background noise) committees. They're called Internal Quality Committees forever, and I'm sure that (indiscernible - background noise) practices, but that data has not been available to payers, like me, and to consumers. So now it's available inside and outside. So you've got double pressure. First, they want to do the right thing intrinsically, but now you've got an extrinsic course. So it's, why does it matter? We're going to move the business. So it's going to happen whether people like it or not. You know, it's -- like it doesn't happen in the rest of the world? I like that's (indiscernible - voice lowered) descending on my company once or twice a month, and they tear through every process we've got. So before I get an (indiscernible - voice lowered), I've got (indiscernible - voice lowered) crawling all over my company checking every process we've got, and the first guy did the same thing that's going in the health care business right now. Get those guys out of here. Deflect them. Get (indiscernible - voice lowered). I finally said, come on in, you know, and the first ones were so painful. Now we've been through 200 audits, and they almost never find anything because we've moved to higher ground. We (indiscernible -

background noise) last year, and we found our (indiscernible - background noise) were really, really clean. They said, they're filthy. So we went up to the next level. So the point is it's good for everybody.

CHAIR HURLBURT: Bob and Allen?

COMMISSIONER URATA: So this is a health care program that's good for employees. What about employees' families?

MR. TORINUS: Our free primary clinics, the whole family is (indiscernible - background noise).

COMMISSIONER URATA: Oh, they are?

MR. TORINUS: Yeah. So you know, we look at it as we've got 75% of the health bill for the whole family, so why wouldn't I treat the whole family? Now the kids are pretty cheap, so we don't have health risk assessments for kids, but they come in for high school physicals and whatever, so (indiscernible - voice trailed off).

MS. GREEN: Right now, we have not included families in our (indiscernible - voice lowered) future that that's the next plan. And as John had mentioned or somebody had asked a question about Health Savings Accounts, when you have those -- we're kind of struggling with that right now -- you can't provide free care, except for preventative care, for those folks who have a Health Savings Account.

MR. TORINUS: That's one of the reasons why the HRA is a little more flexible. You can use -- designate it is only

used for health care, and they can't go in and take a loan (indiscernible - voice lowered). So it's only for health care, and it's less restrictive on it.

MS. GREEN: So do you give out both plans?

MR. TORINUS: We use an HRA.

MS. GREEN: (Indiscernible - background noise)

MR. TORINUS: We don't have any chance. It's just better, you know, as a financial instrument. An HSA is better, but the employer has got to fund the cash, too. They're both work. It's just both HR -- I mean, they have the same general effect.

CHAIR HURLBURT: Allen?

COMMISSIONER HIPPLER: Mr. Torinus, we saw a slide from Ms. Green showing how currently more resources are devoted toward reaction or illness than to prevention and health promotion and that the goal would be to turn that around where we're focusing more resources on prevention rather than reaction to specific illnesses. Do you -- in your company, do you guide or drive -- first of all, did you see that change? Did you drive that change or did you simply allow the consumer-driven accounts to guide themselves and move toward that direction?

MR. TORINUS: Again, there's a lot of moving parts, Allen, so it's all sorted out in the same account. The car doesn't operate unless the parts are working, so you've got to

put it all together. So the financial incentives go together with proactive medicine. People variously describe the present system as reactive medicine. Some describe it as sick care versus health care. I think all of that's true. It's been my own experience. I've had those six-minute office visits. Walk in. (Indiscernible - background noise.) Maybe that doesn't happen up here, but Alaska is much -- you don't have a very big system, so trust me; that's what happens. I think that's the fundamental inflator in this country is a specialist-driven system. Most of the stuff can be handled (indiscernible - voice lowered).

And so I didn't get a chance to cover that in the speech today, but there is a stampede there. So the *Wall Street Journal* and *New York Times* said 25% of the top 1,000 employers in the country now have their own onsite clinics. And in Milwaukee and Willamette -- so I talked about (indiscernible - voice lowered) Northwestern Mutual Life have two clinics. They also have (indiscernible - voice lowered) in the country. (Indiscernible - voice lowered), the plumbing company, Miller Coors (indiscernible - background noise), all these guys are basically taking back primary care. They're saying to the systems, you're doing reactor care. You're not doing what I want. You're not keeping my people healthy. So we're going to take back -- we're going to deliver that part of the health arena, the delivery system because you're not getting it done.

MS. GREEN: I think, with that, what happens is that you're able to then really integrate those pieces around well-being and other things we're trying to do. Return-to-Work. All of those things that, when they're outside, they're just kind of siloed again or parsed out. So maybe we missed our opportunity.

MR. TORINUS: (Indiscernible - simultaneous speaking) can't keep up with so many companies. They're again with the really large corps. They just bid on Microsoft's work, 45,000 employees in Seattle. (Indiscernible - background noise) contract (indiscernible - voice lowered), but they did get Safeway's business, $200,000. So these great big companies are basically saying, hey, the system is busted. We're going to use a destructive innovation -- disruptive innovation and come at them. You know, you can't move the system? Fine. We'll come after it. That's a changed management model. It's called destructive innovation. That's what's going on. There's a whole new business model being developed.

CHAIR HURLBURT: The employers, like yourself, with 200 employees as opposed to maybe companies that have thousands of employees, when you bring in a primary care clinic and put a nurse practitioner or a family medicine doc in there, now obviously, you have developed a lot of expertise and have a lot of passion about this, but what you're wanting is a primary care driven model, like most of the industrialized

world has, but we don't in this country. But how do you provide the direction to a nurse practitioner or a family medicine doc in a small company where you're not a health care company or where you don't have (indiscernible - voice lowered) develop expertise in this, how do you develop that? Do you do it yourself or do you contract with another company whose business that is to get the kind of primary care that you want in there?

MR. TORINUS: We're contracting something now. We have one called Intera, but there's a bunch of them out there. But you can contract for as much primary care as you need for your size company. So our nurse practitioner comes in two days a week. The docs are on the site. They're available seven days a week because they're concierge doctors, but they're onsite two half-days a week, and there are coaches there three days a week. The chiropractor is there four days a week, and he goes (indiscernible - voice lowered). The dietician is there three days a week. So we just -- if somebody else wanted to come and share our clinic, we would just add hours. So it is sort of flexible.

Now if you're a really small company, 25 employees or less, it's going to be hard to pull off, unless you team up with somebody, but you can hire these concierge docs though. They'll sign up one person. So if you're going to say, well, I've got ten employees, would you -- if you're already in West

Bend, Wisconsin, would you take on my ten employees, and they'll say yes. And the interesting thing about is it's a wash. So we did claims (indiscernible - voice lowered), and I'm paying about $1,500 a year per life for primary care right now. As I stated before, it's big system.

So now I say, well, I've got to pay for my own doctor. It doesn't cost me anymore. I just -- now I get a full, active doctor versus (indiscernible - voice lowered). I have to change there is a culture change there, too. These docs are coming out of big systems, and they're reactive in how they practice. So we've got to tune them up, you know, get them a Six Sigma consciousness. So for instance, we want them to prompt people when their colonoscopies are due. We want them to prompt the diabetic when they don't draw their insulin. I just had (indiscernible - voice lowered) for the first time. I've been in this three years as a guinea pig, and I've got my first prompt on my annual physical (indiscernible - voice lowered). So you want it to be a proactive system.

MS. GREEN: And I think one of the other things you are seeing nationally, along with the explosion of companies doing onsite clinics, is that there is also a real movement toward what they call near-site clinics for small businesses that are garnering together, and a lot of the folks who do the onsite business or onsite clinics are seeing that as really kind of

another way of business because the small (indiscernible - voice lowered) are clumping together and then working in concert with one of these vendor providers that do the onsite clinics.

MR. TORINUS: It might be bust through (indiscernible - voice lowered) on some of the specialists, too. I've heard that that might be a problem here. So you know, if you had a couple thousand lives, you could probably hire -- you know, get 3,000 or 4,000 together, you could hire an (indiscernible - voice lowered).

CHAIR HURLBURT: Val?

COMMISSIONER DAVIDSON: So I'm really intrigued by.....

MR. TORINUS: (Indiscernible - simultaneous speaking)

COMMISSIONER DAVIDSON: So I'm intrigued by the different models and the different lines of business that you're in. So for example, you created a clinic within your business.....

MR. TORINUS: (Indiscernible - simultaneous speaking)

COMMISSIONER DAVIDSON: Yeah. And your business is not -- so that's your business. Your business is health care, but you also created a clinic within your health care business. So what was the decision point and the factors that you went into that, that were different than we're a health care system, so we're just going to capture the data of our employees who choose to use our business, like any other patient in our system, but rather saying no, we're going to

carve out this clinic to be able to do that? I'm curious about that decision and all of the data points and why that decision was made because I think that's distinguishing from this scenario.

MS. GREEN: It is. I think it's real interesting doing this work inside of health care because, you know, we're health care, and one of the things that we look at is -- now as we're looking at our entire system and how we're to maybe expand this or roll out -- is that we are health care, but we also an employee. So the way we look at it -- one way I look at it is this is from the employer-based model. So as an employer, I have the (indiscernible - voice lowered) as an other employer to try to get my employees healthy, keep them productive, get them engaged, and to participate in all the things that we're trying to do. So it is, I think, a little more difficult because those lines kind of get, you know, blurred a little bit between, but you're a health care; don't you just naturally do all that? But we do things differently. So as an employer, we have other kinds of needs that we want to make sure are happening with our employees that don't really always relate to the larger health care business. So it is kind of this difference in the way that we look at it, but I always say to people, we're an employer, just like everybody else. And in our workforce, we really need to have our workforce healthy and available for work, and if we don't

attend to that, then we're not going to be able to provide the products and services to our communities.

MR. TORINUS: So the leading providers, they have their own primary care clinics and (indiscernible - voice lowered). Of course, the whole of philosophy of LEAN starts with VOC, the voice of the customer. Everything -- every piece of -- it's only a value if it's a value to the customer, and everything else is non-value added. So you strip out the non-value added and concentrate on the value and do a big value stream across that whole wall over there. So you're coming in for a mammogram. Well, string out the whole process and look at every stage in that process. Is it a value to the customer? If not, then we get rid of it. Is it a value to the customer?

So the way that works out is you really get a medical home now. So in walks the customer to (indiscernible - voice lowered), one of their 22 clinics. There is no waiting time. They would have to completely reverse the scheduling system. They now keep two-thirds of their slots open. You can get same-day appointments. You walk in. You're within -- they meet you first. They take your test -- any tests that have already been prescribed for your office visit, they take them right away. They're in the doctor's hands before you finish the office visit because they don't want you to have to come back a second time for the results of the tests. If you get a

mammogram in the morning, you've got your results by 1 o'clock. If you have it in the afternoon, you have it the next morning. Everything is geared around the customer. So if you think about that, so it's a real medical home. All the medical records are there, the stands, the next patient, the pharmaceutical history, family history. They've got everything. It's all in one. EHR has arrived.

So I don't see why it's any different. In fact, you think it would be easy to do in a hospital system than it would be for me to do it. In the beginning, I went to the big systems and said, why am I in the health care business? Why aren't you doing this for me? Be my vendor onsite. (Indiscernible - voice lowered), so we did. And now I want -- because of the economics, I want my doctor in charge of the system. I finally figured that out. I want to be in charge of the front end of the supply chain.

COMMISSIONER DAVIDSON: So I guess that goes to.....

MR. TORINUS: I get to set the pattern of health care.

COMMISSIONER DAVIDSON: So I guess that goes to my second sort of phase of where you're headed, because I think it's (indiscernible - voice lowered). So I'm going to stick with (indiscernible - voice lowered).

So I'm curious about how -- so if this is working for your employees and you are a provider of this service for your employees -- for the employees of an employer, then is there

opportunity in the -- I would assume, I guess, and maybe I'm incorrect that this model is also being looked at by Providence for the employees of other employers. And so.....

MS. GREEN: Yeah. And I think that's -- you know, now I'm in a different position, so our medical group is taking over the work that we've done the last few years, and I think that's always been the goal is to develop a model that could be, you know, taken out, but it's not as easy as it sounds because, if you're doing it internally, you have certain ways that you do things. But as I said in the talk, you have to really good data systems and ways that you're going to manage this if you're going out. You could go out and put the clinic somewhere, you know, and say, here, we have these services, but if you haven't really aligned your plan with other things to it, you could just be creating more use of services in a -- you know, this is convenient, so people might just come and use it because it's there and it's free. So I think those are all the things that I think about when you think about taking that model and taking it out, but it's got all the right kind of pieces around it and then that organization that wasn't, they have the right plan design that's really going to drive the right kind of utilization and the behavior that you're looking for, rather than just create another utilization of convenience factor.

MR. TORINUS: If I were CEO of a big hospital team, I'd

be out competing with these onsite -- for that onsite business. You've got the outpatient services; you've got inpatient. I'd start competing for the onsite, the workplace onsite. I'd be going right after. These new vendors are going to come up.

CHAIR HURLBURT: Jim, then Bob?

COMMISSIONER PUCKETT: Do you have a survey or have done any analysis on the impact your onsite clinic and your wellness programs have on retention?

MS. GREEN: You know, we have not done that yet, but I know that that's something I've wanted to really look at is having that as one of the metrics, looking at our retention, looking at our engagement. The other thing I want to link up before we look at outcomes are the HCAP scores. You know, hospitals are now -- you know, we're being reimbursed based on different kind of formularies, particularly of note here, and I think it's real important that you look at all of those kinds of factors in terms of what is being successful with your employees because we know that, if our employees are healthy, engaged, and you know, present, they're going to deliver -- even if it's not better quality service, they're going to deliver service that the patient feels like or internalizes as a better quality of experience. So I think those are things, as we move into this next phase, that I'm really going to think about and investigate into how to make

those linked up to that, but we do know that retention is a huge piece in our organization and turnover costs a lot of money. So if we could link that up, that will certainly make the case.

MR. TORINUS: We did an employee survey that I was worried about, this stuff having a negative impact, and surprisingly, it was just the opposite. Our health plan is the number one payer (indiscernible - voice lowered), and I got thinking about why is that.

Well, first of all, people like being in control. You know, there's tons of purchasing risk for purchasing (indiscernible - voice lowered). People will pay a little more if they're in control of the end product or end service.

Second, they look at it as investment. If I invest in your MBA, that's an investment in your education and your career. They look at it the same way and invest in their health. So it's a big positive (indiscernible - voice lowered) factor. Huge. Big. They know I care about their health, and I do care. I've got -- GE Health Care is just down the road from me, where they make the scanners, and I've got a lot of their spouses working for us. They like our plan better than the GE plan.

COMMISSIONER PUCKETT: Thank you. I (indiscernible - voice lowered) young lady first. (Indiscernible - voice lowered) has a question. Thank you.

MR. TORINUS: I'll find some work space.

CHAIR HURLBURT: Bob?

COMMISSIONER URATA: Do you think some of these things could be applied to Medicare and Medicaid? I can see primary care, but how about consumer?

MR. TORINUS: Well, I do (indiscernible - background noise). (Indiscernible - voice lowered) with our Medicaid people. Of course, it's a federal/state program. So you've got a waiver for doing it free. (Indiscernible - voice lowered), but so you know, I have two ER -- I do some bicycling with (indiscernible - voice lowered), but she was an ER doctor and (indiscernible - voice lowered). Call 911. Use that system. They have (indiscernible - voice lowered). They got an ambulance ride to the hospital for $1,500. Use that system. Then they get there, and they use the time of the highly, highly trained physician. I said, oh Beth, it's just an act. She said it happens all day, every day (indiscernible - voice lowered). So the minute that Mr. Poor Person, Mr. (indiscernible - voice lowered), here's $3,000 in your HRA (indiscernible - voice lowered) given a poor person an HSA, which is real money, but you can create an account, which is an account which is an HRA. You know, they wouldn't call an ambulance for $1,500. It's their money. It would stop tomorrow. My people never use the emergency room, unless they need to. (Indiscernible - voice lowered) the system is -- any

time anything is free, like that, it even gets a little perverse. Not only is it free so they expect it, they get so the entitlement mentality. They demand it and demand an ambulance, and they get there, and they get sort of uppity with the ER physician about, you know, I want all the tests, and it's so weird. It's a weird dynamic when stuff is free. (Indiscernible - voice trailed off.)

MS. GREEN: I think that -- just a comment on that. I think that you're right. Whenever anything is free, it doesn't have value. So by creating -- I think there is a balance between, you know, either end of the spectrum and that's what we're trying to do, to create now with this new plan design is, you know, the new consumer-driven plan, but also offering enough money to be seeded in their accounts, but it's not just free. They have to do something for it, (indiscernible - voice lowered) expecting forward, but it's just the beginning. So we'll see how that works.

MR. TORINUS: I'm (indiscernible - voice lowered) for a lot of my buddies that are retiring now. So then if they turn 65 and go on Medicare, it's whoopee. I'm going to get my corneas done. I'll get my knees done, you know. Recreation. It almost becomes recreational. I'm serious. So you know, Medicare is $500 billion now on a national budget of, what -- trillion -- excuse me -- $500 billion on -- well, it's about (indiscernible - voice lowered) budget, and it's heading to a

trillion. So we've got to try something different. So (indiscernible - voice lowered), and presumably, we (indiscernible - voice lowered) be consumer-driven plans that get bought with a bunch of dollars. And so then my friend, Ted (indiscernible - background noise). The price of surgery (indiscernible - background noise).

COMMISSIONER HIPPLER: A quick anecdote, since you were talking about never using the ER. A family member of mine very recently had a -- he thought he had a bacterial infection. So he went to the emergency room, and the reason why is because he was a state employee and his health care plan was such that he had already met the requirements and ER visits were free for him. So you know, most people, you would hope, if they think they have a fever and they're coming with something, they call their primary care physician, but sometimes, incentives are such that you don't.

MR. TORINUS: (Indiscernible - voice lowered) $700 for an emergency room visit. Just called a couple hours earlier said the clinic was open on the weekend was $165. (Indiscernible - voice lowered) they are spending their hours on weekends. Emergency care clinics are popping up, so the marketplace is filling some of these needs. The emergency (indiscernible - voice lowered) triage stuff. Yeah. I think these principles that we're learning in the private, a lot of them carry over to the public payer side. And of course, you won't hear a

word of that (indiscernible - voice lowered). They don't deal with the real issues much. Simplistic (indiscernible - voice lowered). It's almost insulting.

CHAIR HURLBURT: We're.....

MR. TORINUS: (Indiscernible - simultaneous speaking)

CHAIR HURLBURT: We're right at 3 o'clock.

COMMISSIONER DAVIDSON: Tell us what you really think.

MR. TORINUS: I don't have any opinions.

CHAIR HURLBURT: So we're at 3 o'clock, and we've got a Reactor Panel. We've got a 15-minute break now. So this has been an excellent day. We want to have the full time for our panel, so please be back in 15 minutes.

3:00:49

(Off record)

(On record)

3:15:13

CHAIR HURLBURT: We have an excellent Reactor Panel. We'll talk some about (indiscernible - voice lowered), particularly in the last couple of sessions. I think each one will be great. (Indiscernible - voice lowered) things that, in their own situation as employers and as leaders, they've been involved in. It was referred as (indiscernible - voice lowered). We did have a luncheon meeting in July where there were four employers there. Two of them were represented here, but we were addressing many of those issues.

Dean Rampy, who is the Chief Financial Officer with NANA Management Services, was actually not in the July one, but we heard about some of the things that NANA is facing as a large employer, both in the state, and of course, out of state, and the one thing that I heard from them in the July meeting, I remember there was a procedure, one specified that could be done here in Anchorage for $11,000 and something was done in Salt Lake for $2,600. So beginning to look at issues, like that.

Kathy Carr, who is the Vice President for Human Resources at GCI, was here on that panel, and we heard some of the things that large telecommunications company here in the state is looking at with their employees.

Commissioner Becky Hultberg, the Commissioner of the Department of Administration, is here, who has responsibility for state employees, retirees, for their health care costs for many of the active employees. That's through union trust, but the State foots the bill on that, and it's an added compounding variable in dealing with health care for (indiscernible - voice lowered). Since Commissioner Hultberg has been in the job, she has been taking a fresh approach at this cost to the State, which is eating the State's lunch, and along with Medicaid, making it difficult for Representative Keller and others in the Legislature, to figure out how we're going to fund roads and education and everything else along

with that.

Mayor Mike Navarre is here from the Kenai Peninsula Borough, and I don't personally know him, but I remember seeing (indiscernible - voice lowered) issues and concern about the cost of health care for the employees there, again as the CEO, a big hurdle for that.

And finally, Greg Loudon, Vice President, Account Executive for Parker Smith Feek will be doing that.

So I'm not sure that we have a particular order of who goes first. If you -- we can just go down the list then. Dean Rampy can start it then. We have about an hour-and-a-quarter, and we would like some time for discussion. So probably you've got, what, ten minutes or so.

MR. RAMPY: Well, thanks for inviting me today.

MADAM COURT REPORTER: Could you turn on your microphone, please, and speak into it?

CHAIR HURLBURT: (Indiscernible - voice lowered), but you guys actually do it better than we do. There was difficulty here, so keep the mic really close to your mouth when you talk. Thank you.

MR. RAMPY: Well, thank you for inviting us, a substitute for Mary, the President of (indiscernible - background noise). She's out of town. I do want to say that Kevin Thomas gave the presentation back in July, and Kevin is kind of my boss for one of their operating companies. So I hope I don't say

anything that contradicts what he said back in July. If I do, I think I'll find out soon.

I do want to say that I read John's book last night, and when I finished it, I put it down with a great sense of irritation because I was irritated at myself for not being smart enough to think of this solution years ago. It was a really nice read. Thank you.

I thought I'd tell you a little bit about NMS and some of the challenges that we have and how it may relate to what you folks are doing here today.

NMS is an outsource service contractor. We're primarily here in the state of Alaska. We have five state business lines, but we are in 15 states in the lower states with the majority of our employees up here in Alaska. We have about 2,800 employees total, but out of that 2,800, only about 900, maybe 1,000 participate in our health plan.

The challenges that we've had over the past few years are just the same as everybody else. We've had -- in the last five years, our costs have increased on annual rate of 17%. We've tried various things to try to get those costs under control. John's book is -- obviously, we were kind of headed in the wrong direction. We tried cost-shifting, putting more of the burden on the employee, trying to encourage them to step up to a higher deductible plan. It didn't work. Looking back at it, it was probably a sequence of the wrong education.

Part of the process wasn't completed right. New employees, all they saw were the dollar signs going out of their pockets. They didn't see the other side of the equation, so it didn't go over well.

One of the interesting things that we -- challenges that we have is, because our business lines are so distinctive, we have a wide range of compensation amounts, and they go all the way from, you know, $10 an hour up to $100 an hour. And we have been working with health plans. It's kind of one-size-fits-all. And we -- medical tourism almost is becoming -- for us, and I think it's true for a lot of Alaskan employers that medical tourism is really just becoming employer tourism. We have employees that shop for benefits because -- excuse me -- so many of our competitors are in -- will have no benefits. There are no packages at all. So they will shop, and when they're a housekeeper or food service provider, they'll shop for companies that have a different approach to employee commitments, and they'll look for employers that provide a health plan, which we do, and that immediately puts us a competitive disadvantage.

So we're actually looking at trying to form more plans that would help each of the business line needs. After John's book, we were actually headed in that exact opposite direction of where we should have been, and this has really given me a whole lot of information to think about.

So I think our challenges are the same as everybody else's here in trying to get our costs under control, and working with trying to figure out how to leave our business lines, our different business lines, how we (indiscernible - voice lowered) health care costs for the health plans for those business plans. That's about all I had for right now.

CHAIR HURLBURT: Thank you very much. Why don't we just go ahead on through the group and then we'll have a discussion, maybe at the end? Kathy Carr?

MS. CARR: Thank you for asking us to participate in this session. I think it's very important for all of us, as employers and individuals in Alaska, to understand the challenges we're facing. We're no different than any of the other employers in the state. We have 1,600 employees, primarily in Anchorage, Fairbanks, Juneau, but located throughout the state of Alaska as well as 123 employees in the Lower 48 in different locations. So challenges with a disbursed workforce.

Like I've heard so often before, we have faced year-after-year increasing health care costs, such that it is a major part of our operating budget every year. As John described, we had to do something. We have a very involved CEO whose wife happens to be a physician, a practicing physician in Anchorage. So he has a real interest in our program, in our costs, and is a key player for us in driving

us to look at new and innovative practices, programs that will help us bend that trend down.

At GCI, our pre-employee health care costs jumped 103% between 2003 and 2011. Put another way, our employee bases, they more than doubled in a decade. And we share this information routinely with our employees. We have company meetings with them at least twice a year where we talk about the challenges, talk about the costs, getting that engagement going with them. And we explain to them, because we are self-insured, it affects us as well as them as employees.

So in 2011, our per employee year cost was around $15,800, which is a chunk of change, as they say. That was up from $14,700 in 2010. This year, we're projecting a decrease. I think we're going to see that the (indiscernible - voice lowered) that the quarter holds here. And we believe that, due in part to a number of changes, we implemented in the beginning of this year, we certainly have long talked to employees about health care costs. We've tried to do and offer employees numerous preventative programs. We've had a consumer-driven health plan in place since 2009, but we continue to add, to tweak, to try and make changes that we think will bend that trend down.

So what we did in 2012 is we improved our benefits communication, new website, new materials, new information. We increased our opt-out payment. We encourage employees to

opt-out of our plan, if they have other coverage. We were paying $1,500 a year for opt-out. We increased that to $4,800 to opt-out and saw approximately 35 more employees opt-out of our program.

We added the 10% co-insurance. We did some plan design changes to our plan. We introduced two new programs that we think are playing well with the employees. Haven't seen all of the numbers come through yet. Of course, too early to tell, but one was a teledoc program where employees for minor illnesses, sore throats, urine infections could call a central number, talk to a doc, and get that resolved, get that prescription, get that resolved and not have to go in to the clinic, get an appointment, go to the emergency room.

The other new program we implemented is what John, this morning, called the Center of Value. We call them Centers of Excellence. We partnered with Bridge Health to offer that program to our employees. It's a new concept, but -- and we haven't had a lot of employees take advantage of that yet, but the five or six that have, each one of them have come away with rave reviews of the program. The quality and care, the program details, the help they received, the outcomes were all top-notch for them. So we are very encouraged and very much supportive of that Center of Excellence or Center of Value concept.

Our program offers facilities at 124 locations in the

Lower 48, and we think it's just a matter of word-of-mouth, good outcomes, good stories, and we will see more and more usage of that program.

We also -- while we have long offered wellness programs, the mammograms, the flu shots, the health fairs onsite, we followed Providence's example and really implemented an aggressive wellness program to include the online health risk assessment and the biometrics screening. We didn't make it mandatory. We did make it voluntary, and we had a 68% participation rate first time out. So we thought that was just an excellent response. We've just finished our second round for 2013 implementation. I believe we didn't increase participation, but don't think we saw much of a decrease either. Employees are understanding, accepting that they have to help us with the ever-increasing costs we're experiencing.

While that coaching program hasn't been -- you know, they don't always like that commitment, they have, at the end of the day, said, you know, I lost the 15 pounds I needed to lose or I didn't realize I was pre-diabetic until I went through that screening process. So again, it's the employees with some of those success stories that will, we think make a difference in making that program successful for us as well.

We offer discounts on the rates. Beginning January 1st, if you complete the health risk assessment and the biometrics screen, you can save $108 a month in your premiums. Employees

like that, thought that was fair and reasonable. It looks like, for 2013, we're going to hold that, not make major changes because year one is, you know, the base year, and we have to go from there, but it looks like we are going to be able to encourage to stay and keep those kind of innovative programs in front of our employees and see the cost trend start to bend downward. So we're excited.

What we haven't been able to do is the concierge program, the clinic onsite. That's something we're looking hard at. Some issues, because of our -- we provide the HSA to employees. We base it on salary tiers, and we also offer our employees an HSA interest-free loan. So while they get their HSA deposit in January of each year, this one on a calendar year plan, we also offer them the opportunity to get additional monies from GCI in January to put into their HSA accounts to supplement with their HSA donation and what their deductible would be. Employees really like that program. They have to pay it back over the course of the year through payroll deduction, but again, it makes them comfortable that they have sufficient money up front to meet that deductible, if something serious happened to them early in the plan year.

So those are some of the things we've been trying to do, and I think we're meeting with success by implementing many of the things John talked about this morning, but clearly, we have a ways to go yet. So we'll continue to look for

innovative ideas and programs that seem to be working.

The other thing we're very concerned about is the Cadillac tax facing all of us in 2018, if that's not repealed or changed. So we keep that in the forefront as we try and do design and plan changes.

We are also looking at the Defined Contribution concept. Now culturally, that would be a big shift. That requires a great deal of communication and education with your employees, but with exchanges, both private and public, looming out there, it's something you can't, I think, ignore. You have to evaluate, work out how would that work, and does it fit with your culture and with your recruiting and retention requirements, with your emphasis on healthy workforce, but again, a concept that John alluded to this morning that we are also spending a great deal of time evaluating.

CHAIR HURLBURT: Thank you. That's exciting. Commissioner Hultberg?

COMMISSIONER HULTBERG: Thanks for having me here. I'll forewarn you; I usually do this ten minutes in a 50-minute presentation, so I'll try to be very brief. And also Jim Puckett is here as one of your Health Care Commission members, and he's our Director of Division of Retirement and Benefits, and he really hates when I speak and when I come to things, like this, because I get all sorts of great ideas that he has to implement.

So a little bit of background, Department of Administration, just for context, manages the State's active and retiree health plans. We also have a division that does our collective bargaining, so we're responsible for bargaining for our contributions to the Union Health Trust. We have 11 (indiscernible - voice lowered) bargaining units; we have 40 (indiscernible - voice lowered) health trusts.

So the way that we write health care is fairly complex. To add to that complexity, we manage the retiree plan. We inherit the retirees of municipalities and school districts. And so in some respects, we inherit people that we can't necessarily impact, from a health status standpoint, during their active career. So we inherit either other people's successes or other plans' failures, and we're responsible for providing that care.

To add another layer of complexity to that, the retiree plan in Alaska is covered under the Diminishment Clause of the Constitution, which says that retiree benefits cannot be diminished, which has determined to mean, if we change anything that is to the detriment of the retiree from a fiscal standpoint, that is considered diminishment and we have to offer an off-setting enhancement, which becomes very problematic in a plan that needs flexibility in order to be equitably managed.

As a result of that -- and I apologize if I'm talking too

fast -- we have a $4 billion health care liability in Alaska that is related to the health care experience of those retirees. That liability is often lumped in with the unfunded pension liability. You hear it described that way. It's $11 million and climbing, but the health care portion of that is about $4 billion.

So in our department, overall -- and I'll give you a few statistics. We have about 6,300 active members in our plan and about 10,000 dependents. We have 36,000 retirees and about 28,000 dependents in that plan. We have about another -- we have probably about 10,000, give or take, and maybe more than that employees who are part of the Union Trust. So I'm giving you rough estimates, just to kind of give you a picture of those plans.

So that's kind of the challenge that we have in managing our health care spend is we're not just managing one plan. We're managing multiple plans and then also the employer contribution towards the Union Trust. It becomes very complex very quickly.

So what are our concerns? Obviously, the general cost trend. If you look back from the past decade and even two decades, our cost trends tend to be somewhat flat for a year or two, flat as in a growth rate approximating inflation, but then they jump to double digits. So you can't really look at a year or two of a flat trend and claim success, and I say

that because our trend has been fairly good the last two years. We're trying to keep it that way, but over time, history has shown that our experience then tends to jump.

So we have annual spend between the retiree plan, the active plan, and the contributions to the Union Trust approaching $630 million. You can add about $200 million of that for the State's portion annual contribution for the unfunded health liability. So all-in-all, we're talking about over $800 million a year for those plans.

So those are our challenges that I've laid out, and let me move quickly to what we're doing about it and then reflect on some things I've heard today.

As I said, our challenges are trends, but our challenge is also the sustainability of those numbers, given the State's fiscal situation. So we're always kind of looking through that list.

This year, we have implemented a new employee wellness program and also which has a disease management component to it. We're covering care for active members 100% for the first time this year, and we're also covering tobacco cessation. And you're saying, well, you're kind of late to the party. A lot of organizations are doing that, and I would say, yes, we are. The State of Alaska, in the past, has not taken as active a role in managing our health care spend as we need to, but we're changing that now. We've implemented health

coaching, and we've started the started the conversation, albeit unintentionally, about medical tourism and that's been mentioned a bit. I won't go into that.

So what do we need to do? That's what we've done, and where do we need to go? As I said before, we're trying to move from a much more passive approach to health management to a more active approach. We have -- I'm not going to pretend, with the 11 different bargaining units we have and the dispersion of our workforce, that that's going to be an easy transition to make, but it's a journey that we've taken the first step on and we're committed to taking the next step and to, hopefully, down the line, seeing improved contracts because of it.

We're going to also be pushing for transparency and price and quality. One of the most significant issues we have with our plan members is balanced billing. We have lots of -- I get lots of feedback from employees saying, well, I thought my plan would cover this, and I got a surprise $3,000 bill in the mail. And yes; you did because the provider is charging that much more -- that much over UCR. And so we have to address price, quality, and transparency, and we have to, as a plan, do a better job of educating our members on how they can navigate this difficult system that we call health care without magic words because, quite frankly, that's what it kind of comes down to now, if you're trying to understand what

something is going to cost. Should I expect my members to understand the concept of UCR to know that, when they're asking what their plan covers, what they really to ask is, what's the UCR event procedure, what's the CPT code, what is UCR, and how much is my out-of-pocket cost and total going to be? It's very difficult to explain to members, so we need to educate them first, but then we need to work with the provider community to help them understand the impact on our members from this lack of price and quality transparency.

To accompany that, if we're telling someone that their only choice in the community is to spend $3,000 extra out-of-pocket, that's not an acceptable option. We need to give them other choices. We need to give them-- we believe, and I believe, that health care is a very personal decision, and the more that we empower our members to make the best decision from a price standpoint and from a quality standpoint that we are serving them better.

So we're going to look at how we might expand the travel benefits, so that we can provide them options so that we can identify good quality outcomes. It's hard to find -- it's to get good quality data yourself, but there are now companies engaging in networks, actually, that will provide you guarantees that those facilities in their network are within the top 25% in their specialty area. So there's now the ability, which I don't think used to exist a couple of years

ago, to actually contract for quality and so we need to move in that direction.

So we've got a lot. As I said, I feel like, from the State of Alaska perspective, we're a bit behind the curve as an employer. We are government. It does take a bit longer for things to move in government, but we're taking that next step. And in the interest of full disclosure, many of our resources that I need to do these things right now are working on a contract for a third-party administrator or an RFP for a third-party administrator because we've recognize that, if we're going to take this journey, we need stable vendor partners, and we're required, every five years, to rebid our third-party administrator (indiscernible - voice lowered), et cetera contract. So if we're going to take the next step, we need to get stability in our vendor partner. So we've elected, a year early, to go out to seek new vendors for these services. So I sort of can't get behind this RFP, at this point, but hopefully, we'll be there in -- I won't even say -- very soon.

So just a few reflections of what are our challenges. Well, we have a lot of challenges that we have a culture in the state of Alaska that really is not a culture of engagement. It's been a very passive culture from an employee standpoint. The employer pays 100% of the economy plan premium. So we don't even -- we have, for our economy plan,

no employee union contribution. And so there is a challenge inherent in that because, if are to change the model, if we are to change our plan to look seriously at aligning plan design with behavioral incentives, we have to address that partly through collective bargaining and that's going to be a challenge, but it's, I think, something that we need to take on. We're going to have to look at our plan design.

So we have cultural change. We have difficulties with complexity and the environment we're in, and I think my final thought is -- and I don't know how long I talked, but it wasn't 50 minutes. The final thought is that, you know, in reflecting on the concept of destructive innovation, I thought that was a great concept to bring to this discussion because, essentially, what it says, when you're in a market -- when you are in a situation where, as a customer, you have a need and the market does not respond, you create what you need. And the question, I think, we have here -- because we are a market that is not as mature as the markets in the Lower 48, I think the question that we really have here is, is the market going to respond to us or are we going to have to create that destructive innovation that we need? And I think we are at kind of a critical point in Alaska because we're seeing what is happening in the Lower 48 and we're saying, as an employers, we want that. We want you to bring new models. We want to do things differently, but I think the question,

again, is, how are we, as employers in the provider community, going to work together to accomplish that objective?

CHAIR HURLBURT: Thank you very much. Mr. Navarre?

MR. NAVARRE: Thank you. Well, I appreciate the opportunity to be here. Actually, the health care issue got me back into politics. I was out for 12 years. I was talked into getting on the hospital board, the local hospital board, and one thing led to another, and I started looking at, you know, from a private sector standpoint, our company was impacted every year health care costs went up.

When I got on the hospital board and I started paying a little bit more attention to what was happening, I saw that the revenues to the hospital had increased from $30 million 13 years ago to $150 or $160 million in gross revenues just at our local hospital. A lot of that was from out migration that we were keeping in the community, but also it was because health care costs were going up.

One of the things that struck me in the presentation by Mr. Torinus was, as he said, we've let it happen and that is absolutely correct. We have let it happen. I recall, when I was in the Legislature, we had several opportunities and we formed a couple of different task forces to focus on the issue.

One of them dealt with employee health care costs, and I was remarking to Commissioner Hultberg that employee health

care costs for the State of Alaska were going over $100 million for the first time, the (indiscernible - voice lowered), and it was going from, like, $100 to $120 million. We put a task force together. We focused on it a little bit, and they came back and said, you know what? We found (indiscernible - voice lowered). We could do a few things differently, and there won't be an increase this year, which screamed, to me, that we were paying too much to start with, but being that as it may, we were happy that we weren't seeing an increase, but we have let it happen.

And I recall also, when I was in the Legislature, and we'd say, now why is there a separate index for cost increases in health care? And the response is, well, it's health care. Well, carry on. And so we've allowed it to get to where we're at today.

Now I'm confident that the employee wellness program that we're working on implementing and the two tier system and incentives and things, like that, I am confident that we will see savings in our employee health care costs, and our cost per employee are about $20,000. I'm sure that we'll see some savings. From my standpoint as the mayor and as an employer, that's great. We will see that impact in our budget.

But as a mayor of the Kenai Peninsula Community, I'm also concerned about the private sector and about the residents and where will these savings that we see end up now investing

themselves because one truism in health care is that what has happened over time is we've just seen a lot of cost-shifting whether it's the private sector or the government sector, and you know, we talk about this free market economy we had earlier this year about a Certificate of Need and a surgery center, and people were saying, well, gosh, we need to let the free market work in union health care and that's why we need this competition for the local hospital. And the reality is that government pays so much of the cost of health care currently through, one way or another, either Medicaid, Medicare, premiums for employees that we are the biggest buyer in the system, and I thought we were a big buyer and we could command some attention from the local hospital, which is also owned by the Peninsula Borough, although it's managed by a non-profit.

We own two hospitals. We own South Peninsula Hospital and Central Peninsula Hospital. One of them has a MIL rate of 2.25 MILs that's supporting the hospital. The other one has a MIL rate of two-tenths of one MIL that's supporting the hospital. Central Peninsula generates enough revenue to pay for the bond issue. If they didn't, then the taxpayers would be on the hook, but we do.

So what are the challenges and what are the opportunities? The challenges are that -- the status quo. This is where we're at, and there are a lot of vested

interests in health care. When you talk about reducing the costs of health care in the small partner, as an employer, it doesn't really have that much of an impact on our costs. Well, I thought I spent a lot of money, but of the revenues that they generate, we're less or about 1%. The Kenai Peninsula Borough employees are less than 300 employees. So it's not that significant.

Can we get some reductions by asking for them? Yes. We will be able to get it because we own the hospital, and they want to be able to work with us. But I don't want to see that shifted to other people in the community.

So one of our challenges is the status quo. We've accepted it not only as policymakers and as a society, our communities, we've accepted it. From the history of civilization, healers have been at the top end of reverence, and quite frankly, compensation now. And you know, I've had lots of opportunities to access health care. I've had four knee surgeries, shoulder surgery, ankle surgery, a broken arm, broken elbow, numerous visits to the emergency room. I am a health care consumer. And it's too expensive. And I've had great doctors. And on the Kenai Peninsula, we have two very excellent hospitals. We have -- actually, there are three, if you count Seward, but I'm just talking about the publicly owned ones. We have incredible medical providers. We have -- the doctors in the medical community are excellent. We have

employee physicians, and we have independent physicians. And quite honestly, sooner or later, there is going to be a big collision. Maybe it's already started. You know, I've talked with our federal congressional delegation. I spoke to (indiscernible - voice lowered) when the Commissioner got it. I talked to Governor Parnell about doing a demonstration project on the Kenai Peninsula because we have somewhat of an opportunity because we own two hospitals. We're geographically not isolated, but we're in a contained area, if you will. And they said, well, what do you want to demonstrate? Well, I want to demonstrate there is a better way to do this, which I'm confident that we could, but how do you get from the system that we have in place now to where we should be?

If you look at the ICER study and other studies that have been done about health care costs in Alaska, we spend in excess of $10 billion a year in Alaska on health care to Alaska residents, $10 billion a year. If you were going to spend $10 billion a year -- now I'm extrapolating from the ICER study and saying that, in addition to the costs in the ICER studies, the costs that were spent by Alaskans outside of Alaska on health care, I'm confident that it's in excess of $10 billion, $10 billion. If we had $10 billion to spend and we were starting from scratch, is this what we do? No. The system is not sustainable. The system is broke. There are

oxen that are going to have to be gored. And those interests -- maybe I should say there are interests that will be impacted, and those interests are going to fight.

So what you have to do is, I think we have to look at it long-term and identify, not treating the symptoms and trying to, piece-by-piece, add on, or as you see something pushed out in one area, push it back in and it pops out someplace else. You have to look at where you want to be. We didn't get here in ten years or 20 years or 30 years. We got here over a long period of time, and we need to focus on the long-term of where we want to be at the end of the day and start figuring how you incorporate those vested interests into that solution in the long-term, so that you can transition to a health care system that is less expensive and maintains a high level of quality.

So also I just wanted to mention, on the Kenai Peninsula, one of the things that we have is some transparency because we have employee physicians. You can go to the hospital website, pull up the financial statements, look at the 990, and we'll tell you how much our orthopedic made last year. It will tell you how much our emergency room docs made. You know, one of the secrets is that nobody ever knows that kind of stuff. How much should we be paying an orthopedic doctor, not how much do they want to make and how much are they used to making, but let's shine a little light on these issues. And I don't want to pick on orthopods because I may have to have access to them

again. But such specialties are demanding a disproportionate share of the revenue, and we have to recognize that. We can't ignore it. And so getting to that level of transition and seeing what some of the things are that caused the situation that we're in now.

I can remember hearing in the Legislature, well, you know, the reason that health care costs are high and why it costs more to go see a doctor is because, you know, doctors go to school for seven years and then they have their residency, and they come out with a high level of debt. Fine. Let's pay off the debt at the outset. If you come practice medicine in Alaska, we're going to pay off the debt. We'll have a fund that will pay off that debt, if you stay, for providers or whatever it takes because don't let them continue paying for that over the lifetime of their history in medicine because it doesn't go to pay off their medical costs. It goes to their benefit. And again, I don't want to pick on doctors. I could pick on chiropractors. I could pick on dentists. I could say that our entire health system is too expensive, and I don't think there is anyone who would disagree with that. So we have transparency on the Kenai Peninsula, to some extent, but we need more. We need to know, not just what we're paying for different procedures, what it costs to deliver that procedure.

I had a discussion at a local bar. I try to avoid those discussions as much as I can. When you're in politics, that's

always a good idea. But -- and a dentist was telling me that, you know, he doesn't like to do Medicaid patients and Medicare. You know, I said, why not? Well, because it costs me money. I said, what do you mean it costs you money? And he said, well, if I do this crown, it costs -- or I can only charge Medicaid $800, but if it's a private payer, I can charge them $1,200. It costs me money. And I said, wrong answer. What does it cost you to deliver the service? What does it cost you? And we don't -- you know, I know there is a lot of regulation in health care and it's confusing as heck, and I appreciated the discussion that Commissioner Hultberg had about the billing system and somebody getting a bill that was higher than is usual and customary.

You know, I tried to help my dad before he passed with his Medicare bills, and my own (indiscernible - voice lowered) to get them in, finally, you end up -- I was in the emergency room a year ago. I had stitches put in. They did a CT scan in order to make sure I didn't have a cracked orbital, and believe me, emergency room physicians don't like people to ask them why they're doing the procedure. They are the doctor; you're not. But if the doctor, in that situation, which he was, is a contract employee, is there incentive for them to order tests? Was there a real purpose behind it? I wanted to know this because, I'm a, I like to think, sophisticated user of the health care system. And so he said, yeah, you know, if

it's -- if you have a cracked orbital in the nasal passage, you could lose your eye. Well, that's pretty serious. What are really the odds of that? Very, very, very small, but it could still happen. And I had the test done, and it was expensive. Then I ended up getting bills for years after that because it seems like -- I think there were four different bills that I was getting for that one visit to the emergency room, and it was difficult to sort through it. So it's too complex. I think we can simplify it. In order to simplify it, you've got to make a bunch of changes. And if we're successful at what we're trying to accomplish by reducing health care costs, somebody is going to make less or the flip side is we'll have more access for those who don't currently have access.

CHAIR HURLBURT: Thank you very much. That's an impressive amount of homework, trying to understand the health care system. Thank you. Greg, go ahead, last, please.

MR. LOUDON: Thank you. I'm going to start out, and actually, I didn't have anything prepared. So I'm just going to reflect and that's why I went last because I lost my material.

I took two days of notes, and I just (indiscernible - voice lowered) to reflect upon -- I was going to say I work for Park, Smith & Feek. I'm actually the Benefits Consultant. I was going to say that with (indiscernible - voice lowered),

although, reflecting upon it, I'm also a business owner, and I employ people. I'm a part of my firm. We have 200 employees based out of Seattle. We have 30 here in Alaska, and we have been employing people here for 25 years.

I'm an economist by training. I believe that people do what they're incented to do and that's not only in plan design with independent consumers, but it's also in the provider community. And it's been said many times here today that we have the health care costs that we deserve. We've allowed the cost to increase and that's exactly what's happened.

I'm thinking back a little bit about my observations on the state of health care in Alaska. I grew up in Fairbanks. I remember, as a child, my dad was covered on a generous plan. My mom was a state employee. Thank you, Becky. (Indiscernible - voice lowered), so paid nothing. Just go to the doctor when you want to.

I'm also Alaska Native. I discovered, in my mid-20s, that there actually was some value being an Indian Health Service beneficiary, and my children were both born at ANTHC here in town and receive care there. So I've observed in my own family what happens when you have no incentives to not use care. By not having to pay anything to go the facility, we use a lot more than we probably would otherwise.

Back in 1996 is when I started in the business as a Benefits Consultant here in Alaska. At the time, there were

PPO plans. I couldn't sell them. Nobody wanted to buy them. The average deductible was about $100 or little less, deductibles on a health plan. Today, almost every single plan available or out there as a PPO, at least for the facility -- and Smith can sit out on a preferred provider organization contract. We are giving something of value to the provider. We are directing care in exchange for a discount. At its most basic sense, that is the quid pro quo when we get to that relationship.

On behalf of my clients, I'm a -- my personal clients are mostly largish self-insured clients. I have some that have been incredibly innovative over the years, and I'll share with you those stories of how they have paid off.

On the flip side, on the PPO, we have almost no plans in Alaska that have PPO direction for physicians. We've just seen some changes in that in the insured market in the last few years where you have a co-pay plan. You pay $25 to go to the doctor, if you go to an in-network physician who has contracted for discounts, but on the self-insured side, we have the CMAP.

The significance of this is, since 1996, I think I still have a handful of clients, large clients mostly that have deductibles that are under $500. If you're a small employer, you can't afford to pay for that. If you're going to an insurance company, you're buying the products that they have

available to you. And what we've seen -- and I think John mentioned it during his discussion on the CDHP, consumer-driven health plans, that the uptake rate in Alaska is about 7% for HRA and HSA plans. I would argue that's a lot higher for small employers in Alaska. I'm working a job with Davis (ph). I know they're non-Premera. I would say that's the fastest growing market segment out of any product, and it's driven simply because that's the only thing people can afford, but it's also working.

I'm jumping around. I want to try stay focused, but there are just so many things I want to talk about. Some of my larger employers, there is a group, one of my clients, that is actually a coalition of self-insured providers. There are about 35 of them today. It started out with five or six groups back in 1995, and I was hired in '96. I've had the opportunity to work with them all this time. They have been incredibly innovative on cost containment on just about anything you can imagine, direct contracting with providers. They have contracts for physicians starting in Fairbanks back in '96 and '97 where we paid them a flat amount of money, and we bought a number hours of mid-level practitioners, not nurse practitioners -- we don't see them very much in Alaska; it's physician assistants -- and we were able to fill up their time until they cried uncle and said, we can't have anymore volume. You need to pay for mid-level time, and we'll more business

on. So that's how that was managed.

What we found with that group is that a lot of the innovative tools that John talked about that you need to go on consumer-driven health plans, you need to have transparency. You need for your consumers to be empowered. You need to know that, if I want to go to Dr. Smith, it's going to be $100. If go to Dr. Jones, it's $150. Another relative thing that you need to know is, what's the quality difference between the two? In Alaska, we have no idea. There are very few exceptions to that, and we're starting to see changes.

One of my groups of self-insured clients that were in this coalition wanted to change that. What they found is that the truly innovative tools and products are directed to large employers, 10,000-plus. How many of those are there in Alaska? Very few.

The other problem that we have being a small market, just from the lack of transparency tools, it's also a low margin business often on the tools. If you're providing -- if all you are doing is providing data analytics where you're looking to find out what different people charge and provide that back to someone else, it's a low margin, and then unfortunately in Alaska, it's also low volume - 650,000 people, half of them are covered, in one capacity or another, by the federal government, which means that our private health care market is about 300,000 people. So we have to spread -- all the

innovation that needs to happen to disrupt this market has to spread over 300,000 people.

We have disintegration of providers, and one of the challenges that we have, by statute, by regulation, simply by culture of people not wanting to be told where they have to go to the doctor, is we have avoided or we have protected the health care market for being as competitive as it can be. I would argue that the one place in Alaska where we can truly see competition is right here in Alaska, or in Anchorage between the two hospitals. And what we have seen is a lesser increase over time, and we've also seen dramatic discounts that have been given to preferred provider partners that want to actually buy services from us.

The other thing that we see here, very plans, if any. In fact, I can't think of a single one that requires a primary care provider, a single provider where you go to, to direct and manage your care. As a result, people (indiscernible - voice lowered) for a specialist. There are a lot of friendly deals between surgeons and primary care docs. They send their buddies their business, not always a bad thing. You get good information, perhaps. You don't get good prices. Nobody knows how much it costs to go to a doctor.

Mike, I know you were talking about transparency down on the Peninsula. We might know how much your employee physicians cost, but we don't know what we're going to get

charged.

My wife went through a serious health condition a few years ago, surgery and a long chemotherapy treatment. We tried to find out how much it was going to cost. I'm in the business. My wife has a Master's in Health Administration. She does this for a living. We kept a three-ring binder, about six inches by the time we were done. Every time we got a bill, it went into the binder. We'd log it in an Excel spreadsheet. Every time, you know, we came back from our care, we'd put that in there and try to match them up. We gave up after about six weeks and that's what I do for a living. The fact of the matter is, if I have anything to contribute to this discussion, health care costs are just (indiscernible - voice trailed off).

CHAIR HURLBURT: (Indiscernible - background noise) what I'm going to what to do is make Tammy and John honorary commissioners, and their role will be to ask questions, but I want to, again, just reinforce the concept because what we've heard all day is payers are hurting. Payers are basically employers, private or public, or taxpayers, depending on the particular benefit.

Some of you heard me tell my story that, when I was in medical school, which was more than a month ago, the (indiscernible - voice lowered) for how you dealt with heart attack was HOAP. We didn't know how to spell. It was HOAP,

but humidity, oxygen, analgesia, and prayer. Now we are a long way from that today, and if any of us had a heart attack now, we wouldn't want to be treated with just HOAP. So that has been improved, but the per capita health care costs for the United States when I graduated from medical school was less than $150 a year, $150 a year. It is now over $9,000, a 6,000% increase in my lifetime. Some of it is going from HOAP to cardiac stents, but most of it is just too damn expensive.

So if we'll some, maybe, questions for our panelists -- and thank you, all, very much. Val?

COMMISSIONER DAVIDSON: It's so loud. First of all, I thought this panel was an incredible cross microcosm of the truth of the system is exactly what we create for ourselves and that, collectively, we truly are the problem, individually and collectively. And I could run through the list. So for example -- and the decisions that we make individually and as companies impact everybody else. For example, one of you said you have 2,800 employees and 900 participate in the health plan. So how are those other 1,900 employees covered? That's one question.

Another person said you encourage people -- you pay people to opt-out and so that means that somebody else is paying that cost. Another person said -- another person presents what has and continues to be the gold standard of the insurance plan, which is the State of Alaska plan. Another

person has had so many surgeries and broken bones, and you're that guy who goes to the ER and needs the surgeries and drives up those costs. So have you changed your behavior?

And then one person, you know, works for an insurance company or sells insurance, is an IHS beneficiary, which I am as well, and my -- I tell my children everyday, every time we go to see a provider in the tribal health system. They know exactly what that costs and the value of that health visit.

So I think, collectively, you're right. We are the problem, and we have a system that is exactly what we created. And so I think one of the challenges we have though is we still have this mentality of this is what I'm doing, but we don't necessarily own up to this is what I'm doing for me and the people I represent, but what's the impact? What is the impact on everybody else and all of us, collectively? And I think that's the challenge that we're struggling with.

So I applaud your courage, and I guess the question I have is, let's take this interesting microcosm, wonderfully diverse panel and the people who are here and ask ourselves, how do we get out of this in a way that doesn't take care of our own without regard to sharing that with everybody else?

MR. NAVARRE: I'll go. I was just getting to that point. No. I think it's a fair question, and I think it's a very good question. We hear all kinds of things about how much more health care costs are in Alaska versus out of state, a

lot of different statistics (indiscernible - voice lowered) now. I just was going off this sheet that you guys handed out, out front. If we just look at that, if we say that our physician -- excuse me -- our hospital costs are 37% higher than our peer states, all right, that's bad. That's not good, but what are the reasons for it? I think we hear a lot of good things from the different facility managers. We've got higher energy costs. We've got higher personnel costs. We've got overhead, shipping for supplies, et cetera, et cetera.

I can understand that. It's a little easier to buy, but then you get to the point it's 70% more for physicians. Why? Because we pay them. For years and years and years, we let people receive as much care as they wanted with no direction. We didn't try to contract. We, by regulation, by statute, prevented the docs from having to compete, and our costs are where they are.

I think that one of the things that was talked about today was medical tourism. We've had medical tourism going in-state for a long time. I've got clients all over the state that incent their employees to come to Anchorage for care because it's so much cheaper. That's already happened. When we look at the costs of health care plans for the larger employers, those are significant amounts, especially the high dollar clients that go out of state already. And we haven't called it medical tourism, but that's what it is.

I've talked to some of the hospital clients that we have, you know, some of the clients that are hospitals that provide benefits to their employees. I've talked about what's driving their own costs. Well, look at how much you're charging. Your rates go up by 90% every year on your top line that you're charging for everybody and then you wonder why you get (indiscernible - voice lowered) on your insurance. They're directly related to each other. If we want to stop medical tourism -- and I know that the hospitals, especially here in Anchorage -- and I have to give them credit because there is that competition. The two facilities look right across the street at each other, and they know that, if they don't discount, the other one will. But if the physicians don't give something up -- Mike brought it up -- whose ox is going to be gored? If they don't give up some of their pricing, we're going to be sending patients out of state. We have to and that hurts our hospitals. That hurts our communities. That impacts our ability to provide care to people here in Alaska.

COMMISSIONER DAVIDSON: Thanks.

MR. TORINUS: This transparency thing seems to the one that really bugs people. I mean, you've got (indiscernible - away from mic).....

COMMISSIONER ERICKSON: John, can you just speak right into the mic?

MR. TORINUS: If you've got two guys with Master's degrees who can't figure out their bill, that's a problem. And I've got the same thing. I had my hip done. I sent it off to my CFO; he couldn't figure it out.

So I want to slice through to probably the purest form of transparency is a lower price. And so when I first started asking providers for lower prices, oh, we're too complicated, and we have too many silos, and this mess is more complex than building a car. I said, well, there are 3,000 parts in a car; it's pretty complex. I said, just give me a price on vaginal births, you know, normal vaginal births. We do a couple million of those a year. Should be able to hang a single price on that. And they still resisted, and I found out they don't do cost accounting. So then he said, well, you can't do cost accounting in hospitals. So I said, well, let me send you my cost accountant, and we'll figure out the price of a vaginal birth on (indiscernible - voice lowered).

So I think one of things you need to do is (indiscernible - voice lowered) prices because that is pure transparency. If you know you pay $23,000 for a new hip in 2012, you can watch that price in 2013 and know exactly where it's going. You can't tell where it's going right now. So I would recommend that. By the way, some of the (indiscernible - voice lowered) prices we're getting now are coming with a warranty on the surgery. (Indiscernible - voice lowered) for 23.5, and

they're so confident in their quality, (indiscernible - voice lowered). If you know statistics, it's a very narrow bell-shaped curve. They're real confident about their outcomes. They're warranting the surgery. So there is a (indiscernible - voice lowered) on them. So I think that would be one good push on this Commission.

MR. NAVARRE: I think the only provider (indiscernible - voice lowered), at this point, that's able to do that, with the exception of the Tribal Consortium, that has their integrated model is down on the Kenai where they do have employee physicians and they do have the ability to do an integrated bundled pricing. In Anchorage, we can't do that. We don't have any providers that are, at least, what are being sold to consumers. We don't have the (indiscernible - voice lowered) providers.

CHAIR HURLBURT: It might be more than that. If you look at Fairbanks, Banner Health has a hospital and has the data on Valley Clinic. Ketchikan has PeaceHealth Hospital, and they are an All-Physician Step II, and they're working with the hospital. So I think we're starting to see where there will be more opportunity in Alaska if we do that. Commissioner Hultberg? Did you have.....

MR. NAVARRE: I'm sorry. I didn't mean to speak. I know there are several others that are, I guess the difference being hospitals have their own physicians that are incented to

do something about it. The exception is, on the Kenai, that the Borough owns the hospital, and by virtue, they also employ physicians. Everywhere else -- I think everywhere else there is a management company that is seeking profit in operation of facilities.

MR. TORINUS: And (indiscernible - away from mic) because they're on contract to get the business. First, Blue Cross wouldn't process the single model price formula. They finally caved in, and they're doing it. They get the business; the other guy doesn't.

COMMISSIONER URATA: There is no competition in the rural area.

MR. TORINUS: Sure. There is no competition in rural areas, but I still hold their feet to (indiscernible - voice lowered) price, you know. Show us the price, at least. You know, if you've got no competition, it's monopolist. The pricing system (indiscernible - voice lowered).

COMMISSIONER HULTBERG: This is not originally what I was going to say, but I think -- but the core issue now is it's becoming not only affordable, but a significant value to employers to transport people out of the state for a variety of procedures. And so suddenly, that fact that someone in is a rural area is less of a factor maybe than it used to be because the delta in cost is so significant, and it's one of the reasons that we are looking at the Centers of Excellence

type approach because they offer a bundled payment and guaranteed quality, and we can't find that here. We would love to have some Alaska providers provide quality, transparency, and offer a bundled payment because it is not optimal for people to leave their community for health. That is not the desired outcome. It is absolutely the last resort for payers who have no other option, and I think that is, as much as anything, what I think we're hearing from a lot of employers is we are at the cost we absolutely cannot do this anymore. We cannot absorb these price increases.

I can tell you, in our active plan, we track utilization and (indiscernible - voice lowered) cost as a way to describe our overall cost trend, not discounting the population growth effects. And in the last year, our utilization declined 6%. A good thing. We're managing better. We can't push that number down forever though, but our per unit cost went up 13%. And so even in an environment where we're having a good plan year, the good plan year is not because prices have moderated. It's because our utilization has been lag, which really concerns me because that tells, when our utilization goes back up, we're going to be dealing with double-digit price increases again.

So you know, that's not exactly what I started to say, but I wanted to respond to the idea that, you know, we're all part of the problem, and I think that's absolutely part of the

message is that, as employers, we have not been at the table. And as employers, we have to now be at the table in order to drive change in the market. And from my perspective, we have a lot of challenges and a lot of reasons why our plan is the way it is, including collective bargaining, quite frankly, political issues, communication and change of management, which are huge issues in terms of behavior, and the constitution.

So yeah; we have a lot of challenges, but from my perspective, this status quo is absolutely not sustainable because we see the train wreck coming. In some ways for some employers, the train wreck is upon them, but from the State of Alaska's perspective, or at least from my perspective, I think we have the ability with the volume that we have to help force change in the market, which would be beneficial to all payers. And so it's not that -- you know, from my perspective, I don't abdicate my responsibility and push costs on other people. I want to help use my volume to help drive change that can impact the market.

MR. TORINUS: Kathy, you use (indiscernible - away from mic), so you're getting bundled prices, right?

MS. CARR: We are; yeah.

MR. TORINUS: And of course, what happens, if you've got a model price in this competition, then they've got to go back and clean up their act. So if they're too high, their cost is

too high, then they've got to back and use some new techniques and get their costs down. That's what you want to happen. You'll never get them to reduce the prices, unless people get their costs down, internal costs down, but they won't do that unless they're pushed.

MR. LOUDON: I think we have do a two-tier approach. One is looking at how we can reduce costs, but public education about the changes that we need to make and recognize -- getting the public to recognize that it's not going to be simple, it's not going to be easy. That transition to where we should be is something that, you know, I'd like to see it be as smooth as possible, as a consensus-driven collaboration, all of the buzz words, but the reality is there is going to be -- there will be blood. Somebody is going to get -- somebody is going to be impacted.

It's easy to talk about bundled payments, and I think bundled payments and vertical integration are something that we're going to see and it makes good sense, but bundled payments are really, you can equate it to an allocation decision. You're paying $1,000 for it now, for all the different components of it. We're going to give you a bundled payment of $800. You guys figure out how it gets -- who gets what. That's difficult. Why don't we, in the course of that, also recognize where things are out of sync in health care and the costs that are being charged for health care and health

care services? We talked about 70% higher than our peer states for physicians, 37% higher for hospital charges. What are the reasons? And in some of those cases, let's just say no. Let's figure out a way to say no and figure out a timeline for getting to that as the transition. And if we can keep putting our fingers in the dyke, which is what we've been doing now for a number of years, or we can say we need to a new dam.

CHAIR HURLBURT: Tom and then David?

COMMISSIONER HARRELL: Right. So I'm in the unique position with the DOD/VA that medicine that we practice, the delivery system we practice is, essentially, socialized. So what's intriguing, to me, is, when I hear the conversation, how do you incentivize this?

So to the market-driven processes, I think it's very difficult here in Alaska. And I'm a newcomer to Alaska. I've only been here a year and four months. But the medical tourism piece doesn't work because a large number of the high dollar procedures that we're talking about where you can actually make an impact also require support mechanisms to be in place after those procedures or interventions take place, including childbirth. So to shift that care or to threaten to shift that care to the Lower 48, and probably the Washington State area, to provide it isn't going to work.

So I'm interested in your thoughts. You probably can't

speak to it honestly in an open session, and I understand that. I mean, that's just fair, but for a round table as well, in terms of incentivizing, it seems, to me, that there is a bit of a put up/shut up time coming where the health care industry, particularly here in Anchorage as the largest population center for Alaska, is going to have to say to the current cadre of providers -- and I can say that because I am a cardiologist -- no. We're not going to accept this sort of monopoly, a mopped down market where you are free to charge 200% or 300% over what is a standard rate in the Lower 48 to provide this service. But then beyond that, how do you incentivize new providers?

So say you get a situation where the current cadres here will not see the light. The only other option that I see that's reasonable to achieve is some sort of recruitment incentive to replace the team. So I'm just curious of folks' on that.

CHAIR HURLBURT: Let me react to that. My boss sometimes tells me I'm a glass half-full kind of guy, and sometimes, he means that. But I think that the energy, the heat, the pressure to make change is not really going to come from providers, whether it's hospitals, whether it's physicians and that's (indiscernible - voice lowered). An example I use, if McDonald's could sell all they wanted and get away with charging $10 for a Big Mac down the street, that's what

McDonald's would charge because that's the American way.

So I think that the heat is going to come from payers, whether it's employers directly, whether it's health plans, and realistically, that's where it's going to come from, but my hope, my vision is that we won't have blood on the streets or that we won't have somebody coming in and doing it because, if the change is not really led, largely, by providers, by hospital administrators, by physicians, by others, it will be worse than people doing it who don't understand the business, and I think we can see that.

I was up in Fairbanks talking about the cost of health care at Fairbanks Memorial a week-and-a-half ago or so. The moderator was the Medical Director, a family medical doc for Tanana Valley Clinic. (Indiscernible - background noise), and he came to me and he said, Ward, would you come back and talk with our physicians about this? So these are docs saying, we recognize this is a problem. I think the people in the business -- everybody understands it, but has a unique understanding that it is a business, but there are unique moral and ethical connections to it. And so if docs, if the hospital administrators and people, like that, can provide the leadership, we can get there. So I think I would be more optimistic that we can avoid blood in the streets, but the intensity and the pressure really does have to come from the payers, from the employers and so on, but I believe in the

business, like you, are good enough that, when the heat is there, the leadership will be provided and we will end up diverting from what is a unsustainable course now, in philosophy.

COMMISSIONER HARRELL: And sir, I certainly agree. One would hope that altruistic instincts would take over and folks will do what is right. It is an interesting paradox that the very problem that we are experiencing is, in fact, the result of a capitalistic market because, if I can charge you "X", I'm going to charge you "X" and that's exactly what I should be doing as a provider of a particular service. But you're right. From the medical perspective, there is an ethical portion of this that needs to take over and drive it.

My assertion is that, if, for some reason or another, the collective group can't reach that decision process on their own, then some degree of force, as you were talking about, needs to be applied, and if, again, they didn't still choose not to, that they could after other people.

MR. TORINUS: I don't look at this as a moral/ethic debate. I don't think it's a war. I don't think there needs to be blood in the streets. This is a just a vendor relationship. I'm a vendor to a lot of people, and they're tough on us. They question our quality, question the price, and I respond. That's just a normal, economic, healthy relationship, and I don't see it's any different for health

care as a vendor. That's what I question. I want better quality, and I want zero infections in the operating room. I want bundled prices. I want margins on the surgeries, and I'm going to get them. You know, the CEOs are (indiscernible - voice lowered) stepping in; we're going to get what we want, and if one provider doesn't want to find it, we're going to find it someplace else. If both of them don't want to do it, we'll find it -- we'll invent the solution.

So you know, I just spent a morning at the biggest health care system in Wisconsin called the Aurora. They have 30,000 employees, and they have 50 (indiscernible - voice lowered), and they're trying to figure what to do about this. They see the train coming, and they're getting ready, and they're trying to talk about wanting to change doctor compensation in response to all of this. And so I was there for shock and awe for their physicians (indiscernible - background noise) in a world out there, but it's just -- this isn't disrespectful. It's just tough. There is nothing wrong with being tough.

CHAIR HURLBURT: David?

COMMISSIONER MORGAN: I have a question for the panel. But first, I had an interesting experience about two weeks ago where we had payers, which were the Alaska Health Insurance Underwriters, at one end of the hall, and then at the middle, (indiscernible - voice lowered) of the meeting (indiscernible - voice lowered) was the Primary Care Association. They had

their Medical Directors and their CEOs. So I was scheduled to give a little talk. We all gave talks on things, and it worked out I had two lunches, too. That was the best part.

So I was just having (indiscernible - voice lowered), but this article was the talk of the underwriters, which is the medical tourism question, and I happened to make a few copies of it and handed it out to the medical types in the community health centers and the private care centers. (Indiscernible - voice lowered), so when I went up to talk, this entered it, and I said, well, you know, one of the things they talk about is they don't have a procedure for what you're talking about (indiscernible - voice lowered). And then there would be follow-up, and they have to go back once or twice, just to make sure, you know, the stitches didn't come loose, or you know, did anything fall out or whatever it is, and I was asking the doc, I said, well, it has the procedure. I said, well, some of these -- is that reviewed, do you have a list or a checklist as a physician and your client? Could you do the follow-up? I said, well, on some of them; yeah. I said, well, at the end of the hall are the guys who pay. Maybe you guys ought to get together and make a deal. If they go out instead of paying the $900 round-trip for the second and third visits if there is not problem, why not contract for $300 to do the follow-up? And if they need to go back for consultation, they can.

And when I left, lo and behold, there was two or three of the underwriters that approached and some of the Medical Directors were getting together. Caines (ph) was right, in some ways, and Adam Smith, too, that the market will -- I agree with you that these are reasonable people, that there are always opportunities, and those that will change will find those opportunities and make them happen. And I don't think we can make it happen. I think it has to happen (indiscernible - voice lowered). And I have always been optimistic that we can work our way through this, if we can just get everybody together.

Now my question is, I would like for the five of you, the five you to help me in that I'd like for you to go to the New Hampshire health cost website. I'd like for you to look at it because it talks about transparency, and basically, everything that we've talked about today, and I'd like for you to send any amount -- I'll give you each my email. I'd like for you to say this stinks, or hey, this could be useful. This website that they've put together, it has a whole lot more than just costs and transparency; it has other stuff on it. But I'd really like to hear your opinion because some of you are doing this stuff. Some of you want to do this stuff, and virtually all of you are having to figure out this stuff. And I'll give you (indiscernible - voice lowered) with my email, but I have to ask the Borough Mayor a question.

Is your -- as a hobby, are you, like, a new rodeo stud? What's the story? I have to know how you're breaking all these limbs.

MR. NAVARRE: Well, my mother used to tell me I need to give up those kids' games or I'm going to get injured, and you know, I play softball and basketball and have had numerous injuries, and I keep threatening to retire because I've found that my reactions are somewhat slower than they used to be, although I've really been injured once in the last ten years.

COMMISSIONER MORGAN: I understand. I served in the military back when I was -- it was 1969 and '70 in a really hazardous area as a Second Lieutenant, and other than a few stitches, I got through that whole ordeal. I came back and was Commissioner of Boy Scouts, and I never got hurt as bad in my entire life as that one weekend at (indiscernible - voice lowered) when me and the canoe collapsed walking down. So I understand what you're saying, but really, I am serious. I really would like to hear from people that are trying to do this and get your opinion of the New Hampshire site, if that's possible.

MS. CARR: And how did you bump into the New Hampshire site?

COMMISSIONER MORGAN: It was in our briefing materials of examples.

MS. CARR: Are there any other ones?

COMMISSIONER MORGAN: Well, they have the -- I'll give you -- go to our website. I guess they have a paper there, right, Deb? But what was the other one, Massachusetts? It was New Hampshire, Massachusetts, and the other one was -- it was -- the third one was basically just insurance information from -- I don't know the other one, but the New Hampshire one had everything we -- including a button for the uninsured. So I'd like to know that. If we have to do homework, you have to do homework.

MR. TORINUS: Just a thought. You know, I was out at a big private equity firm, you know, 18 companies, and they were all at different stages of the march to best practices. They had hired our MBA, main consultant, to head this operation. They're spending a billion dollars on health care, so it was worth hiring a guy, like that.

And so they done a rating of their companies against 15 best practices, you know, transparency, quality, prices, (indiscernible - voice lowered) price, consumer-driven, and I mean, there were a lot more prices, but I mean, they rated their company at where they were on best practices. And then they were (indiscernible - background noise) about a three-year look of the margin (indiscernible - background noise). Some of them were on, you know, their own goal lines. Some were on the 20. Some were on the 30. Some were, you know, near the red zone. And you know, they figure they get to save

about $200 million a year. So you couldn't -- you know, if you wanted to get an organized concept or an organized approach to this thing, you can lay out the best practices and come up with some kind of template that you try to move the various institutions and compass a three to five-year period. You can't do it instantly, but you can do it over three to five years.

CHAIR HURLBURT: Commissioner Hultberg, you had another comment.

COMMISSIONER HULTBERG: Yeah. This was just following Mr. Torinus' comment. In the interest of full disclosure, I read his book. So I was just going to agree with him that we've a lot of discussion just in this room about providers and what providers should or shouldn't do. And I think providers are acting rationally in a market that we have given them. And so to a great extent, we are, you know, in some ways, blaming providers for the situation we are in when we continue to pay them and they continue to act rationally.

And so from my standpoint as I look as a government -- but when I consider myself looking through the employer lens, the question that I have is, what am I going to do to change that? And you know, there are probably a lot of answers to that, and the conversation on medical tourism really started as a bullet on a slide in front of the Alaska Retirement Management Board, which then got picked up by the *General*

Empire three times, three stories later and then, you know, here we go. And (indiscernible - voice lowered) that was one bullet on the slide about a lot of things we can do to contain our health care costs.

And so the reason I think that gets attention is that represents the kind of disruption in the current market that's opening everybody's eyes. And so the question is going to be, what do we do about it? What does the provider community do about that? Do you just fight against it and try to keep employers from doing it? Because I think that you've already -- I mean, the train has left the station on that completely. I have not realized how many employers are already doing medical tourism. Granted, you can't do it for everything, but I can send someone to Seattle for a colonoscopy, pay for the travel, and it's still cheaper. And so when we're looking at that kind of cost difference, you know, it's pretty mind boggling. But like I said, I think the question now is, given that the conversations are now occurring and on the table, how are we going to engage with providers? Because I do think, to Dr. Hurlburt's comments, that this conversation not just has to have provider participation, but in some ways, needs to be provider-led and that's really what's missing right now, I think, in the current conversation.

MR. TORINUS: Lead with the payer side, and then hopefully, get some enlightened providers to come along with

it.

CHAIR HURLBURT: Like buying a house, if you're not in a position where you can't walk away from the deal, you're in a very good position, and it's challenging in this to not be able to walk away, but the medical tourism or whatever may need to be a part of it. It doesn't mean that you're antagonistic and enemies, but as negotiating partners (indiscernible - voice lowered). Tammy and then Jeff and then Larry?

MS. GREEN: One comment I would make is I think all of those are the right kinds of questions to ask and the solutions to consider, but I think one thing -- and it's kind of hard to say it sometimes. I think we also have to look at self-responsibility and really help people understand their role in the situation we all are a part of now. And it's not that we're saying everybody has to be accountable and there is no help, but if we don't change kind of that enabling mind set that we have with individuals, we're never going to change the system because the system is made up of individuals doing certain behaviors.

And so I think, if we're really going to change the paradigm as a society, we have to embrace that whole concept of, you know, when you look at the things that are really driving our health care costs, they're lifestyle-related. We all know that. So it's not that everybody is at fault, but

what can we do to create another part of the system that really works with all of those other pieces of the medical system to really change the way that we can enable healthier behaviors. I know that sounds Pollyanna-ish and all that, but I truly think that's the answer. We just haven't figured out how to do it.

And the other problem with that is, as Becky said earlier, our system doesn't reward -- you know, we -- our providers are only doing what they're being paid to do. So we haven't created a system that rewards our providers for taking care and keeping people healthy. We have a system that pays people for sickness and helping them after-the-fact. So if we're ever going to get upstream, it's like in that slide I have. We have to figure out how to turn the faucet off because we can't mop up the water fast enough to keep the -- you know, to keep that from coming out.

So I just wanted to put that out there, that I think, if we can all challenge ourselves to look at how we really integrate that, we talk about it -- I've talked about it for 20 years, but I think that now it's no longer an option. We have to figure out how can we integrate that in a meaningful way that resonates with individuals and that it's not just a didactic "here's what you have to do," but how do I engage people to get excited about their own health?

COMMISSIONER DAVIS: Well, this -- first, I'll just say

this has been a great conversation, so thank you, both you and all five of you.

I have so much to agree with here. In *City Slicker's*, Curly did one thing. The one thing in health care costs is there is not one. It's an "all the above" situation. It's personal responsibility. It's (indiscernible - voice lowered) by including quality. It's transparency. It's getting (indiscernible - background noise). It's all those things. But Commissioner Hultberg, in a meeting last week, said, everyone likes to talk about the travel benefit, and it's true. Everyone likes to talk about travel benefits. And the person who was quoted widely in that article that David held up, I just want to speak to one thing about the travel benefit. And that, often times, it has raised this whole notion of follow-up care.

I'll just give a specific example. Because of the difference in prices for a knee replacement here, it makes economic sense to fly two people to the Lower 48 -- take their pick where they go -- to a contracted facility where you get a contracted provider to get the knee replacement, to put them up for the period of time required for the follow-up care, and flew them home, and have no cautionary for the member, and still save money for the plan sponsor. Now that tells you how far out of whack this has gotten that you can do all of that.

And Dr. Hurlburt, you're absolutely right. If you have

no leverage, you have no leverage. And so if nothing else, perhaps this creates some semblance of leverage. And then we will then get people stepping up to the new incentives that they have been presented with because people are acting rationally and economically. They're not trying to do something immoral, in virtually all cases. But that's the way the game has been structured.

Just one last comment. We actually looked at this whole notion of bringing in the next team, and I felt that the difficulty in that is, say, you bring someone at a five-year contract. Well, if I'm making $250,000 a year and you're making $750,000, as soon as my contract is up, I'm (indiscernible - voice lowered). So I just don't think it's sustainable, but real change for the people who are here, driven by change in incentives, I think can help, I think, on the price side. Thank you.

CHAIR HURLBURT: Larry, Bob, and Val.

COMMISSIONER STINSON: I'll say some obvious things first. I think you probably are aware of most of this. It is very, very difficult to recruit physicians to Alaska. We've been trying to do so for a long time. Fairbanks has had a shortage of general surgeons and orthopedists forever. They keep trying to recruit from other sources, and when they do come up, they don't stay. It is very, very difficult to get -- you know, does that justify over-paying? But I don't think

so, but it does put the physicians in a relatively protective spot.

And as Commissioner Hultberg pointed out, if you have the opportunity to make what is being offered, you're going to take it and that's one of the ways -- that's one of the reasons why they stay there. I'm not justifying it. I would take a bundle deal in a heartbeat, but I'm also not an orthopedic surgeon or a nurse. So it really depends on the specialty. It's hard to get people up here. It's hard to retain them. I'm not dismissing any of that, but that is definitely a factor. I know a lot of people tried to recruit people to come up, and it's difficult. We've had many people come up, and if they come up in February or March, they'll spend a couple days and then they say goodbye, and they don't come back. So Alaska is relatively insulated in that regard.

I think, from the other speakers and what they've been saying, whenever the rubber hits the road, it's only then that I think some of the surgeons will take this seriously, based on my conversations with them, and what you'll see is -- I think you'll be surprised. Some of them will take it, and some of them will either retire, leave, or tell you to get lost, but all you really need is one, and I would start it. And what I'm saying is heresy right now, and I probably will be punished at the local Anchorage physician meeting, but it's going to come. It's got to come.

In my specialty, I would do it without hesitation. I don't know about family practice. I don't know what Bob would do, but I think, in the non-surgical specialties, they probably like certainty like that, but that's the situation as I know it.

COMMISSIONER URATA: I would echo what Larry said. I think that there are shortage problems in Alaska, and I think, because we've increased the size of our medical school class, the WWAMI class, that's going to be part of the solution in the future.

I also think that -- you know, I'm not an economist, but I've kind of (indiscernible - voice lowered) in the market, and I think, if you changed the rules of the market, businessmen, like doctors, will change along with it or they will leave to where there are more, what they think, greener pastures. But I don't -- and I agree with everybody that we've got to change. And so I think the key is how are we going to change, and are we going to get all the players involved so that, when we make the change, it will be as painless as possible and as smooth as possible, and will we come up with the correct answer. I think that's the key. I don't think there is a question about whether not we need to change.

So I think, in terms of specifically sending people down south to get a tan and a knee replacement, that is a small

part of the potential solution, and I think that will probably start people thinking about change. And I think that you'll -- just like Larry said, some docs will go along with it; some won't, and those who won't will probably have to move on. But I think we can all get through it.

COMMISSIONER HARRELL: Just a few comments that essentially summarize (indiscernible - voice lowered). My opening was really about what you said. That's (indiscernible - voice lowered) best offer and negotiate agreement and that's what the health care system here has to be aware of and mindful because a certain percentage will pack their bags and go, but some percentage won't. The question is, how to incentivize? You can't incentive them with more pay because that's the very problem we've got. So how do you incentivize folks to step into a different flow of stream and go along with it? And it's not necessarily sending in the whale and saying, well, he does provide some degree of solution. Believe me, I understand the recruitment issue because I lose most of my providers to the prime market here because I can't pay them, in the Air Force, what you can pay them. So they punch their card and hit the road. And so I'm constantly turning physicians over.

I just can't see, in my small brain at the moment, how you can incentivize the community and move forward, unless you're willing to take some short-term risk and some short-

term pain as a health care system because a number of them are going to say, thank you very much; I'm heading to the Lower 48.

CHAIR HURLBURT: Your system, your boss at Potomac is basically saying, we will walk. We will not put this DOD function in Alaska or we may not put it there because health care costs are so high. So instead, we'll put it at Fort Campbell or Fort (indiscernible - voice lowered) or somewhere else. So in a sense, your system is almost saying that's got to be a part of our consideration or we're going to walk away from Alaska because of those (indiscernible - voice trailed off).

COMMISSIONER HARRELL: That's exactly correct for me. If I cannot increase direct care in this Joint Venture facility, that's exactly what will happen because the resources can be better spent.

COMMISSIONER BRANCO: I've kept quiet for a while. I'm perhaps the only one in the room that's not widely excited about the prospects of significant change because I'm on the provider side. I'm perhaps one of the few who is an employer, a consumer, an insurer, and a provider. So I have all the elements in the game, and it does feel as though there is an approaching "blood in the street" moment, and it is in our best interest to work together to achieve the changes that need to happen. And the reason I get worked out -- and I'm

worked up today -- is because we're talking about employed people's benefits and payment for that benefit. And there is no issue there. Every (indiscernible - voice lowered) is in a line. I'm perfectly aligned with helping my bundled payments opportunities to reduce costs, and most especially, to keep care local in our state. I don't advocate (indiscernible - voice lowered). I don't advocate banking and mortgage tourism. I want -- and these are all more expensive in our state. I want all of this preserved, but from a rational point of view.

My heart goes to those, the other moral and ethical obligations that I have. And we talked about -- we heard about discounts being offered as a way to price control. I've been awfully proud, in Ketchikan for 10 or 11 years now, to receive calls and (indiscernible - voice lowered) actually, one of them, but receive calls from insurers asking for a discount. My answer has always been no because I refuse to pass on the cost for this kind of aligned group to the rest of the consumers involved.

So contrary to one other statement, the largest price increase in our community has been 5%. I've average 3% or less over the 11 years because -- for that very reason. My governing board won't go higher to make a profit, to add a profit. Everything is reinvested in equipment in the community.

And I'm deeply passionate about this because they hold me to that standard of being good stewards for the community and trying as hard as they can to control the costs that are spread to every employer, and we're not winning. We're clearly not winning. All the things you listed that impact the cost of health care, they're all there. They're my challenges. How do I provide it? A $65 million revenue organization. My bottom line, at the end of the year, is $500,000. Maybe a million in a really good year. We invest that in equipment.

So now I have no point that I was going to end that statement, other than let's get control of health care costs.

CHAIR HURLBURT: We're just about at -- we've end of morphed into the last half-hour, but we were just going to have ongoing discussion on this anyway. We're just about at the end of the day. Deb, is there any other thing?

COMMISSIONER ERICKSON: We'll continue tomorrow morning with discussion and capturing thoughts from the Commission members that they want to make sure we document in our report for this year and then plan to continue next year related to this topic.

The other thing that we're going to do tomorrow morning is go over the concepts that we've captured so far. You have them in your Meeting Discussion Guides for the things we discussed earlier in the year at the past couple of meetings,

and our End-of-Life Care discussion is also captured in there.

You should have all received, at your places before this most recent break or during this most recent break, the written testimony from Donna Stephens. And you might have already noticed that there are written comments submitted to all of you from somebody who has emailed me, and I just included it in the front pocket of your notebook as well. So I just wanted to point those few things out to you.

So we probably could wrap up three minutes early, since you might have a little bit of homework to do tonight or tomorrow morning to think a little bit more about this. We'll have a final question or comment before we thank our guests and our guest speakers today.

MR. LOUDON: I just wanted to clarify my "blood in the streets" comment. I want to get to a transition plan that builds us a system that we can afford and that everybody has access to. I don't want there to be blood in the streets. I just think there are a lot of issues that have to be dealt with.

I want to thank those of you on the Health Care Commission for your work also and the time that you have spent. It's incredibly important.

One of the recommendations 15 or 16 or 17 years ago when I was on panel was that we should -- that health care was more important than the Permanent Fund Dividend, so we should take

the Dividend and put it towards health care, and I'm just going to caution you not to go there.

CHAIR HURLBURT: I think John's comment (indiscernible - background noise) because it is important business, and we're small enough that we're not often going to be a leader, but it sounds like we really are stepping out in an area where (indiscernible - voice lowered). Thank you so much for coming up.

COMMISSIONER ERICKSON: I think we're in recess until tomorrow morning at 8 o'clock.

4:57:52

(Off record)

SESSION RECESSED