ALASKA HEALTH CARE COMMISSION

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P R O C E E D I N G S

08:01:32

(On record)

CHAIR HURLBURT: I'd like to welcome you back again. I just want to mention two items here, and I'll stand up and (indiscernible - voice lowered) the second one here. But my first question to everybody in the room -- and I don't think I'll ask you to show your hands -- is, has everybody had their flu shot? Okay. Thank you.

For the record, (indiscernible - background discussion).....

(Pause - background discussion)

UNIDENTIFIED MALE: Did you bring any?

CHAIR HURLBURT: I didn't bring any, but I'll bet there is a Walgreen's right down the street. And in fact, I saw that, at UAA at the Student Health Center, for $15, you could go in, anybody. You didn't have to be student. You could go in and get your flu shot.

UNIDENTIFIED MALE: We give our guys, our staff is free if you'll do it.

COMMISSIONER ENNIS: Do we need the regular or the super vaccine, which are you recommending?

CHAIR HURLBURT: The super vaccine is for seniors, for folks who are over 65, and we probably will not know until about 2014 or 2015 if it has any good beneficial impact. We

do know that it gets back at antigen levels. It gives higher antigen levels because older folks don't react as well, but the last two flu seasons have been really light. We've been really lucky, and you don't know if it's going to be a good year or a bad year. So you can't tell in just a year or two. The CDC says, by 2014-2015, they expect to know. So right now, it's dealer's choice. I take the high dose stuff when I go.

UNIDENTIFIED MALE: Does it cost more?

CHAIR HURLBURT: Yes. It costs a little more, but (indiscernible - background noise). It's for seniors. So don't worry for young kids, like yourself.

UNIDENTIFIED MALE: What about (indiscernible - simultaneous speaking).....

CHAIR HURLBURT: Anyway, that was really good. Thank you, because almost everybody really had it, and the few who didn't I would really urge you to do that.

The second is Pat made my day already, and he asked what this was. I want you to see it says 39. Anybody, other than Pat now, know what 39 means?

UNIDENTIFIED MALE: Your age or birthday?

CHAIR HURLBURT: This is a project of the March of Dimes, and it's actually a joint project with all of the state health departments (indiscernible - voice lowered) March of Dimes, and what it is, is to get away from elective inductions and C-

sections prior to 39 weeks. You know, we can do such miraculous things now. We can take a 26-week baby and normally keep them alive, and anecdotally, even 20-week babies, and you can keep them alive at mega millions of dollars in costs, but -- and with lifelong healthcare problems, but because we do that, then it becomes easy for the mom to say, you know, my mom or grandma, she can only be here now and she's got her business to run; she's got to leave. Let's go ahead and do the induction. The doc to say, you know, I've got a golf tournament, and I have been working at this all my life and let's go ahead at 37 weeks or 38 weeks. And we thought that wasn't a bad deal, but we really know that 38 weeks is clearly inferior to 39 weeks in terms of the immediate short-term impact on the baby and lifelong impact. So this is no elective inductions or C-sections prior to 39 weeks.

There has been a limited amount of money that's come in, so federal money, enough for just two hospitals. And so two hospitals in Alaska, the hospital in Wasilla and the hospital in Soldotna, are the initial ones that have signed up for what they call a (indiscernible - voice lowered) stop program and that means, if there is going to be what looks like an elective induction prior to 39 weeks, everything stops, and they get together and say, is this really medically justified? ANMC does that already and so you'll be hearing more about

that for hospitals wherever you are, but it's a really good thing. That's why Pat made my day. And Deb, I'll turn it over to you.

COMMISSIONER ERICKSON: Okay. We are going to use the Meeting Discussion Guide and spend some time just reflecting and brainstorming this morning related to End-of-Life Care and see if we can capture some concepts that the group can agree on and want to consider sharing with the public, with public comment, prior to developing our annual report.

And then we're going to spend some time going back and just reviewing the concepts that we captured related to End-of-Life Care and telemedicine and see if there are any changes or updates to that, and we have Stewart Ferguson coming a little bit later this morning. I don't know if you recall from the last meeting that Stewart and Paul Cartland, the State's Health Information Technology Coordinator, had promised to come up with -- well, regardless of what they promised to come up with, they came up with a little more information and a recommendation for you all to consider recommending to the State related to centralized telemedicine services. So they actually put together a PowerPoint presentation for you that's in the notebook, and Stewart is coming over later this morning to share that with you and have a conversation with you about it.

And then the one other thing that I would like to do --

and we have some preliminary thoughts in a slide -- is talk about what our agenda for the coming year might be and to help with context both around thinking about what we're going to potentially include as recommendations for this year, especially those related to telemedicine, but for planning for the future, I took our last three reports and consolidated all of the current existing recommendations of the Commission and have grouped them under the major themes that we had identified in our summary and Executive Summary this past year.

And one of the things that I'm going to propose is that we consider, in the coming year, this group of recommendations, new recommendations we might add to it, spend some time refining this and consolidating it and completing it as a more comprehensive complete packet of recommendations in the coming year. So you have that in front of you, and again, it's just for context. We're not going to revisit any of those at this meeting or prior to next calendar year.

So what I would like to do first is spend some time capturing your thoughts from yesterday, and particularly, initially, what you think you've learned, what you would like to see eventually show up as a Finding Statement, just in concept.

COMMISSIONER DAVIS: So I'll (indiscernible - voice lowered). I think, first of all, an obvious conclusion I've

thought this morning is that employers can have an impact on healthcare costs with people covered by their plan. That's very clear.

COMMISSIONER DAVIDSON: I would propose a friendly amendment to say that employers do have impact and just haven't necessarily fully (indiscernible - simultaneous speaking).....

COMMISSIONER DAVIS: One way or another, I mean, they're.....

COMMISSIONER DAVIDSON: Yeah. They're paying for it, and they're not paying attention, which is where he was, and then suddenly, he was engaged. So I would say employers do have an impact.

COMMISSIONER DAVIS: Yeah, and they have a positive impact with some fairly simple straightforward interventions, but they're -- they are simple and they are straightforward, but they require a lot of energy to do.

COMMISSIONER DAVIDSON: And I would also say they have an impact on healthcare value for employees. It's not just about cost; it's about value.

COMMISSIONER DAVIS: Yeah. Thanks for capturing that. That's -- it's very clearly -- Mr. Torinus described a situation where (indiscernible - voice lowered) great value and quality is up, and costs are down and that's the whole trick. And I would just add that he is a fantastic data point

and what a delight that was to have him with us, but there are good signs -- and I mentioned this before -- around the Towers Watson Annual Survey of Employee Benefits. The last one that came out showed exactly what he is describing. If you do nothing, you get what you deserve. You get 15% trend. If you do a little bit, you get an 8% trend. If you do a lot, you get 3% trend, and a lot is a list of things, many of which, Mr. Torinus had pursued.

Deb, I think we provided that study before, have we not, the Towers Watson study, to you and it's on our.....

COMMISSIONER ERICKSON: Yes, but I don't know if it's on our website right now. So I will make a note to myself to include it on the website.

COMMISSIONER DAVIS: If you don't have it, I can find it and send it to you.

CHAIR HURLBURT: I think that the size of the turnout for the luncheon, the magnitude of the -- tons of questions that came up to the front table after the talk and the large number of people that (indiscernible - voice lowered) afterwards to talk with him indicated not only that the employers do have an impact on it, but that there is a very precise reservoir of employers here who very much feel like they need to look at improved, sustainable ways of doing things.

COMMISSIONER HARRELL: It may be an embellishment of what's there. It's important to incentivize the employee or

the patient, and if we focus on the health delivery portion of it, we're missing the point because it's treating health and that's behavioral. So as the far as the (indiscernible - voice lowered), I think it's important that they need to be focused on incentivizing a healthy lifestyle for the employees.

CHAIR HURLBURT: And the other thing he did that I thought was good on that was, as a non-medical person, identified that the former relationship between the physician and the patient was, you do this and thank you very much, and now it's, you are the educator and it's joint decision-making. He clearly recognized that was important in terms of value, in terms of quality, in terms of cost for the plan, and as a non-medical person, recognizing (indiscernible - voice trailed off).

COMMISSIONER URATA: Can I just.....

COMMISSIONER ERICKSON: Can I ask -- I just missed -- Ward, did you say between the employee and the employer as they were developing the plan or between the patient and the provider?

CHAIR HURLBURT: I was talking about the relationship between the provider.....

COMMISSIONER ERICKSON: Between the clinician and the.....

CHAIR HURLBURT: ....and the patient there, that it's a

changed role from what it was, where the provider was always the decision maker as a source balance and decided for the patient what was going to happen. He described, which I think physicians often recognize now, that you're an educator and it's collaborative decision-making. Do you have PSAs done? Well, here are the upsides and here are the down sides in joint decision-making.

COMMISSIONER URATA: I think that, you know, his three points of how he made this work go along with some of the concepts that we mentioned -- that were mentioned by this Committee of how an ideal healthcare system works and then he said that, you know, consumer-driven was his first point, and you know, that's the same as our -- similar, very similar to our patient-driven concept. And then he called -- said that proactive primary care -- and in our concept, it was, you know, primary care should be emphasized over what's going on now. And then he calls it Center of Value, and I translate that as meaning transparency in terms of costs and value. And so I think those three things are very similar to what we defined earlier as an ideal healthcare system.

COMMISSIONER CAMPBELL: (Indiscernible - voice lowered) need to go a little bigger than what we have there now, but the employer must become more proactive managing their healthcare plan.

COMMISSIONER KELLER: I mean, this goes back to -- what

impressed me is, you know, his comments about the need, you know, for engagement and involvement and how the issue -- that he had to learn the issue, the management of behavior of people, relationships more than systems. I can't remember his exact wording, but it hit me that, obviously -- you know, I don't know -- you know, we have a public pay system. Compared with employer/provider systems, that's common (indiscernible - voice lowered) learn from both (indiscernible - voice lowered).

COMMISSIONER DAVIS: Yeah. Just sort of different words, Dr. Urata, same idea. There are four elements that are required, skin-in-the-game somehow -- and (indiscernible - voice lowered) involved financially, which that means engagement. So that's -- I think of those as part of the same. Incentives. He's not shy about paying people to go to the Center of Value. Transparency, which cost and quality (indiscernible - background noise). And then the proactive primary care. And if we capture those as really the four elements -- and as he kept saying, there are lots of moving pieces here. All of that can be done 1,000 different ways, but that's where the focus needs to be.

COMMISSIONER STINSON: And that was also consistent with the person who presented the Providence system. I mean, the things that they had in common were exactly those points, and I think that's what we should focus in on.

COMMISSIONER HIPPLER: I didn't hear Mr. Torinus talk as much about incentivizing a healthy lifestyle as about how to properly react to what actually happens in current employees' lifestyles. I like the idea of incentivizing employees to be whatever we consider to be healthier in some metric. My only concern is that there is a little bit of a moral hazard there in the sense of, if we're so focused on prevention as an employer, what's to prevent us from taking the next step, as an employer, and saying, you know, the best prevention is not hiring someone who is obese?

So I'm not -- I like the idea of changing behavior, but I'm concerned that we do it in such a way as to not put a blessing on having different tiers of people in our society.

COMMISSIONER ENNIS: Well, my company is moving in this direction, and I feel that, particularly in the area of healthcare where we have difficulty with recruitment and retention, one of the most important things an employer can do is show that they care for their employees, and I think this pairs well with that attempt to do that. But I find I do have some similar concerns to those that Allen just expressed, and as I began thinking about really -- I'm looking for the right word -- a more personal nature of healthcare, and for example, the biometrics and the measurement and the records that are being taken and kept by an employer, that that dividing line between professional and personal issues may become somewhat

fuzzy. And I think I overheard someone say around my table, well, programs like this are going to make for some interesting conversations over the water cooler, meaning that someone's personal medical problems, which are now really part of the workplace concerns, could, you know, despite all efforts of confidentiality, be breached. So you know, there is a little bit of that, I guess, mild concern that this is an element we need to be really careful about and incorporating the really positive interest in their employees' well-being and health issues. There is a slight opportunity that it could be misused or simply be very uncomfortable for an employee.

COMMISSIONER HARRELL: I'm always intrigued. I really am. I find myself flip-flopping inside of my brain. What (indiscernible - voice lowered) to be conflicted with myself. However, I will say, just for the room, since, again, I know that some of you have had military service, my physical fitness is a matter of record. My BMI is a matter of record. My blood pressure is a matter of record. My lipid count is a matter of record, and my Commander knows every lump, and because, as part of my employment, I have to be of a particular health status. So I don't find it particularly onerous or intrusive because an employer, the federal government in my case, has a right to make sure I'm capable of doing a particular job and not inflict expenses on the

taxpayer down the road as a retiree. So just as a cultural difference, coming from a completely different mind set, interestingly enough, I have no problem with that because it's the lifestyle I've lived for over 20 years, and nobody thinks twice about it.

There are water cooler conversations; that's a fact. When we go out and do our fitness tests, you better believe everybody in the hospital wants to know what my score was, to make certain that I am towing the line. So interestingly enough, I don't have an issue with it, and otherwise, I would find myself going, yeah, yeah. So again, I'm conflicted, but I just want to share that with the rest of the group.

COMMISSIONER URATA: It may be that, if you advertise a job and that's part of your advertisement, then, when they apply, the potential employee will (indiscernible - background noise) these are the rules of the job that -- you know, my cholesterol, my weight, my BMI will be known, and in some cases, have to be in a certain area to be hired. I don't know, are there any laws of discrimination on obesity or smoking or alcohol?

CHAIR HURLBURT: I believe that there is some legal precedent value (indiscernible - voice lowered) that obesity -- some people contend anyway -- would be a protected category or that it's disability and that may or may not be the case, but I think that there still is both the need and the

opportunity to change the societal norms and expectations.

Now as far as smoking, Providence Health System here will not hire smokers and that -- apparently, they believe it's sustainable. And Val, I don't know if you have an answer on that.

COMMISSIONER DAVIDSON: So I guess a couple of thoughts on that point. I think that people either love or hate HIPAA or are somewhere in the middle, and you know, patient information is confidential, and when you are seeing someone as a provider, they are expected to keep that information confidential, unless they are required to disclose it for other -- unless they give their consent or they give their -- they are required to disclose it for other legal reasons. But HIPAA is there for a reason.

I mean, I remember, when I was little, growing up, on the radio, everybody tuned into the radio everyday at 4 o'clock because, would the following people please report to the VD clinic? It was there -- HIPAA was created for a reason. I mean, people have a right to expect that, when they go to see a provider to disclose the things that they want to improve or address in their lives and their health, they have an expectation of privacy, so that they can have a full disclosure and have a meaningful conversation.

And there are a couple of things that we talked about here that are sort of notions of incentives versus skin-in-

the-game. Skin-in-the-game is a phrase I've never understood. To me, it feels almost violent. I mean, I don't know. I don't get it. So people who -- and every time it's described, it's about money, but is it really about commitment. So for example -- yeah. And so for you, you have skin-in-the-game when you have your physical because you are accountable to other people who work with you and who are interested in what that means in demonstrating your commitment to your team. So that's your skin-in-the-game. It doesn't mean that you are paying more or you are getting a cash value for that. You are having that skin.....

UNIDENTIFIED MALE: Personal impact.

COMMISSIONER DAVIDSON: Whatever it -- yeah. I don't like that phrase because I'm pretty sure nobody sheds their skin to go and access healthcare. It just is a really odd -- to me -- maybe it's a cultural thing -- it's just a weird phrase. And I think that there are other kinds of ways for people to have a vested interest that are not purely financial, and I don't know if it's just from growing up in a small community where you realize that, if we're all living together in a small place or we spend a significant amount of time together, my impact necessarily impacts yours, and your health necessarily impacts mine. It's the reason that Ward asked if everybody had their flu shots. And so with that kind of -- I need a better phrase, but it's more than just

financial, and I think we should be careful about having that be only a purely financial thing.

COMMISSIONER DAVIS: I don't disagree with (indiscernible - background noise) it is more than financial, but let me describe what I meant is a high deductible health plan because, as you read John's book and you think about this, third-party reimbursement, it has been the fuel that has driven this whole thing. And so that's kind of odd to come out of the mouth of someone who has made his living for 17 years or more -- longer than that -- on the third-party reimbursement side of things, but it is the creation of the moral hazard that, you know, what I consume -- the marginal cost of me consuming the goods is less than the actual cost. It is a fact that people will consume more. So I mean, specifically, financially, high deductible health plans have been shown to result in immediate 20% to 30% decrease in costs. So all the other stuff you said, add that on to it, but that's specifically what I meant as a (indiscernible - voice trailed off).

CHAIR HURLBURT: Wes and then Pat?

COMMISSIONER KELLER: I just wanted to say about the biometric (indiscernible - voice lowered) don't underestimate the -- it's a (indiscernible - voice lowered). (Indiscernible - voice lowered) last year (indiscernible - voice lowered) healthcare, but HIPAA requirements and restrictions were

applied, but (indiscernible - voice lowered) so they're considered biometric information. And you would not -- I cannot impress on you how high up the food chain the concerns go there, you know. That is a really big deal. There are companies, for companies, like LexisNexis, which you've probably heard of, that do nothing but store that biometric information, and the confidential issues and everything are not well-founded in law. It is really a touchy thing.

On a lighter side, back when I was a staffer before (indiscernible - voice lowered), I (indiscernible - voice lowered) Senator Dyson who wrote a bill that said that the public schools had to publish their BMI information, not (indiscernible - voice lowered), you know, in general, if the Legislature published their BMI. He never got a hearing on the bill. It is a political (indiscernible - voice lowered), and a lot of feelings about it. (Indiscernible - voice lowered.) It was like, hey, that was a (indiscernible - voice lowered), but I don't know.

CHAIR HURLBURT: But there are a number of school districts around the country that do report the percent of BMI on their report cards now, and I think they do that as a way just, you know, like you rate elementary school kids of (indiscernible - voice lowered) with all the other system check kinds of things, but (indiscernible - voice lowered) paying attention to. So I mean, I think it's been around long

enough that there has probably been time to challenge it, and it is being done someplace. So Pat?

COMMISSIONER BRANCO: I want to do a quick end to this and then shift gears, but I want to agree with Colonel Harrell quickly.

During my naval career, several times a year, I had to demonstrate my physical fitness in exactly the same categories. My BMI was public record, public within our public. But those were the conditions of my employment, and even though I was a Hospital Administrator and a Hospital Corpsman and in several different roles in the military, one of my key roles was preparing us to go to war, adverse conditions, and physical fitness was an absolute minimum requirement.

Today, in my hospital in Ketchikan, I'm not likely to go to war or have to run across two miles of rough terrain in order to get to work. What I'm engaged in, mostly, is -- and (indiscernible - voice lowered) -- my brain, limited capacity as it may be, some heavy-lifting, like this, but it -- my disabilities have little impact on my daily activities in the role that was hired for. So obesity is a factor, and as long as it doesn't contribute to the rising cost of my company's insurance of me or a drain on the resources of our organization, my ability to perform my function, regardless of whatever disability, personal choices, and/or other activity,

I think it is a matter of a form of discrimination if we loosen it to be just a social characteristic. If you smoke, if you're overweight, if you have two left feet and can't dance or if you can't sing, if we find something wrong with you, and therefore, can discriminate against you, I think we run down a dangerous path. But as long as we keep it confined to the ability to perform the work you're hired for, then it ought to be sanctioned and appropriate.

Shifting gears, I'm going to touch on medical tourism once more because I can't tell you -- I dreamed about it last night. I thought about it. I consternated about it, and I'm -- I'll do the simple part first. I understand capitalism. I understand market value. I understand competition. If someone else could produce a product for higher quality and less cost, by all means, go for it. And we've put it under the cloak of choice, and when it's under the cloak of choice, people do have that decision. They can get on a plane, get a colonoscopy, a facial, and have a night -- and catch a play while you're in Seattle and that's terrific, but that choice only exists as long as the other player in the market remains at the same cost and level of service. When you expect -- once you move a business out of a community, you can't expect that that choice will remain forever because market forces will drive the local entity to close. So the ability to (indiscernible - background noise) and expect the same

treatment will disappear eventually. You'll have to get -- and you'll get on the plane to go to Seattle for your curative care, and it won't be quite at the same emergency level. I worry about letting a short-term, like competitive advantage, take over because there will be an impact. Businesses can't sustain low volume/no volume for very long.

CHAIR HURLBURT: Larry?

COMMISSIONER STINSON: I'd agree with Pat. Another point that I heard many, many times, and they were talking -- I think Dave brought up -- underwriters about -- for their follow-ups. What I hear from the surgeons -- and I have seen this, and as a pain physician, I've been consulted on this -- that, particularly -- I won't even get into it, but one spine center in California, that I could talk about off record, that does all of these medical tourism things for real -- much less expensive. All of these people come back. They all have problems. The surgeons don't like to get -- because now you already have a damaged situation that they like to say we weren't good enough to be consulted on in the first place. Now we get to get involved when things are really bad. And the (indiscernible - voice lowered) is, while there are some plus sides to medical tourism that you already talked about, it is way more common than what people think that there are problems with it. And you're not going to get on a plane with an infected wound in your back, draining pus to fly down to

California, plus the doctor down there won't see you anyway. So it's much more problematic than what it may, at first, appear.

CHAIR HURLBURT: Jim?

COMMISSIONER PUCKETT: (Indiscernible - voice lowered) here on the Commission want to try to get the providers (indiscernible - voice lowered) Alaska. I can't imagine that any of us here would want to do that. I know, certainly, my Commissioner and I, we want to have providers local for people to go to. That is the optimum, but I think reality is there is tourism going on.

I remember, when I arrived in Alaska in '69, that I was already, at that time, hearing about people that would fly into -- out of Fairbanks, they would fly into Anchorage. They would fly into Seattle. So the reality is it's always happening in the state, but I think all of us would agree that, when there is such a significant difference in the price, the local provider is going to have to adapt.

And I'll give a little anecdote, if you don't mind. In my prior life, I was a contractor. I built custom log homes for people. I can assure you I did not appreciate when I saw log homes going up in the community around Fairbanks and they were being provided by a major company, but a company out of different country (indiscernible - voice lowered). And so I can personally identify with your concern and fear, but I can

assure you we don't want to harm to the medical community in the state, but the financial reality is something has got to give, and we've talked about it enough yesterday, but the market is going to make that -- it's going to force people to make that change. (Indiscernible - background noise) have to change their business model for that, to do something. Otherwise, the employers will create something to fulfill that need.

So I didn't dream about it last night, but I can assure you the desire is not to drive them out, drive anybody out, but the reality is there is going to have to be some changes in that relationship on the financial side.

I know, at the State, the State cannot continue on this trend, but my division, alone, paid $620 million last year. Now I don't know about you, but that is a huge number for 15 people in my division to handle that. You know, when we're close to three-quarters of a million dollars, something's got to give. We cannot continue on that trend. We can bear it right now, but barely, and we have to push it down. We've got to do what we can to bring it down. But there is no desire to drive anybody in the state out of business.

CHAIR HURLBURT: That's like $1,000 for each one of us to take care of somebody else, and (indiscernible - voice lowered). Allen, Jeff, and then Wes?

COMMISSIONER HIPPLER: Well, to say I don't know much

about medical tourism would be an understatement. I don't know anything about it, but -- well, actually when I was in Bethel a couple of times, I went to Anchorage for medical services. Maybe I do. Maybe I'm a consumer of medical tourism.

In defense of medical tourism, one objection was brought up. While these people, they go out for treatment and they come and they're sick and there are problems, I would argue that relates to the problem of transparency. There is always a risk with any medical professional that something goes wrong when you seek treatment, but if there is transparency, in theory, quality transparency, you can evaluate the risk of getting a procedure if Point A goes to Point B. That's not so much an argument against medical tourism as an argument for more transparency.

There is another argument about, well, what I would consider cost-shifting. The argument is, right now, we're overcharging for certain procedures so that we can undercharge for other procedures. We're overcharging for some procedures so we can subsidize an existing service. Well, okay. That's a market inefficiency. That -- well, it's nice to have that service subsidized, I admit it's very nice, but by it's very nature, it's a market inefficiency. So when you allow the market to resolve inefficiencies, that kind of thing can happen. And what that means is you have to look at the big

picture and say, for every change, there are going to be positive and negative effects, and the positive effects outweigh the negative.

COMMISSIONER DAVIS: So I'm sorry to (indiscernible - voice lowered). So this is gravity. We're talking about gravity. Our clients are demanding options because they're -- you heard from Commissioner Hultberg yesterday. You heard it from Kathy Carr. You heard it from others. They are at the point of saying we cannot do this anymore. And when we have developed this layer of transparency through the work of this Commission (indiscernible - voice lowered), they say, you know what, 200%, 300%, 400% of the comparison states? This cannot stand. We will not put up with this any longer. So it's gravity. People have always gone to the Lower 48, gone home, wherever they want to go shopping. That's going to continue, but clients are demanding a response, and in fact, we lost a major client because of our -- my resistence to this because of what Pat articulated.

But what I've come to know -- and I think I know more about it now than I wanted to know, Allen -- is that this -- and I'll put this on record -- is largely symbolic. This is a shot across the bow because, if you think about it, all right, and you told me the recovery period is four weeks -- well, first of all, let me back up. It's like any other human endeavor. You do it right or you can do it poorly or you can

do it somewhere in between. So we've tried to do this right in our development of a program, which will be available January 1st, and it applies to 12 procedures, 12 procedures because the medically-appropriate travel and the cost difference is such that it makes financial sense.

Twelve procedures are not going to drive providers out of Alaska. And we know that the uptake is fairly small. Ms. Carr described five or six people out of GCI's population who have taken advantage of this, and they're list is quite a bit longer than ours. But it is important because we don't have market forces that are counter-veiling and that's why we have 200%, 300%, 400% of the Lower 48. And this is, as Commissioner Hultberg said, not ideal, but it is one thing that can be done to create some awareness. And what I'm told by physician friends is that it's expected that this is coming by the physicians who say, you know, we've ridden this horse, but it's about over. And again, this Commission is not about pointing fingers. When we listened to what an employer can do, this was one little tiny thing. This was one of few words on one of Commissioner Hultberg's slide. It's the thing people like to talk about, I think, because it generates so much energy and it does keep people up at night, but I understand and I believe and recognize your concerns, Pat, but I really don't think we're going to see anyone's business go away as a result of this.

CHAIR HURLBURT: One historical note. Back when the hospital in Glennallen was open and Jim Pennio (ph) was a physician there and the (indiscernible - voice lowered) ran that, their charges for OB care were less than half of Anchorage charges. They were not appropriate for high risk OB cases, but for standard risk, they were. And a reasonably number of people elected to drive up the road and go up there and deliver their babies. So there is some history for that. I think Wes and then Val?

COMMISSIONER KELLER: This topic and (indiscernible - voice lowered) the whole thing on market forces in healthcare. Jim's example is a really good one, a log cabin. (Indiscernible - voice lowered) say you're building and buying a log cabin, you would really appreciate the fact that, gee, you've got someone, besides Jim, out there, so you can compare, you know, quality and price, all those kinds of things. But in healthcare, it is so -- we're so far down this road (indiscernible - voice lowered), you know, the market value is bad. I mean, you can't (indiscernible - voice lowered) competing, you know, service in another community because we have regulated it, you know, so incredibly that, you know, your hands are tied. You have to fight, you know, with your arms both tied behind your back, you know. It's just -- I think it's a real caution (indiscernible - voice lowered) the market, but I will defend the value. It really

is a quality thing, you know. I mean, I know what kind of log cabin I'm going to get because it's (indiscernible - voice lowered). I know what kind of colonoscopy I'm going to get because of this discussion, you know. I mean, it's a valuable thing to have happen to us, but what really makes me uncomfortable is the person that (indiscernible - voice lowered) the market because it's so easy to go from here all the way down a (indiscernible - voice lowered) path. We've got to further protect Larry, you know, with our policies and our laws, and when we do that, we've got to be really careful. I mean, this is just a -- it's a tough world. I mean, the market in healthcare, it's scary stuff.

CHAIR HURLBURT: Val and then Pat?

COMMISSIONER DAVIDSON: So I think it's really a question of intention with a mindful eye on outcome because, you know, these 12 procedures may not seem like a big deal now, but what happens down the road, and you know, the first auto manufacturer that said, hey, we'll just have a few parts manufactured in China or Japan or pick any other country -- or let's take an issue that's even nearer and dearer to our Alaskans. Everybody is all up in arms that (indiscernible - voice lowered) are now being made in China. Well, it just seems like healthcare has typically been about ten or 20 years behind manufacture in terms of modeling. And so just as there was a shift in manufacturing to go overseas because it was

cheaper or they were -- pick your reason.

COMMISSIONER ERICKSON: Environmental conditions.

COMMISSIONER DAVIDSON: Yeah. Whatever. Pick your reason. And now there is this huge backlash and there is this huge swing in the other direction of, oh, wait a minute; we didn't realize that, by doing that, we've impacted jobs here in America, and oh my gosh, we're not necessarily getting the quality that we thought we were paying for. And yes; it's cheaper, but are we getting the value? And I think there is a lesson there that we should be mindful of as we are exploring notions like medical tourism.

So I think it's a question of intention, and I think it's a question of keeping an eye on impact not only immediately but further down the road because there are all kinds of unintended consequences that we may not be able to see it yet. And how do we right-size those kinds of things when they happen, and at the same time, recognizing that we are in this situation for a reason? It's not working right now. And so how do we, collectively, make those decisions intentionally, being mindful on the impact and have (indiscernible - background noise) revisit the issue to make sure that we're not creating another problem in yet another industry?

CHAIR HURLBURT: Pat?

COMMISSIONER BRANCO: Wes, I think your analysis was spot on, and I don't ever want to be mistaken for advocating a

perverted system. We really -- we have big troubles, and I've known -- when did I get here this time? This time, I got to Ketchikan in 2001, so 11 years, and I've always recognized Seattle as my competition. I don't recognize Bartlett as my competition or I don't Petersburg or Anchorage. Our patients go to Seattle. And the odd thing -- and for Allen's benefit, it isn't overcharging for profitable areas and undercharging for those that are not profitable. It's a very, very perverted system of healthcare economics that we have in which we provide -- 90% of what I do is less than cost. I subsidize the operations of home health hospice, our long-term care operation. Long-term care is just about breakeven, but most of the operation we do is under the cost it costs me to provide.

The only two areas, thus far, that have any margin on them are surgery and imaging. And it's a sad fact. I can't do anything about that, but my community expects that we'll provide the full array of services to everyone without relevance on their ability to pay for it or a government payer system. It really is a very unusual market force, and Wes was spot on when he said, my hands are tied behind my back because I can't even call anybody, any other healthcare provider and ask, what do you charge for a colonoscopy? I'm not allowed. It's against the law. I can have severe sanctions from Medicare just for asking the question, not even getting the

answer. If somebody calls me and I share the answer with them, we both have trouble. That's a very, very bad system. So when you don't even have price transparency among people -- like some of us in this room are old enough to remember gas wars, gas stations (indiscernible - background noise) at cost. We're 28 cents a gallon. Oh, yeah? Well, we're 25 today. They would drive back and forth. That was price transparency at its finest. (Indiscernible - background noise) market, and eventually, they both found an equilibrium. Oh, if we both charge 33 cents, we can keep working for the rest of our lives and be friendly competitors. Friendly competitive is a goal I think we all want to have. So we're letting market forces drive us and compel us into action.

And so the other piece, the very best thing that happened is Virginia Mason got caught about eight years ago with a bit of problem disclosing or not disclosing their prices. And so the sanction that they had to do was publish on the Web their prices for their 75 most common procedures. Well, what a lesson that was to me because now I could take the colonoscopy story that's in the beauty shop that says we can go to Nordstrom's, we can go to get a colonoscopy, and we can go see a play for less than it costs to have a colonoscopy in Ketchikan. I can now begin to adjust my prices to be more competitive because they were forced into that.

My only regret now is now their data is too aged for me

to (indiscernible - background noise), but that was the one moment and opportunity where I could actually do some price analysis and try to stay competitive. The rest are just stories. Payers have a bit of an advantage because they get to see who they pay what to. I don't.

COMMISSIONER ERICKSON: Jeff was (indiscernible - voice lowered) asked a question first. I'm just recapturing some thoughts for findings, and I'm wondering if you were just making, potentially, or suggesting indirectly a recommendation related to transparency.

COMMISSIONER BRANCO: Absolutely. Absolutely. I am a strong proponent of price transparency, and I do it, and I advocate in a particular way because the difference between providing a colonoscopy in Barrow compared to Ketchikan is truly night and day. If we can have aggregated information, cost information, we can begin to see how we compare acuity adjusted, case-mix adjusted (indiscernible - voice lowered) cost per discharge, average price per discharge, we can start to move that scale and find out who the outliers are. If it's $22,000 for a routine admission to my hospital on case-mix adjusted basis, that's way out of line, and I really have to focus, and I could change what we do and be responsive to the market.

COMMISSIONER DAVIS: Were you just making the case for an All-Payer Claims Database?

COMMISSIONER BRANCO: Hell no.

COMMISSIONER DAVIS: This Commission is sliding. So I wanted to respond to your very thoughtful questions, Val, as to intent. There are two major intents behind our offering of (indiscernible - voice lowered) in general. One, first, is to respond to the needs of our clients. That's what they're demanding, and they won't be our clients anymore if we don't. They'll find someone else, which is why I said it's gravity.

And the second intent is that -- is to create -- hopefully, create some market pressure because the best outcome possible -- let's just use orthopedics because there are orthopedic procedures on that. The best outcome possible would be for one of the very high quality groups in Anchorage to say, you know what? You're right; 200% of comparison states is too much. We'll do it for 150. I'm making up numbers; 200 I'm not making up, but we'll do it for 150. Well, you know what? Now it's not economical for people to travel to get that. They should get it here. And if that can happen, if that does happen because we create some market forces, and better yet, they say and we'll work with the hospital to give you a bundled rate and a quality guarantee, that we want. That's what I would love to see be the outcome of all of this, and it just goes away. There is no reason, at that point, for an employer to pay for someone to travel. So that's my thought. That's our intent, my intent. Thank you

for asking the question.

CHAIR HURLBURT: David and then Bob?

COMMISSIONER MORGAN: I guess I approach it a little bit different, about midway. (Indiscernible - background noise.) I feel like a (indiscernible - voice lowered) at this point.

Community health centers basically have to follow regulation, have to post their prices and their methodology of their sliding fee scale, and their cost (indiscernible - voice lowered), which comes up with their Medicaid and Medicare rate, is posted. It's required. You can walk into their lobby and open up and look on the wall, and there they are, and they're obligated to post the -- they may have 100 charges because they are primary care, but 40 of them is 90% of the activity. You always have a little -- a few at each end.

So the concept of price transparency for primary care in community health centers is no big deal. Instead of sending it to the regional office and to the national office at Barrow and our UBS reports and just photocopy it again, or if we had a web-based system, like (indiscernible - voice lowered), just fold it in and there you are.

On the other hand, hospitals are different. Surgery centers are different. You just don't do it the exact same way, as long as we approach it in the way you described it on hospitals. And if we look on the (indiscernible - voice lowered) system, it does break the major categories down with

different methodologies to get the transparency. It's (indiscernible - voice lowered) data, and you can still compare what you will have to pay out-of-pocket to get a (indiscernible - voice lowered) providers and their quality.

But I can only relate a story that basically all of us have learned on a municipal level. It was four years ago -- or three years ago. It was the most eye-opening experience I've ever had with the way human beings react to any type of (indiscernible - voice lowered) with this stuff.

As Chair of the Municipal Health Commission, we had just a major budget hole. It was like -- I think it was, like, $19 to $20 million. So each of the Commissioners, working with their Directors, went through, tried to do synergies and (indiscernible - voice lowered), and it was a small thing, but it opened my eyes on how people react to things. What (indiscernible - voice lowered) well on the Community Council a year later. An organization in town got $70,000 from the health department to do youth activities. With some help from the Commission and the Director, a private foundation gave them $110,000.

So there was a big -- you know, you didn't have to be a Nobel laureate in economics -- well, we don't have to give them the 70. They now -- they had said, in their grant from this organization, we're going to give you -- we think you guys are so great; we're a private foundation. To help

everyone out, we're going to allocate $110,000 in a grant to you. Now we didn't sit down and say it, but everyone in this room knows what happened next. The $70,000 came out of the budget (indiscernible - voice lowered).

So we're sitting at the Assembly meeting, and we had our big book of budget for each department, and suddenly, 25 children, some of them in wheelchairs, come down the middle of the hall, basically to say they should keep the money. Now after some discussion, it was finally found out that several of those people that came to testify really had nothing to do with the program, but the administrators did. We worked it out.

So you're right. Any time you do something, even if it has no material effect -- it's sad Val left -- really in dollars, people react to it because they're thinking about what's going to happen to (indiscernible - voice lowered) maybe. You know, will it affect the market that, suddenly, auto parts are being made in Guam or someplace because of the way we approach? But all of us here, especially several of us that are now about 60, have to think about the next five or ten years, hopefully, and we have to try to make some adjustments to deal with these problems while we can -- while we have the luxury of having some money and some people to do it with.

So I agree with Val in some way -- I wish she was here,

but we'll talk later; we work only blocks apart on campus -- that sometimes we react with the assumption of the worst that's going to happen and not necessarily sometimes -- as Ward would say, sometimes good things happen. You know, let's, at least, have a positive note that it's (indiscernible - voice lowered) half full, not half empty.

So in my own mind, I think we should think about it, but not necessarily not do something because of what we think might happen 15 years from now. I do think we are going to have to have some transparency. We need to the transparency. It doesn't necessarily mean that the information or how it's framed for hospitals is exactly the same as surgery centers. There are different metrics. There are different sets of standards, and there are different ways of computing costs and price and when they're paid.

So once -- Alaskans like to say, what happens to work in New York doesn't necessarily work here. I think we have to be mindful that maybe what works on the physician level or the surgery center or the primary care center or the hospital is not necessarily the same.

So I think we're going to get there. I just think we're going to have to be a little careful as to how we set out what we're going to have on that flip side or however we do it. That's all. And being very careful, you can suddenly suggest something, like the Commissioner did, and pick that one thing

out of 12, and suddenly, they've got five articles or they're bringing kids down the center of the aisle at the Assembly meeting to talk about what a bad guy you are for doing this.

Just for a point of information, I can't figure out why I'm supposed to go and talk at -- get this now -- the Alaska Coalition for Housing and Homelessness this afternoon about healthcare and nutrition, which I mean, I don't know. Of all the people on the Commission or even in healthcare on the municipal level, I'm still trying to figure this one out. I worry that all those people that were at the Assembly meeting are going to (indiscernible - background noise), but.....

COMMISSIONER ERICKSON: Weren't you just warning us (indiscernible - simultaneous speaking).....

COMMISSIONER MORGAN: Yeah. I'm warning. You may have to just visit me in the hospital for the next visit. But I think what I'm hearing is we're going to get there. We're just going to have to give a little and make sure what we're doing doesn't do damage is all, right?

UNIDENTIFIED MALE: Correct.

COMMISSIONER MORGAN: Now that I've settled this, I'll settle the Israeli (indiscernible - background noise).....

COMMISSIONER ERICKSON: Did Bob have a question because I want to -- go ahead.

COMMISSIONER URATA: Well, I have some comments, but go ahead.

CHAIR HURLBURT: Why don't you go ahead because you've been waiting quite a while? And then we can.....

COMMISSIONER ERICKSON: Okay. I need to (indiscernible - simultaneous speaking).....

CHAIR HURLBURT: It's probably time for (indiscernible - voice lowered).

COMMISSIONER ERICKSON: That's exactly what we're going to do.

COMMISSIONER URATA: So you know, again, I've got 17 years on Bartlett's hospital board, and through that experience, you know, part of our -- part of the thing -- to determine our costs, we look at, you know, who was making money and who wasn't. So surgery was always making money, but ER, OB, med/surg -- or imaging also, just like down in Ketchikan, would make money for us, but OB, med/surg, ER would be in plus/minus. You know, whenever you saw a drug bust, you would see all these addicts come in because they needed pain medications, and of course, they wouldn't pay a thing because there wasn't anymore drugs on the street for a little while. But then -- and of course, they are non-payers, among others.

So anyways, procedural things are more expensive, I think, because we're having to pay, but I guess the hospitals down south probably face the same things, but I'm not sure. In our hospital, we don't have the capacity to backfill, you know, major decreases in prices depending on what our volume

is. So it's always a plus/minus.

But the other thing is, did we ever talk or have a person look at how doctors and hospitals determine their prices here? Does anybody know how that works?

COMMISSIONER DAVIS: Keith does. It's DART (ph) board, right?

(Pause -- indiscernible - background discussion)

COMMISSIONER ERICKSON: Use your microphone.

COMMISSIONER URATA: Let me -- I'll give you what I understand of the situation from what I've seen. And so like at the hospital, you know, it's illegal for healthcare providers to compare prices -- it's a Medicare rule -- because that leads to price fixing. And so that's a no-no. So what we would do is we would get as much information as we could, which is not very much, and we're not sure how accurate it was.

Medicaid publishes their prices at various hospitals in the state, their discharge charges. So that was what we would look at, and we would see where we are in comparison to like hospitals. We, of course, would look at Providence and Alaska Regional, Fairbanks, Ketchikan, Sitka, and then we would try to make ourselves competitive and that's how we would determine our prices or our price increases. And so that really doesn't give you much data or ability to make a rationale decision, in my mind, or good business.

Now I'm going to go back to the private sector in private practice. Now I want you guys to know that, when I first started out, I had to pay money out-of-pocket several times because I was a terrible business person. And I had a local accountant, but I finally got an accountant from Seattle who specialized in private practice. And there, we were taught that you look at what the insurance reimburses you and you charge at 100% of that. Does that make sense? Not really because, each year, it goes up, up, up, up. And as Mr. Davis said, it's inflationary. But we're not supposed to call clinics. We don't know what other people charge. There is no transparency of prices.

And so the key to be success is to maintain a good reputation with your patients and check the EOBs. Now isn't that a perverse way to determine prices? And that's part of the reason why we have this price problem. Did you have any discussion with anybody else that would tell you something like this?

CHAIR HURLBURT: We did not have that discussion.

COMMISSIONER URATA: Maybe that's somewhere we should go is to find out how physicians determine their prices. Well, the key is, for us in Juneau, it's like Ketchikan. We -- our competition is Seattle, but it's hard to determine what their prices are, unless they (indiscernible - voice lowered). I don't know. I'm not on the board anymore, so I don't know if

that knowledge is (indiscernible - voice lowered).

So my plea is, you know, I believe in market forces, at least at this point in time, and I think one of the keys to market forces is to know what people are charging, so you can compete with that. And I think that's a good way to determine prices and that will keep the price down and encourage competition. And then if you're not doing very well, then you have to change the way you do your business in order to keep your prices down and give people value. And let's see -- so I would speak strongly in this -- in transparency, and I think that would be done through this thing that was talked about yesterday, the All-Payer Claims Database, if that's used properly.

CHAIR HURLBURT: Wes?

COMMISSIONER CAMPBELL: If I could, just a comment. I was sitting here thinking about something John said yesterday. He said, (indiscernible - voice lowered) three (indiscernible - voice lowered), and I can give you a cost-based accounting on what the price ought to be and that just fits in with what you're saying because the decision on what to charge is based totally on price, you know. (Indiscernible - voice lowered) cost base. So maybe (indiscernible - voice lowered) transparency ought to include something for insisting on a cost-based accounting.

COMMISSIONER BRANCO: We all to need to understand

accrual accounting because, unless we're going to really radically change our perverse healthcare system, I would love to have cost accounting. That's cash in/cash out and that's really manageable. But yeah.

COMMISSIONER ERICKSON: So Dave, I'm going to get you in trouble with Val.

COMMISSIONER MORGAN: Oh, my.

COMMISSIONER DAVIDSON: If you're going to be in trouble, why don't you (indiscernible - background noise)?

COMMISSIONER MORGAN: Let me just tell her. You're talking about what I said before?

COMMISSIONER ERICKSON: Well, you don't need to help. I will synthesize. Dave was talking to your empty chair for a few minutes. I don't know if that means something, but he was pushing back a little bit on your suggestion about intentionality. So you can clarify for me and Dave, but this is leading toward we're actually checking in on process in an indirect way, but I just wanted to explain where this conversation had gone because what I want to do, at this point, is talk about state government's role and check in with all of you just to make sure we're not missing something to Val's point.

So when we were talking -- where did it go -- intentionality -- did I lose it? So the point that was made, Val, when you had to step out for a couple minutes was a

concern pushing on intentionality that we can become so over -- we could over think the possibilities so much and become so over-concerned that we don't do enough to address the process and the problem. And it made me think of a point that Jeff made though. At one point, Jeff, you suggested that, just because we're having this conversation now, insurers and providers are already starting to work together to address this concern. You said that out loud a little while ago.

And so my question is then, at this point -- because our recommendations are to the Governor and the Legislature -- what is the State's role, and what recommendations do we want to make on the part of state government to facilitate addressing the issues that we've been talking about this morning?

And so I've heard transparency over and over and over again, and I assume, because that's come up over and over again, that that's something that folks could agree is a state role of some sort. Is there something else that we're missing or just by having transparency already in this one study, hearing publicly about some of the major employers' and payers' plans, we're driving improvement in the system just by having the conversation? Do we need -- does the state government need to do something to facilitate this relationship between payers and providers or are we done with that, I guess, is my question, and it kind of gets back to the

intentionality question because, Val, when you said, how do you work together to fix it, are you suggesting a state government role in facilitating the fixing of it or is transparency it? Is that the State's role and then the payers and providers are going to work together and fix it?

COMMISSIONER DAVIDSON: No. What I was talking about was the point that I made yesterday, is we have to be careful about saying, I'm going to fix this problem that is facing me and I'm an employer, and so as an employer, I'm going to fix this problem without being mindful of the fact that we have just shifted those costs somewhere else, and what is the impact over there, and what's my part of that impact?

And so I mean, the example is of, well, we're going to pay people not to be covered under our plan. Okay. Then who is covering that cost? Okay. Well, you know, we're going to do this. Those costs get shifted, and we have -- what my point was, are we being intentional and mindful of the impact on our whole healthcare delivery system and employers, employees, citizens? I mean, if we keep squeezing this, it's not a bubble. It's a big old intestine. Call it a balloon or whatever. It is messy, and it is uncomfortable, and it is awkward. I mean, a balloon is something -- nobody minds squeezing a balloon because, well -- but I mean, it really is an intestine. It's a terrible analogy, but it's true. Nobody wants to touch it. Nobody really wants to really -- well, I

think we want to talk about it openly, but how do you move away from, well, I'm taking care of my own; I'm doing the best I can? Now if all you fools out there could get your needs taken care of, we wouldn't be in this mess. I mean, we say that more politely, but I think that's the conversation we keep having by sector or by interest group and that's -- the piece that I'm trying to -- I guess I wasn't very clear earlier and now perhaps I'm being too clear that there is an impact, collectively, and it is impacted by our intention. And my intention may impact Jeff's. Or my intention may impact -- I mean, look around the table. The things that I do necessarily have an impact on everybody else. And are we really being mindful of that complete picture?

COMMISSIONER URATA: So if you're asking about state role, I think that it's important for the State, because they have such a huge group of insureds, you know, a large employer, that they move very low and very slow because there are unintended consequences, and if they do a big shift and things -- the things that we haven't thought of occur, that could be adverse to hospitals or local providers, local hospitals and that would not be a good thing. So you know, do what Mr. Davis is doing now, that's 12 procedures, very small. Go low and small, and see what the consequences are. See if there are things that occur, and what's more interesting to look at is, you know, how do the local providers respond to

that, you know, from a price point? And I think that's the way the State should go, and what we should recommend is transparency, and you know, something that is accurate, that's reliable, and that people can look at and count on to be true.

CHAIR HURLBURT: Keith?

COMMISSIONER CAMPBELL: I guess I'm a little conflicted from the standpoint that, if you followed John's analogy yesterday, the State is duty-bound to act (indiscernible - away from mic).....

COMMISSIONER ERICKSON: Keith, can you put your mouth closer to the mic, please?

COMMISSIONER CAMPBELL: Oh, sure. If the State is -- if you follow John's thinking and analogy that the State is duty-bound to act like a prudent purchaser and with their (indiscernible - voice lowered), they could drive the bus home, wherever they want to drive it. And it needs to be carefully done, but again, we heard what the pressure the State is under, as every other employer in the state, that we've got to get control, a little handle on this, but how -- I guess my problem is, how aggressively do we recommend these major purchasers to move along this transparency route and whatever comes down the road? Pricing schedule. Cost accounting is a must, but very few people do a very good at it. Unless you have that, you can't negotiate with any (indiscernible - voice lowered) unless, of course -- the

providers, of course, whoever has got the biggest club.

So again, I don't have any answers, but we need to (indiscernible - voice lowered) the question, but this also (indiscernible - background noise) big hammer. This can't go on very much longer.

CHAIR HURLBURT: Wes?

COMMISSIONER KELLER: I can't help but throw in that we always talk about moving slow. I think that there is an urgency, and I wanted to say (indiscernible - voice lowered) claim an exemption from the Legislature, and it's all dangerous talking for the group, you know, but we do have it all figured out. (Indiscernible - voice lowered) for my peers and I'm sure they would agree that the Legislature is looking to this group, this Commission to come up with some answers, and the scary part, frankly, is that the Legislature and government has the power to make big changes, you know. We have an opportunity here, and the opportunity is we must act, even if it's risky because there is (indiscernible - voice trailed off).

COMMISSIONER DAVIS: So Val, as always, brings good points. I think there is a difference in what -- I'm trying just to put what you're saying into different words. There is a difference between shifting your costs off to someone else, which I think the example you gave was paying people to not sign up for your plans, so they're going somewhere else.

There is a difference between cost-shifting to others and making changes as an employer or providing information as an employer or negotiating with providers as an employer that actually improves cost and quality, and I think -- when I think about what Mr. Torinus described, he wasn't shifting costs. It was initial with the high deductible health plan. That is a shift to the employees, and I (indiscernible - background noise). That's okay and that's required because it leads to a greater end, which is where production awaits and improvements in quality, but everything else he described was a win-win and good for the system. Identifying a provider who has high quality, zero defects, best price, total (indiscernible - voice lowered) with a guarantee and his employees knowing that and being able to make that choice and actually being rewarded for it, that's a good thing. That's a win-win. That's a win for the system, for the market, for everything. And I think -- because I think about the approach he took. It was a very responsible approach, in that it did not just lay impacts onto others, but helped his people become healthier and provide better outcomes because they had cost and quality transparency.

So somehow in our Findings, I think there is a distinction there, and we're -- I'm not saying lay it off on someone else. We're saying find ways to help your employees become more prudent consumers of high quality care, and the

result is lower costs and higher quality, win-win.

CHAIR HURLBURT: Allen and then I'd like to (indiscernible - voice lowered).

COMMISSIONER HIPPLER: Just to follow-up to your comments, in Mr. Torinus' experience, his company actually ended up sharing a larger percentage. I believe, in his book, he was referencing the share of healthcare costs for the employee versus the company, and I think the company's percentage actually went up, even as total expenditures went down. So it is possible to change things, you know, in a way that may seem like cost-shifting, even if there is not a whole lot of cost-shifting taking place in some areas.

The second thing is we were -- oh, I thought were beyond Findings. We were streaming Recommendations a second ago.

COMMISSIONER ERICKSON: I was just updating from this most recent conversation. I was listening to you though. Go ahead.

COMMISSIONER HIPPLER: In Recommendations, there was a -- I think the first or second recommendation was related to transparency. Oh, there we go. Price transparency is required.

Price transparency is good, but price sensitivity is required to make that meaningful or price elasticity, as an economist would say. So you can know all the prices in the world, but if you don't care, it doesn't make any difference.

Price sensitivity is more important than price transparency.

And I'm not asking you all to remember what the supply and demand curves look like, but suffice it to say the demand curve should be curved. And one of the problems we're facing is that the demand curve is a straight line right now. It is not curved. That is to say, there is -- the consumer will purchase the same amount of the service, no matter what the price. The consumer does not care about the price, in certain cases. That is one of the problems. We need to make the demand curve actually curve, so that the consumer seeks the value.

COMMISSIONER ERICKSON: I was just wondering if there was a specific recommendation in there or.....

COMMISSIONER HIPPLER: I'll just leave it at that.

COMMISSIONER HARRELL: So not so much a recommendation, but a commentary. Again, I work in a different system than the majority of you do, and I would submit that, even though my time here in Alaska is transitory, I am keenly interested in what goes on here as a provider. And so completely understand, Bob, the caution in wanting to be slow because of the impact, but drawing from some of the political debates going on right now, the healthcare situation here in Alaska is reaching somewhat of a moral imperative in terms of what we can do here and must do here because, to use another cliche, the train is coming off the track, and nobody denies that. So

there is always tension between entrepreneurial risk and market forces and bureaucratic processes. That always exists. Within my own construct, the DOD is, often times, much more facile than the VA even though we're both federal entities in terms of trying to get things done, and it creates a tension and a frustration between our organizations as we try to move things through, but I think -- to add to the commentary, I think the State needs to be willing to assume a level of risk that would probably make it uncomfortable, if anything is going to get done. I think too much of an incremental approach will end up being detrimental and result in, really, a continuation or prolongation of current stagnation.

So I would urge this Body to consider -- whatever recommendation we come up with needs to be tinted with an element of risk. Otherwise, there won't be any significant progress.

CHAIR HURLBURT: I'd like to come back and maybe ask Bob a question related to some of your earlier comments, and it relates to what Allen said in terms of the normal laws of economics where, in healthcare, basically the provider controls the demand so much that there has almost never been a situation where the supply can outstrip the demand, whether it's for CT scan machines or neurosurgeons or (indiscernible - voice lowered) or whatever. So that has an economic impact. When you talk about pricing and you talk about getting

competitive information and you talk about trying to relate your prices to cost, you would not be in your specialty if your primary driver had been to maximize your income as a physician. But I think, regardless if you are a neurosurgeon, relatively few people become a neurosurgeon or physician speciality without a significant idealistic component of what they want to do.

But to mention two anecdotes. One of my former surgical partners at ANMC came to us, long-haired and pony-tailed, with the idealism that (indiscernible - voice lowered) with a lot of that, and you might recognize who I'm talking about, but he went into private practice in town. He was an excellent surgeon. He was very capable, very responsive, a good doc as far as his patients were concerned, and a good doc as far as his referring physicians were concerned because he worked hard and he was responsible. And it bothered his conscience a little bit when he said to me, Ward, he said, you know, my first year of practice, I netted $900,000. Now general surgeons don't make $900,000. They do better than you do, but they don't make that kind of money, but that's what he made in this town, partly because he worked really hard and he's really good, but then it was very easy, like the frog in hot water, and he became accustomed to that.

I have another colleague, whose specialty I won't mention because this is now, who is excellent who recently told me he

was in a meeting with his colleagues in a similar and related specialties and made the point, we need to be concerned about how to (indiscernible - voice lowered) procedures we do, but I'm sure he makes, at least, five or six times what you do.

Now in setting your pricing and needing to know the competitive information, cost is important, and you can't set your prices so high that you're not going to get business because you're going to have so much balanced billing or Jeff won't pay you or your patients will go down the street, but don't you really set your prices as high as you can get away with and to keep your business? You want to keep your doors open. You want to keep busy. You need to keep busy. And then this is not an evil thing. It's just business. And I honestly, sincerely, in my heart deeply believe it's a unique business, but it is a business. So don't you set your prices as high as you can get away with? And then a part of what you get away with is, what can you set -- because we have a third-party payment system, and if I'm your patient, you just don't sit down with me and negotiate, which means either I walk out the door or I pay it, but you sit down with Jeff or with Jim or with other payers and then you have a healthy, productive dynamic tension of how much can you charge. And isn't that really more than -- well, it cost me so much and I need to get so much more to send my kids to college or buy groceries at Safeway or whatever. You have a question?

COMMISSIONER BRANCO: Ward, I'd love the answer to that one, and it's part of this perverse business. And I don't use that word lightly. We often say, amongst ourselves, our prices really don't matter because they're not what we're paid. It isn't a grocery store, which you put a price, and that's the amount you're paying, regardless of the background of the person paying. Our prices our adjusted. Medicare does not pay charges. Many insurers don't pay what we charge. Usual and customary rates apply and so the price charged isn't the price paid. So we put very little reliance on that. We really are much more focused on what's the cost of care and trying to arrive at a balance of charging the right amount because, in the end, the self-pay individual who is personally responsible, cash out of their own pocket, they're liable for 100% of that price, that charge and that's a rough -- that's the real point of cost-shift. Those are the ones. The ones who can pay do, and I hate saying that out loud because it just sucks. It does. You know, it's the worst form of cost-shift, but it is the reality. The price charged is not the price paid.

COMMISSIONER URATA: Right now, currently, I think, we're collecting 80% of our charges, 70% to 80% of our charges, and it comes, you know, three or four months later. Medicare is, you know, at best, part of the -- you know, the thing here is because they pay 60% of our charges or less, depending on what

procedure is being charged for. So you know, we -- so I guess what you say is sort of what we do, you know. We don't look at our salaries and try to price our stuff to our salaries, although that was something that we thought we should do at one point in time, but we don't do that currently, and we don't raise our prices totally based on what the EOBs tell us to, but you know, that plays a major role. And so you know, I think that that's probably something that having more market forces in play by having transparency, by having a little competition here and there will kind of make things more (indiscernible - voice lowered), if you will, because we don't have the usual market forces playing. And so it's -- you know, it's always (indiscernible - background noise). What if we did have more market forces involved? But then you have these rules for Medicare that say you can't check prices because they're afraid of price fixing. It's so easy to fall into that fraud thing, you know. And so.....

CHAIR HURLBURT: And an assumption, on their part, that you're going to do it wrong.

COMMISSIONER URATA: Yeah. Well, I guess they do a lot of that in Florida. That's why we have RAC audits now. So we have to pay for those RAC audits, and we've passed all our RAC audits, but you know, it's just crazy. We have to take time off to go copy records. It's our cost, but it's the government's rules that say you've got to send us your

(indiscernible - voice lowered) so we can audit you, and it's strange. They -- well, they haven't found anything (indiscernible - voice lowered) so far. But you know, that's a part of where we're at here.

COMMISSIONER ERICKSON: So if there was a state law requiring all providers to post on their websites their prices for the top 25, 50, 75 procedures, would that overcome the federal law restriction?

COMMISSIONER URATA: Pardon me?

COMMISSIONER ERICKSON: If there was a state law that required all providers, or at least, hospitals and physicians to post their prices for the top 25 or 50 procedures, most performed or most billed procedures, would that overcome the problem created by the federal rule, the federal CMS rule that doesn't allow providers to share prices between each other? And Pat -- Jeff is shaking his head no, and Pat wants to say something.

COMMISSIONER DAVIS: I'll retract that head shake.

COMMISSIONER ERICKSON: But.....

COMMISSIONER BRANCO: It would not because it presumes honesty, and while I may be forthright and honest in publishing my list, it's only accurate -- and if it's purposefully audited, it's only accurate on the day that I produce it. It can change overnight. And so the constancy and the currency is really what's -- so mandating that I

publish prices will compel me to do so, but I don't know that it will prevent the federal allegations of price fixing. It may, but I don't think so.

COMMISSIONER ERICKSON: Yes, Jeff?

COMMISSIONER DAVIS: So a couple of things. I was shaking my head because price transparency sounds really easy, but it's not. It's hard work, and we're working hard at it, and there are so many things that go into it. For some procedures, knowing what that things costs, yeah, that's -- I mean, an office visit, you can compare that. When you get into procedural stuff, what's the infection rate, how much did the surgery center charge, what was charged for anesthesia, and was there imaging, all of those things, so you really have to start looking at cost per case. But I think our recommendation or our finding that a recommendation in transparency is required is right, but we're going to have work -- if the (indiscernible - voice lowered), we're going to have work really figuring out how you do that in a credible way. It takes a lot of actuaries' time to really figure that out. So I'll say that.

So I think, you know, we're on to something here. I don't know what, but I think Mr. Torinus actually led us down this road yesterday.

Three years ago, I was an Assistant Administrator in hospital, and I'm guessing things haven't changed much, but

I'll check it out with Pat. But what we did to figure out what our prices were was to figure out how much is it going to cost to run this organization, how many things are we going to do and sell, who is going to pay how much of that -- you know, Medicaid is 60% of what we charge and Medicare and blah-blah-blah -- how much is private pay, go through all that giant math problem and figure out here are the 1,000 we do. What do we have to charge for each one of those to make this all add up? So it had nothing to do with the cost of that particular service. So that's how you get $100 Band-Aids and $100 aspirin because you just attach it to something.

So I think what Mr. Torinus was arguing is that, by doing the things that we described earlier, by making people have some price sensitivity, then, all of a sudden, you care about price, and when you start talking about price, then the person providing the service has to start caring about costs, but it doesn't happen until you get the first thing. And then once you start caring about costs, then you get a more efficient system.

COMMISSIONER ERICKSON: Which is a consumer-driven health plan.

COMMISSIONER DAVIS: Exactly.

COMMISSIONER ERICKSON: So.....

COMMISSIONER DAVIS: It's more things.

COMMISSIONER ERICKSON: So what does the state government

need to do, just provide the leadership.....

COMMISSIONER DAVIS: I think -- it's perhaps leadership. I think that the State (indiscernible - simultaneous speaking).....

COMMISSIONER ERICKSON: State Employee Health Plan setting an example.

COMMISSIONER DAVIS: Other than that and transparency, I don't see the (indiscernible - voice trailed off).

COMMISSIONER URATA: Yeah. I think the other key part is that the employees need to have "skin-in-the-game." I looked that up on Google and showed Valerie that it's a statement by Warren Buffet about people owning part of the stock, you know, the CEO owning stocks. They have skin-in-the-game. So the employees need to have skin-in-the-game and so their deductibles should be a lot a higher than what they currently are, but that's a challenge because it's, you know, union negotiations. They already pay for part of their premium, but I think they need to pay a higher deductible and maybe then they will have skin-in-the-game. That's the key part.

CHAIR HURLBURT: Larry, did you have something a while ago?

COMMISSIONER HIPPLER: I just thought I'd throw that out there because I hear a lot of people say this, but deductibles, for me, they've never driven behavior ever. I am a consumer, and it's never changed for me because, once you

meet your deductible, right, then the percentage kicks in, and the percentage is a lot more meaningful than the deductible. So there are lots of percentages out there, but if your healthcare plan pays a certain percentage of UCR, my personal experience has been that's a much more significant driver than deductibles. I'd just thought I'd throw that out there because, as a consumer of healthcare, that's been my experience.

CHAIR HURLBURT: But I think deductible is code word for deductibles, co-pays, and co-insurance, which are three ways of sharing the cost. And then what you're saying is maybe that co-insurance, where you're responsible for 20% regardless.....

COMMISSIONER HIPPLER: My lack of medical terminology (indiscernible - voice trailed off).

(Pause - background discussion)

COMMISSIONER MORGAN: That's what we used to do (indiscernible - voice lowered). If your device, like this, would go off, you would have to stand up in front of the group and sing your college or high school fight song.

UNIDENTIFIED FEMALE: Go ahead, Representative Keller.

COMMISSIONER MORGAN: I think, when you read John's book and as you look at the systems that those businesses are putting into, it's a combination, not just a hybrid. It's not just a hybrid. It's a bunch of things that they put in place

to get every -- to get the consumer, the employee to think about it, to think of what he is using and how he is using because he's going to have to pay for some of it, if not a percentage, of how it will affect him personally, you know. So the person doing the checkbook who, in most households, though we men don't like to admit it, our accountant is usually the wife who balances the checkbook, control that. They -- the sharpest pencil I've ever seen is my wife doing -- purchasing stuff, you know.

So I think what the State can do is lead by example where it can, prepare a process where -- his biggest problem, when you read his book and hear his talks -- and I've heard his two-and-a-half hour version two years ago in Boulder -- was getting what we're talking about right now. What does it cost? What's the price? And what is that? So then he could develop his elasticity curve. And I think that's what we could work on.

I think Medicare cost reports and FQAC for primary care is helpful start. It's not exactly cost accounting, but it's about as close as you're going to get without developing your whole system. I've worked in a state where hospitals had to follow (indiscernible - voice lowered), just like (indiscernible - voice lowered). You can put stuff in, like that, but (indiscernible - voice lowered) reimbursement, and I've always worked either in patient accounts or

reimbursement. We have a saying -- I have it on the -- I took it down when I came to (indiscernible - voice lowered), but we used to have a board saying, check the rules all you want; I always make more money. So you could put a lot more stuff in there, if you want, but hey, believe me; there is guys, like me, who will figure out a way to gain the system. I'm just -- I'm a real -- I'm basically the (indiscernible - voice lowered). I used to do, what does a DRG cost? So you could game out whether you want to provide that DRG, based on the reimbursement picture we get, you know. We've had the box with, you know, high volume (indiscernible - voice lowered).

So I think we can set the stage so we can get -- so there is, at least, a line through leadership on the state and to do what we did yesterday. I think simply us, a couple of companies will come up or bring John in, and I'm willing to bet you, from what I saw afterwards, he's going to be back with certain groups -- will help. Just doing that will help, and we used to -- I also -- at Prov, when I worked there, we called it the Squawk Factor. Simply doing what we're doing now, we'll begin to lead entrepreneurs to figure out ways of doing better, raise quality and lower price, not just shift because, between the systems, I don't think shifting -- that's just so delusional. But we're going to have to get that line, make that elasticity line become a real elasticity line, and I think we can do that by where we're going and where we're

getting at. We can maybe provide websites where we can put things and post things, so people -- remember, 16% of our insureds are buying it and so they kind of need access to their information. They're not exactly like John where he has a company at his disposal where he can sit down and negotiate and find out information. And also some of the Trusts and some of those groups need the access to it.

As we said in our journey almost three years ago, there is going to have to be a lot of different things and a lot of different solutions. We're not going to find a magic bullet. And I know that's what Warren Buffet defined as what skin-in-the-game is. We, in the Southeast and the South, where we were developing our institutions and our states and counties in the 1600s, 1700s, and early 1800s, where the colloquialism comes from, I won't exactly explain it here, but it's a little more graphic than -- it had a lot to do with our relationship with some of our neighbors, but I'll explain that not on tape, if you don't mind. It's kind of repugnant, but the original use of the word had to do with militias and who they were dealing with, if you really want to do the history of it.

So to get to where -- we're not going to go there. So to get to where I think we want to get to, I think we're doing it. The market is working in this (indiscernible - voice lowered). I think we're getting there, discussing it, bringing an education, and also starting to move the markets

and employers to do it. So I don't think we have to come up with -- I, personally, don't -- (indiscernible - voice lowered) to come up with a recommendation saying everybody has to do "X". I think we can come up with some stuff that we need to do, but we have to sort of build it with different information as we go through. Your system of price and costs is different than his, and I think we need to work our way through that. It will take a little bit more time, but I know we can do it, just simply by the people out there who (indiscernible - voice lowered). So that didn't help any, but hey, I had to say it.

COMMISSIONER ERICKSON: Jim was next and then we should wrap-up.

COMMISSIONER PUCKETT: I was going to share that, from what we heard from our consultants and actuaries, the most effective thing that will drive the consumers to take interest and accountability, whatever you want to call it, is not a deductible. Although if the deductible gets high enough, obviously, that's going to do some of it. They paying the percentage of the cost every time they go for a procedure. So it would be a model. The ideal model, according to them, would be the companies or the insurance will pay 80%; you've got 20%, no matter what it is. So that's what they say would be the most effective to drive consumers to take a real close look at what they're doing.

COMMISSIONER ERICKSON: Let's wrap-up for a break. Dr. Ferguson is just emailing me and saying that he is on his way and will be here in just a few minutes. So we're going to transition to telemedicine next, but just for folks in the room and for the groups that are wrapping up, there are lots of notes of ideas for findings and where we're at right now with the general concepts for recommendations. The price transparency is required. Price sensitivity is important and that state government is leading by example, recognizing that, and should continue to and that the Commission should continue to engage the business community in learning about opportunities for increasing value in healthcare. So there is just some preliminary findings. Yes, Allen?

COMMISSIONER HIPPLER: A question, are we discussing the All-Payer Claims Database?

COMMISSIONER ERICKSON: We were not going to discuss All-Payer Claims Database today, but if anyone has some questions about it in next steps, we can do that after the break. Let's break for 15 minutes, and we're five minutes early. If we could try to be back by ten after ten, that would be good. We don't have a whole lot of time today.

9:54:16

(Off record)

(On record)

10:10:33

COMMISSIONER ERICKSON: We are reconvening and getting a little punchy at this point in our meeting. Thank you very much to Dr. Stewart for joining us this morning, breaking away from another meeting, and hopefully, didn't speed across town.

DR. FERGUSON: No.

COMMISSIONER ERICKSON: Drove the speed limit across town, and he's going to share with us a recommendation that he and Paul Cartland developed together, Paul Cartland, the State's Health Information Technology Coordinator. And Stewart Ferguson is the -- remind me of your title, the ANTHC Chief Information Officer? Chief Information Officer with ANTHC, but I wanted to, first, remind the Commissioners to look -- we've had the draft Preliminary Findings from our June meeting related to telehealth, again still just in general concept form, and also Recommendations that are in your handout on slides -- starting on slide 25 and going on to.....

CHAIR HURLBURT: Page 13.

COMMISSIONER ERICKSON: .....page 13 of the actual handout document. Opportunities. And a reminder to consider these in the context of our current recommendations regarding telemedicine, which is in the other handout that I provided of our current recommendations and our one recommendation related to telemedicine, or actually, a whole series related to health information infrastructure, but there were two specific to telehealth/telemedicine, and one is that -- it's encouraging

state government to work with federal and local partners to ensure Alaskan communities have access to broadband telecommunications infrastructure and that the Department of Health and Social Services investigates innovative reimbursement mechanisms for telemedicine services. And since these recommendations were made, a lot of ongoing and continuing work is happening in both of those areas related to those recommendations, and we have updates related to that in our reports from 2010 and 2011. So I just wanted to explain that and provide some context.

At our June meeting, there were a couple of different ideas, and just looking at those slides related to recommendations, one was that the State develop pilot telehealth projects to foster the collaborative relationships both between the different delivery systems and different sectors and also between payers and providers. And we also had an offer from Dr. Ferguson and Paul Cartland to look into making some recommendations related to a common, centralized network service for facilitating telemedicine.

So as background, especially for folks in the room and on the phone who aren't familiar with our work and our conversation that we had back in June -- and I'm going to open up a separate presentation, and it's on our website as the Health Information Technology Telehealth Presentation. And I'll turn this over to you, Dr. Ferguson.

DR. FERGUSON: I apologize for being late. It's great to be here. Just to check, how long -- I don't think it will take that long.

So one of the roles I have this year is I am also the President of the American Telemedicine Association, and you know, sometimes when you step into those roles, you get a chance to be less involved in the details of running the program and you start to look at how other people run their programs, and it gets you back on 1,000 foot view so often missing in our daily lives.

And I've been meeting and having conversations with some excellent international leaders in telehealth, and I've really been interested to try to figure out where are places seeing linear growth in telehealth and where are places seeing exponential growth in telehealth. Lots of differences in those models.

So I met with the CEO of a company called American Well. Interesting company. They sell telehealth mostly to employee benefit plans. So what they're seeing -- they're actually at the point now where they have four million consults a year. Huge growth. There are other companies that have that. There are programs out there, and the best example that I often use is in Ontario, where they're doing 200,000 consults this year. They expect to be at a million consults by 2015.

And so the question is, how do you scale and design a

system so you can get this exponential growth versus what is seen as linear growth? And the problem, I think, that we have right now in Alaska is we have a system, at least, within the AFHCAN where the way that we will get more usage is by having a few more providers use the system or a few more specialties use the system, but we're not adding sites. We're not adding patients. We're going to probably start to hit a point where we'll do more cases, but it will not be exponential growth.

And the one common thing in place of exponential growth is they make it really, really simple for patients and providers to meet, I mean, and that's the trick of all of this is, as long we're trying to work all the details in between that and the patients can still only see the same providers and how will we design it, we start to see this linear growth. And I think, in Alaska, we're really not designed for exponential growth, and I'd like to talk a little bit about what might work in Alaska.

So the problem statement -- Paul did a really nice job with your new site, by the way. He did a great job. You know, basically, the doctors aren't where the patients are. We know that to be a problem in Alaska. I think, with the growing choice of providers that we see in the future, that might become an even bigger challenge for us, and of course, there are things you can do to (indiscernible - background noise) to mitigate this.

The solutions. So we do all of these, at least in the tribal health system. We bring the patients to the providers. We bring them to Anchorage. We fly them around. We try to get providers out to the regions as much as possible, but that's with certain limitations. And of course, then we try to connect them electronically, and we've done more and more of that every year.

But Paul and I kind of fleshed this out, and this is kind of my view of how I see it. We have patients that are, often times, seen in organizations, and over here, we have providers of organizations. And the question is, how do you connect them? And we have a whole hybrid system in Alaska of connecting folks. We have the AFHCAN system that uses primarily store and forward, some video with ANMC. The State of Alaska has a system on the Corrections side. API, Alaska Psychiatric Institute, connects people with GCI to the product, ARTN. There is a whole layering of solutions, but you really have to kind of -- if that patient is going to see that provider, you've got to try to figure out which solution is going to get you to that provider, and it's not really that easy to do it. AFHCAN is functioning. It works really well, but if I want to add on API or another facility, it's a little bit more complicated, and it might work or it might not work.

So we have multiple networks, multiple players. We have multiple health communication companies, which we often end up

interacting with them, multiple different kinds of equipment up there. The connections, I don't want to say they're unreliable, but connectivity is a challenge because we have one organization managing the core system, the video system, another company managing the connectivity, another managing the other end. It's not uncommon for us to be unable to sustain video. We probably have about 10% of them that don't work for us and that might be okay, if you're willing to accept nine out of ten times it work, but it makes it very scary, to me, to offer emergent care, telestroke, and some of the things that we could really offer if we could (indiscernible - background noise) to reliable connectivity and manage and support some centralized system.

The other thing is this whole idea of a service end point index or a provider index. One of the challenges the way that they function now is that, if somebody comes to us and says we would like to offer services to the tribal health system, mental health services, how do you market that? How do you advertise it? How do you let people know what's out there? How do you let them know the options and when they are available and how that would work? We can do it within our system, but from a statewide perspective, if you're a provider and you want to offer services over telehealth, there's almost no rational way, at this point, to let people know you are available and to tell them how to connect to you and how to

make it work. It's just really challenging. So we don't have a really good solution, so it's going to grow linearly because you might get a relationship with one organization and you might provide them services, but that doesn't get you to the next organization or the one after that. It has to be so simple that, when you connect to one organization, you connect to anyone that wants to buy your services and that's how you get exponential growth.

So there is no listing of providers. We don't know who is out there, who wants to offer services. We don't have a way to kind of let people know they're out there.

Scheduling is a real challenge when you're an organization with providers (indiscernible - voice lowered) patients. How do you know who is available when? And then, of course, there is always the question of billing reimbursement.

So really, this is kind of what you'd like to do. You'd like to kind of take everything that's in the middle to make it really easy for folks. So if you're a provider and you want to hang up your shingle and do telehealth, the one place you go you let people know you're available and know what services you offer. You let them know what you're credentialed to do. You let them know when you would like to offer those services, and anybody that wants to buy those (indiscernible - recording interference) to make it work.

Now the reason I bring this up is, when I look at American Well and I look at Ontario Telehealth Network -- two very different systems, one for profit, one for (indiscernible - recording interference) healthcare system -- that's exactly how they do it. You buy into their network. You pay a certain amount per month, but then after that, you know who is available. You know when they're available, and you can connect to those folks. And the level of centralized services can vary. It can be a complete service. So if you're a patient and you want a dermatologist, (indiscernible - voice lowered) dermatologist. I'm available at nine, ten, and 11 tomorrow. And they'll find a dermatologist for you. Or it can be a little bit less full service. You can actually have a relationship with a dermatologist, but because he is connected to that and you're connected to it, you can actually talk together and schedule a time.

So I keep thinking that, if we're going to do this in the state of Alaska, which I think is really where we need to go to really make this work, there are some complexions that we have to face. You know, who would own this? Could it be done through a for-profit? There are models out there. American Well is one example. A not-for-profit? In Ontario, they're all not-for-profit in the telehealth network (indiscernible - voice lowered). Those are all options.

From an administrative model, a couple different options.

They're pretty clear. Central (indiscernible - voice lowered), centralized. What we have right now is really a decentralized model. People (indiscernible - voice lowered) their own networks. They manage their own equipment. I think we need to move towards some level of centralized services. Centralizing management of video would be a definite plus, 24/7 support that's centrally managed and so forth.

In terms of service options, I think, if we did this, we should be really looking at a full suite of services. So for instance, we do a lot of what we call store and forward telemedicine. The software is available. We'll give it to anyone in Alaska that wants it. So -- and once you've got it, (indiscernible - recording interference). So that piece of it is easily solved.

The video, the equipment is out there. The best (indiscernible - voice lowered) videos are more sophisticated end points. The challenge is managing that and making it all work together.

Scheduling is a service that is not easily solved, but can be. There are models for doing that. And of course, the billing, you want to think how you're going to bill for these services.

I can tell that, in Ontario, they have a model similar to what we have in Alaska in terms of a payment structure. They find that the average payment for a telehealth case can be $70

to $150, but they figure the overhead for running the entire provincial system runs around $20 (indiscernible - background noise). So that gives you a sense, and you have to kind of decide, if we built it and we could scale it so it falls around that $20 mark, does that provide the benefit that we want out of it? And I think that's an interesting business model that we should be looking at.

And then this (indiscernible - voice lowered) telecommunication infrastructure, and we have some, I think, very customer responsive (indiscernible - voice lowered) in the state, and I think they'd be very interested in trying to think through how to make this work for us.

So Paul and I were talking about how you could do this, and I think what we need, perhaps, is an independent entity who can actually take on this responsibility of managing a directory of service providers, the physicians and the organizations, who is available, who is providing services, do the scheduling, help people get connections, and it's very important providing that tech support, and potentially, providing billing services.

The Ontario model there is the pure provider, and you provide service through the system. They actually turn around and pay you. That's a provincial healthcare system, so it works for them, but you wonder if that's something that you may be interested in.

So our recommendation to this group is that we should really look into developing a statewide -- he says Health Information Exchange. I'm not so sure that's the word. We have a statewide Health Information Exchange, and it's managed through (indiscernible - voice lowered) and the Alaska e-Health Network. I think I'd like to layer this on, and if (indiscernible - voice lowered) is the right model, that would be interesting. They'd exist, you know, right here, funded by the State, to provide a Health Information Exchange, but some organization that would take on the directory and the other things that we talked about. Sorry. That is the last slide.

So that's the concept, and I think it's big picture thinking. It's thinking through what we can do to really leverage this in the state and make it that much easier for patients and providers and get the services they need. So did I go too fast?

COMMISSIONER ERICKSON: No. No. It was perfect. Do you want to take questions?

DR. FERGUSON: Absolutely.

COMMISSIONER URATA: Does any of this need to be legislative or money from the Legislature? You know, that's who we answer to.

DR. FERGUSON: So in terms -- you know -- good question. It's going to take money to get this off the ground. So if that requires an ask (indiscernible - background noise), but

I'm trying to think. There is a question on legislation. I'm not sure if it requires legislation in this state. I think we have most of what we need to do. We have reimbursement strategies. We have -- supported through the medical boards.

COMMISSIONER KELLER: What do you see as the biggest thing preventing this from happening? If we had recommendations to move forward, what kind of pitfalls are out there? Would there be some of these entities (indiscernible - recording interference)? Would there be proprietary interests that would get in the way? (Indiscernible - voice lowered.)

DR. FERGUSON: There are some technical challenges. There are probably some business challenges. The technical challenges are that everybody has kind of got a system, and finding a way that they can keep their existing system, but make it work in a larger system would have to be worked out, but it can be done. We just have to kind of figure out that. And we take an investment in the core equipment and some commitments from the organizations to participate.

I could be naive in this, but my impression is, when we talk to the health cos. and we talk to the organizations, people really support this because, right now, it's a real challenge to do what we're trying to do. I mean, we see the advantage of this almost immediately. I really do believe that. It will create competition in the provider market. I think that (indiscernible - background noise), but it would

open up that market for folks. I think you'd have to be really clear if this a market open to Alaska providers or out of state providers. That's something that we have to be clear about, you know, and that's just a matter of how far this is going to be allowed to extend. I would be very comfortable right now that this is for Alaska providers for Alaska patients, but (indiscernible - voice trailed off).

CHAIR HURLBURT: Keith and then Pat?

COMMISSIONER CAMPBELL: This may be a question for Pat. It seems that I remember that we actually got a grant or equivalent in most of the institutions in the state; is that right?

COMMISSIONER BRANCO: That is correct.

COMMISSIONER CAMPBELL: So that basis is (indiscernible - voice lowered).

CHAIR HURLBURT: Pat and then Jim?

COMMISSIONER BRANCO: My question goes along -- you came in at the tail end of our conversation this morning, and I would view this as a consumer-driven product generally for the patient consumer. And so I don't see pricing information and transparency on there, but I would certainly hope that you mentioned opening it as a good vehicle for competition. That might be one approach, so that we become more competitive on the (indiscernible - voice lowered) we offer through this network.

COMMISSIONER PUCKETT: My Division has been very actively researching ways to reach out and touch the members that we serve out in the rural areas, and we found some real limitations on bandwidth availability and just simply being able to connect where some of our members are located. And it just looks, to me, like it would be more even more demanding on the technical side. So are we sure that we would be able to -- if we were to get somebody to (indiscernible - voice lowered) this, we'll be able to (indiscernible - voice lowered)?

DR. FERGUSON: So I do -- it depends who you're trying to reach. So for instance, we can reach to pretty much every village clinic in the state of Alaska with (indiscernible - voice lowered) bandwidth to do video, but we wouldn't be able to necessarily reach to the patient's home or smaller locations. So it really depends where, in the village, you're trying to reach, but we have a -- you know, we have an incredibly well-funded infrastructure for bandwidth in the state of Alaska for the health side. So as long as that's the focus and we're not trying to (indiscernible - voice lowered) patient's home, we're probably going to be fairly good.

COMMISSIONER PUCKETT: Thank you.

CHAIR HURLBURT: Jeff?

COMMISSIONER DAVIS: Thanks. Clear, as always. Appreciate that. This is really, I think, of interest and

perhaps something that we could sink our teeth in. I'm not sure of the particular tactics, but it's (indiscernible - voice lowered). But given our geography, given our distribution of people and providers and the fact that we have an infrastructure that's already there -- it's just not being accessed -- there seems to be an opportunity to create some efficiencies and really to extend the reach of providers that we have to primary care and others to bring a lot of waste of the system. So it's very intriguing.

And to your recommendation, I think I like the way it's structured. You were surprised when he said HIE, but there's a couple things in here. It's the Department investigating having AHEN develop a plan. So you're suggesting some work behind -- say okay, well, what does that look like (indiscernible - voice lowered)?

Part of AHEN -- I'm going to put my AHEN board member hat on because this could, perhaps, be one way, by expanding what AHEN does, that you can get to a sustainability plan for the statewide HIE because now they're selling something. I keep forgetting that could be an advantage, but I think this makes a lot of sense and what I'd really like to see, in some form or fashion, (indiscernible - voice lowered) go down this road, and if the Department can do it, then we're not in the Legislature asking for money (indiscernible - voice lowered). Thanks.

DR. FERGUSON: If I could just add one thing to that, it actually, I think, truly leverages your investment in a Health Information Exchange because one of the challenges we provide in telehealth, especially if you do provide video, is you do need to see that patient record. And if you layer this right on your HIE, the provider can see the patient record as they're talking with the patient and (indiscernible - voice lowered) that you can actually have that encounter documented and move through the HIE back to the source EHR where the patient is. And so now you start to really communicate and connect the dots.

COMMISSIONER DAVIS: And give HIE a role that it didn't have before.

DR. FERGUSON: Absolutely.

COMMISSIONER MORGAN: A lot of the primary care providers are already doing some things. Also some of the -- especially in the tribal system, I believe they're actually using this to consult with other specialists that are not (indiscernible - background noise). I don't know if that's tourism or not, but if you don't have a specialist, can't get a specialist, you've got to get to (indiscernible - background noise).

I actually think it's an intriguing idea. No information system, such as AHEN, currently in the United States, actually is self-sufficient, as far as I know. The real problem is, like you said, having the same thing that Facebook has, in a

way. There is always monetizing, you know, to come up with a way of funding it. I know that budget restraints on the state level, I believe they had a -- I think it's about (indiscernible - background noise) appropriation, if I'm not mistaken. (Indiscernible - voice lowered.) That could be a significant portion that may be (indiscernible - voice lowered), if they don't find some way to monetize it, some ways. Why agree that laying it on the structure that's already there -- but it sounds like we've got a bandwidth problem, and now to add more to it, we're going to have to look at expanding that. Is that really the big roadblock? Everybody sees the value, sees the efficiency, but making sure there is connectivity at both ends is appropriate.

The other thing is I can tell you on the reimbursement side, especially on the governmental side, the way that reimbursement is set up, it's kind of tough to get everybody in play. It's getting better of how that's lined up, but I think we may need to visit that, not so much to raise it, but to make it more equitable at both ends of activity and who is doing that, if I've got it right. Correct me if I've got it wrong on that, especially on specialists. It's really hard. You might need to look at that reimbursement rate, especially in our Medicaid area, which, I believe, is the way that the (indiscernible - background noise), just basically keep some providers out of the process for some of this. It's not a big

part.

So we've got -- so correct me if I'm wrong, for heaven's sake, but the big bump is bandwidth. It's not design. The second is getting our reimbursement processes working better so you can get reimbursed because in virtually a large number of Medicaid billing manuals, for that provider that can do it, there are two pages on how to get reimbursed for telemedicine, if that service is included. So we've got the bandwidth bump, which is a technology problem. (Indiscernible - voice lowered) and will keep the cost down and also lead to an avenue of a sellable product, which will relieve, hopefully to Wes' brow, of not having to pay -- to put this much money in.

Thirdly, we probably need to look at how to reimburse, especially on the Medicaid. So those are the three questions I have. Maybe two of them are softball questions. You know, go ahead.

DR. FERGUSON: I'll take the easy one, the bandwidth one. We have -- we consume 60% of the federal (indiscernible - voice lowered) for bandwidth connectivity for healthcare, the NUSAC (ph) program. Sixty percent of it comes to Alaska; 40% goes to the other 49 states and that is for (indiscernible - voice lowered) to the villages for the most part. That connectivity, when we look at it, is vastly underutilized. Yeah. It's vastly underutilized.

So one of the selling points for this is it's a state

initiative to better utilize fairly expensive connectivity that's out there right now. The -- one of the challenges you will have -- the connectivity -- the out-of-pocket costs for connectivity to the villages for most of the sites is that great, and what sites have done is they (indiscernible - voice lowered) connectivity, a link, like a T1 link, and if they (indiscernible - voice lowered) villages at the (indiscernible - voice lowered). So I think, if bandwidth does become a problem, you will find places willing to add connectivity. So that's the connectivity issue.

The reimbursement rate -- you know, one of the things that we really ought to do before we get too far into this is really talk to the providers to see if the reimbursement rate right now will motivate anybody to participate because, if nobody participates, it's really a waste of time. And you might, in that process, start to look at different models for reimbursement or different strategies, and it's really, truly a business plan at that point. You know, if it (indiscernible - voice lowered) value and it takes as much to get people to participate, is it still worth it?

You said you had three questions, and I tried reimbursement and connectivity.

COMMISSIONER MORGAN: The other one, in talking to the physician in charge, your colleague in charge of pediatrics.....

DR. FERGUSON: (Indiscernible - simultaneous speaking)

COMMISSIONER MORGAN: Yeah. Hirschberger (ph)?

DR. FERGUSON: Dr. Hirschfield.

COMMISSIONER MORGAN: He had some programs and some highly intensive type of pediatric cases that are statewide, and there is probably another program, like that, where there is maybe four transports into Anchorage to work with the family and to work with the child, and two or three of them could be done by telemedicine, but you have to be such high level specialists in that process that the current reimbursement rate, especially in Medicaid, doesn't come anywhere near paying a third of the costs of it. This is a very small part of this. So now I'm probably explaining this badly, but these specialists are -- you know, instead of four round-trips, you may only need one to two, if you could use telemedicine, but the reimbursement for telemedicine is so small for these specialists that, to bring them in because you can't pay for the specialists, most of them are either from out of state or there is only one in the whole state or two in the whole state. It's a small part, but it is one of the three questions I had. Is this, like, ringing a bell or.....

DR. FERGUSON: Oh, no. No. So I started -- so we've been working with -- Dr. Hirschfield is a pediatrician -- he's not a specialist -- at SouthCentral Foundation. He has been talking to his colleagues that provide sub-specialty for the

children, and some of them work at our corporation or ANMC. Some of them are at Providence. Some of them are in private practice. And he has actually got pretty much most of the folks in Anchorage to agree to provide telehealthcare to our remote sites. So for them, they see the value. They like to do it.

For our patients, it means they don't have to come in and see one specialist on Monday and wait until Wednesday for the next one. We could probably try to coordinate those and do them back-to-back, you know, or even they're a different date, it's not as much of a challenge.

I was kind of surprised. These specialists are actually willingly engaged and do this, and (indiscernible - voice lowered) estimates that about 20% of Medivacs for children in the YK Region would be avoided if we could actually provide this service, but that's another example of the challenge. So we -- my company has to go get them connected, make sure their video is available, find out their schedules, communicate with the patients and providers. It's more of a challenge for the coordination, the level of coordination than anything else. So I think the providers will participate. They seem to want to. They want to provide the care. And again, we'll figure out the reimbursements, so you don't have to incentivize them.

COMMISSIONER URATA: Do you see a role for primary care in this situation?

DR. FERGUSON: Yeah. Absolutely. You know, we -- you know, 75% of the telehealth that we provide right now is primary care, but that's only through community health aides and family physicians at the regional level. It's hard to get family physician docs on the regional side. So there is an opportunity, I think, to try to do some of this with family physicians not located at the regional level. So there are some opportunities, I think. Yeah.

The Alaska Native Tribal Health Consortium is being asked to look at developing a locums program to try to have a cadre of family physicians that can out to the remote sites. So we know the shortages. I guess the question is, how much of that can be done over telehealth? But we do a fair amount of it right now. And even if we're just using that to try to triage the patient -- we do a lot of triage in family care. Can we wait until tomorrow for a flight or do we need to Medivac that patient? So there is a lot we can do that's -- and then it comes down to -- it's not just diagnosing the patient. How do you stabilize them? How do you travel them? Can you make a travel decision?

CHAIR HURLBURT: Say, right now, they do it by phone, right?

DR. FERGUSON: We do a lot of video and store and forward on the tribal health system for those kinds of decisions, but otherwise, yes; it would be phone and fax. We don't have the

technology.

So and then there -- think about the other things that we can do. So we have CT scanners now in most of our regional facilities. When you have an ischemic stroke or you have a stroke patient, you've got a very short time to decide if you want to, you know, (indiscernible - voice lowered) in those patients, and if you do it, they have to be monitored by a neurologist as you do it and watch for signs. We've love to do that. The problem is it's going to happen at midnight. It's going to happen when my staff isn't there, so I need 24/7 support.

So we're looking at going with a company called InTouch Health because they offer 24/7 support of their systems out in the village. In fact, I'd much rather build a statewide solution for that, that we can all leverage.

COMMISSIONER URATA: You know, we're connected with Providence for that stroke system. So that would be kind of duplication -- if Providence can't join the (indiscernible - voice lowered) because they have a stroke specialist who is on 24/7 with his computer in his car, and he stops, pulls off the road, and connects, and we talk to him and send a CT scan to wherever he is, and he punches in orders, and we proceed, and then we (indiscernible - voice lowered), but the patient gets the clot (indiscernible - voice lowered). So have you talked to them about how theirs worked? They're supposed to be

trying to develop more spokes in their wheel system. They follow the protocol from Jordan.

DR. FERGUSON: So right. Exactly. The problem for Providence to expand, say, to Kotzebue is that we have to guarantee the time, and Kotzebue is up 24/7, and the Alaska Tribal Health Consortium has a piece of that connectivity, GCI has a piece, and Kotzebue has a piece. So that's the challenge. If you have a system that manuals and monitors and keeps the (indiscernible - voice lowered), places, like Providence, can offer services to a larger area as can everybody else.

COMMISSIONER URATA: So we have a joint system solution?

COMMISSIONER DAVIS: So I think that's the beauty of it, Dr. Urata. That's -- so you know, I sit here at Commission meetings and listen with envy as Stewart describes the stuff that ANTHC has because it's like, you know, how can we figure out a way to get that, so the people we serve can also have, you know, access to these things and the people that Jim serves can have access to it? So that's what I really like about this. We've looked seriously at American Well because they have in Hawaii. It's deployed in Hawaii, and we're, from a medical services standpoint, a lot like Hawaii. We've got disparate, distant population centers, specialists in Honolulu trying to, you know, deal with people, a lot of transport issues. We're very much like Hawaii. And it made so much

sense because it dealt with those, and it leveraged what you already had. When they described the situations to primary care where you have primary care docs that, perhaps, want to work part-time or that physician who is also a parent and now their kids are in bed and it's 9 o'clock and they can log on and they can work for a couple hours because that's what they want to do -- I mean, so it uses the resources that you already have. It deals with the situations (indiscernible - voice lowered). We're recreating it over and over and over again, rather than having a broker package. So I'm really excited about this option to look at it from this. I need to look at this further and put together a -- you know, somehow cooperatively put together an entity that leverages what we already have rather than (indiscernible - voice lowered).

Just one last thing. In talking with the group plan in Hawaii who was -- so we didn't go (indiscernible - voice lowered). Oh my gosh, they value their (indiscernible - voice lowered) products. They were so expensive we couldn't do it. I don't (indiscernible - voice lowered).

Anyway, in talking with the Blue Plan in Hawaii about their experience, where they found a lot of use was with specialists for, you know, cardiologist to be able to do the pre-work and post-work with someone who is distant rather than travel, which is as David described, but the specialists used it a lot more than they had anticipated with the pre and post-

procedural care. Thank you for bringing this to us.

COMMISSIONER KELLER: I'm just thinking about the market (indiscernible - voice lowered). It seems like this should be driven pretty easily (indiscernible - voice lowered), right? It's not terribly expensive. If there was a way that a company could make money for every connection, something -- you know, it doesn't seem like it would have to be. I mean, I'm just guessing. I don't know. Maybe it is, but it just doesn't -- it's like an app, you know, for an iPad. You know, once you -- you have done a very good job of putting it out there as the problem, and it seems like, to get the solution (indiscernible - voice lowered), not to mess up the market. (Indiscernible - voice lowered.)

DR. FERGUSON: You know, a good example: American Well had thought through the business and figured it out right, and the biggest growth, probably 90% of telehealth right now is (indiscernible - voice lowered) model providing that service, and the way they do it is they sign up clinicians for some set time, or if they do this full-time, they go from home, and they get them licensed in the states that provide the services. That is taking over the telehealth industry.

What it means for Alaska, if American Well signed up a lot of folks here is, the care will be typically by out of state providers. And so one of the things I'm thinking through here -- I'm not trying to compete with American Well,

but you know, this is a plan where you would like to bring healthcare business to your providers in the state and to serve the people in the state. So this is the model to do it. If we don't do something like this, those other models will start to come in and that will be the future, if we believe it. And it's not necessarily a bad thing, but it's what's going to happen.

COMMISSIONER DAVIS: So if I might just add to that, so in Hawaii, my understanding this is about a year-and-a-half ago now, it's that -- because the Blue Plan was the one paying for the development that they made that decision to use (indiscernible - voice lowered) physicians because, again, they're a lot like us, and they saw it as societal good to support the practice of medicine there.

So we've had a lot of discussion in the last couple days about the other side of that coin. This would be a great way to provide (indiscernible - voice lowered).

COMMISSIONER ERICKSON: Thank you so much.

DR. FERGUSON: Thank you for the time. I appreciate it.

COMMISSIONER ERICKSON: We appreciate you running across town and leaving your meeting. We need a time check and a process check here. We have about ten minutes before we go on to our next agenda item, and Dr. Hurlburt will be up first at 11 o'clock when we move on to our next item. I'm just scanning the back of the room periodically; the rest of our

speakers aren't here yet. Hopefully, they will arrive soon. I'm checking my email to see where we're at. Are you asking for a break?

UNIDENTIFIED FEMALE: Me?

COMMISSIONER ERICKSON: Was it a suggestion?

UNIDENTIFIED FEMALE: No. Not me.

UNIDENTIFIED MALE: (Indiscernible - away from mic)

COMMISSIONER ERICKSON: Oh, thank you very much. Our speakers are in the hall, I'm told. So I'm less anxious about that.

So in the ten minutes before we transition, I want to check in on process as far as recommendations. We have three areas for recommendations that we were on track with to include in our 2012 report: telemedicine, end-of-life care, and the employer's role in health. I was considering suggesting something that makes me too nervous, so I'm not going to. Well, I was going to suggest or ask if you would feel comfortable enough with me, just focusing on getting the concepts that you all have put forward wordsmithed in close enough that we could get them out for public comment.

Last year, we wordsmithed those and voted and agreed on the draft before releasing it for public comment, and I actually feel more comfortable doing that than just getting out a more conceptual document, which means we're going to have to do some work over teleconference. And what I'm going

to ask you to do -- I'm kind of coming up with this on the fly. If you could all -- and I will get a document out to you. So I'm going to get homework out to you on Monday. I'm basically pulling all of these concept bullets that are in the PowerPoint presentation. So it's not going to be new, anything new that you will be looking at, but I'll put it together into a Word document and ask you, over the next week, to identify any issues or questions you have to the concepts. And then at the same time, I'm going to be putting them together into a cleaner narrative form and then see if we can get together on teleconference two weeks from today, with the understanding that you'll get the Word document, at least, three, if not five, days in advance of that teleconference. I see one kind of nodding head.

COMMISSIONER DAVIDSON: The reason I was shaking my head is next week is, like, the biggest in the world.

COMMISSIONER ERICKSON: Oh, with the Native -- it's AFN?

COMMISSIONER DAVIDSON: It's a pretty busy from morning until night, but then you said we had two weeks so then I'm fine.

COMMISSIONER ERICKSON: You're fine then in two weeks.

COMMISSIONER HARRELL: As long as you don't mind (indiscernible - voice lowered) input. I mean, we're all going to be busy, unfortunately, two weeks from now. We're going to have a major military exercise, so I will be

disconnected.

COMMISSIONER ERICKSON: If you need more time -- Colonel Harrell was just mentioning he is going to be in a military exercise at that point. What we could do is have a teleconference making changes to that, and if you all are comfortable, if there is nothing that is too controversial, something we've done in the past for our new members is also voted over email. We have -- our bylaws allow us to vote over email. So if we could have a teleconference to get to the point where everyone is comfortable enough, then I could send a final right afterwards. We could vote over email. Does that sound -- I'm getting the thumbs-up to that. Is that process clear to everybody?

And in the meantime, we're going to be getting our draft and final reports, both from Milliman on pricing study and All-Payer Claims Database. We -- the Milliman was just information gathering and learning, like our earlier Milliman studies. We weren't necessarily going to make any recommendations about those. I have been imagining that any recommendations more specific to the All-Payer Claims Database are something that we'll do during 2013, once we receive that plan one more time to process and think about it. So that -- there won't be any suggestions about recommendations related to All-Payer Claims Database. Does that answer your question? Allen had asked me a question about our next steps with All-

Payer Claims Database on the break.

COMMISSIONER HIPPLER: Yes.

COMMISSIONER ERICKSON: Nodding head. Okay. One final question for you all. I'm assuming that you would like to take the suggested recommendation from Dr. Ferguson and from Paul Cartland as one of the two that I will wordsmith and forward out to you. So I'm seeing nodding heads and a question.

COMMISSIONER KELLER: Yeah. I've got a question, and Jim, (indiscernible - voice lowered). I'm sitting here wondering about -- if the Department of Health and Social Services is the appropriate thing we should recommend there, and the reason is the State has the same problem. You know, (indiscernible - voice lowered) for getting information back and forth between the departments. And while there is no division of IT within the Department of Admin, it just seems that we have to do that option open (indiscernible - voice lowered), and it's just a thought that maybe Jim can -- you can slap me down if I'm out of line, but it is a concern that I have had. We have databases all over the state. They don't talk to each other, and there is a lot of protection, protectivity, you know, toward these databases. Everybody wants their access to the database. They don't want to get it out there where everybody can see it, you know. So I'd like to see the Department of Admin move toward -- you know, or it

seems like that might be a better place to have a centralized IT program, like that, but I'm maybe I'm (indiscernible - background noise).

COMMISSIONER PUCKETT: Well, that would be in a different division than mine. I could talk to that Director, but I certainly can't.....

COMMISSIONER ERICKSON: My understanding is it's more of a support than IT system though, and what I was understanding was that there would be some value in potentially piggybacking on I don't think we should name the specific organization, but I think that's why the recommendation was general to the State Health Information Exchange, but at the same time, specific to the Health Information Exchange because it provides the other kind of health platform and addresses the other health issues.

COMMISSIONER KELLER: Fair enough.

COMMISSIONER ERICKSON: Does that make sense?

COMMISSIONER KELLER: Yeah.

COMMISSIONER ERICKSON: Does anybody have questions about.....

COMMISSIONER URATA: I have a question on the value of the teleconference. A lot of this stuff, can't we just do by email or do we need a teleconference to finalize it?

COMMISSIONER ERICKSON: David?

COMMISSIONER MORGAN: I think, statutorily, what we've done, as a Commission, I think we have to be on the record as

Commissioners that we've reviewed it yay or nay or not there. I think there is -- I think we have to -- though we have complete faith and trust in our Chair, our Executive Director, we've got to, at least, be on the record that we approved what they're doing. I mean, I don't want to -- I think they would be the first to say they would want us, at least, on the record publicly to say, hey, we agree, or hey, we don't or change this or don't show up.

COMMISSIONER ERICKSON: Right. We will do the voting over email. It's been helpful in the past. We've actually been real successful the few times we've done it in the past with limiting to one hour, but providing an opportunity for conversation about anything that folks might have a burning issue around. We are pretty good, I think. I'm saying this hesitantly because we'll do a lot of wordsmithing in our final meeting in December after we consider public comment, but we're pretty good about not wordsmithing in the teleconferences we've had so far and just discussing concepts still, understanding that we're not going to be making a decision either on the teleconference. So if, for whatever reason, you're in a military exercise or delivering a baby or whatever is going on, we don't need to have a quorum to have a teleconference.

Any final questions on our process and next steps before we move on to our 11 o'clock agenda? I'm going to go ahead

and turn it over to you, Ward, and while you get started, I'll pull up your presentation. For folks who are online, Dr. Hurlburt's presentation is available on the Commission's website on the October meeting page, if you'd like to follow along.

CHAIR HURLBURT: I'm going to have three areas to talk about. They have been areas that we have had recommendations to the Governor's office, to the Legislature's on and so it's a bit of an assessment of where we stand on some of those.

I'm going to apologize. It's going to be fast in going through this, so I will go straight through it. I'll spend most of the time talking about evidence-based medicine. And I will apologize to the members of the Commission who were not here two-and-a-half years ago when we talked about this because it will be a booster (indiscernible - background noise). So some of it will make no sense in what I'm saying, but I will be happy to talk with anybody, one-to-one, about this, if you wish, and we will have some chance, I think, in the next year, to talk about it again.

Evidence-based medicine, I believe, is the opportunity that we have that really gets at, in the most significant way, the issues of value, quality, and cost. Evidence-based medicine is not a concept that I was really taught in medical school, nor do I think current graduates are really being taught that. The term is being used a lot now, but what that

may mean is (indiscernible - background noise) and that does not get at the grades of evidence. I think this is a difficult issue to understand for physicians or for statisticians or administrators, but it is very important. And the comments now are generally made that anywhere from 30% up -- and you hear numbers up a lot from 30% -- of what we do in healthcare either does no good or does harm. And if we can get away from doing that, not only does it save money, it improves the overall quality. So we'll go through that. Next slide.

Evidence-based medicine (indiscernible - voice lowered) apply the best available evidence being from the scientific method to medical decision-making, seeks to assess the quality of evidence, the risks and benefits of treatments, including the lack of treatment and that's just a popular definition.

The quote that I read.....

COMMISSIONER ERICKSON: Ward, I'm sorry. I'm going to interrupt for just a second. It's -- since I'm not able to make the PowerPoint work right now, the Commissioners have this in your books, if you follow along.

CHAIR HURLBURT: This is one of the two quotes that I have on my wall. The other was from Bruce Lamoreaux in a session that we were in, but this is from David, the father of evidence-based medicine.

"Up until about four year ago, medical decisions were

doing very well on their own or so people thought. The complacency was based on a fundamental assumption that, through the rigors of medical education, followed by continuing education, journals, individual experience, and exposure to (indiscernible - voice lowered) position always thought the right thoughts and did the right things. The idea was that one (indiscernible - background noise) patient by some fundamentally human process called 'Art of Medicine' or 'clinical judgment.' The physician would synthesize all the important information about the patient, relevant research, experience with previous patients to determine the best course of action."

And so we know that's not reasonable. Next slide. We talked about this, who killed George Washington? The answer was his doctors. And this was a long time ago, but not country bumpkins. Four of the best physicians in the country. Three trained at Edinburgh, the lead English-speaking medical institution at the time. So we talked about that. They thought, bleeding (indiscernible - background noise), and when he didn't get better, he bled him some more. And then when he didn't get better, he bled him some more, and he died (indiscernible - voice lowered) in shock. So we talked about that. They thought there was evidence. Those were the experts. Next slide.

These were some things that I went through in my own *mea*

culpa, in my own history of practice with kids where otitis media, particularly among the Eskimo kids -- well, when I came here -- was as common as a runny nose. We thought what we needed to do was suck it out with a tube and then pack the external ear canal with Chloramphenicol powder and that that was going to cure it. Well, I wouldn't recommend you try that, but -- it did no good. The best experts in the country said, well, these kids (indiscernible - voice lowered). You need to do the TNAs. So we had these high risk TNA clinics on log cabins around the state. It was horrible. And there are other things that I did there. It's much better now because of all the wonderful things we physicians did. We built better houses. We put in water and sanitation. We did some immunizations and so on. They made a difference. Next one.

PSA screening every (indiscernible - voice lowered). I alluded to that earlier. A couple of trials. Today, probably most urologists would say, of course, all you men in this room need to get your PSA screening once you're 50 years of age. And a larger (indiscernible - voice lowered) under 60,000 individuals, a very small benefit, but 48 additional cases that needed to be treated with radical prostatectomies or other aggressive surgery to prevent death. The American trial (indiscernible - voice lowered) no benefit at all. Next slide.

Diagnostic imaging. Huge growth area in healthcare, and

we do them, but the very bottom point there -- the increase in the use of x-ray exposure, and depending on the particular test you get with CT scan, but you may get as much radiation from one CT scan -- (indiscernible - voice lowered) -- going in more than once a day for a year getting a chest x-ray. It's a lot of radiation, and the projections are -- this was in *Scientific American* -- an additional 29,000 cases of cancer a year that we're causing by that. Next slide.

So what's meant by grades of evidence? I referred to that. The bottom one there, the weakest evidence, Level III, those are the consensus conferences. You bring in the best experts in the country and say, what do we do about this problem? Do we do a lumpectomy? Do we do a radical mastectomy? Do we do a total thyroidectomy? Do we do a lumpectomy for whatever the condition is? That is not good evidence. The best evidence is if you could have a blinded randomized control. Well, it's easier to do with drugs. It's harder to do with surgery. Although some things, like the sham procedures, with the injection of putting the stuff in to reformulate the disk between the spines shown to be no good (indiscernible - voice lowered), still very expensive. But those are grades of evidence though. There is a need to understand that. We talked about that.

We talked about evidence-based principles go into practice in two different ways. One is at the organizational

or the institutional level and that comes into play. How do you design your benefits? So when Jim talks about what kind of benefits should we provide for State of Alaska employees or retirees, those benefits should be based on evidence. We shouldn't just do something just because somebody wants it or a physician wants to do it. To the extent we can, it should be based on evidence.

Secondly, in the process of providing that care, when requested, is to come and get the authorization to do something. Then Jeff or other payers should make that decision based on evidence, and there are tools, like (indiscernible - voice lowered), for example. It provides big documents where that's done. It's intended to be based on evidence, but we're all different. God created us all a little bit differently. And so when I get into the clinic and I'm face-to-face with Bob, then he also is faced with applying these -- the principles of evidence-based medicine, and we had that earlier quote from David there, that Bob is conscientious. He gets a CME, reads his journals. He's had lots of experience. He talks with his colleagues. But there is no way he's going to know everything, but his role then is as an educator, and again, in talking about PSA, I come in and I say, you know, maybe I better get my PSA done now. He said, okay. These are the potential advantages. These are the potential downside risks. And the decision is made

collaboratively. But there is always going to need to be the room for that individual decision-making between the provider and between the physician -- and the patient, but those two places come into play.

Categories and recommendations. A couple of ways of looking at it. The more formal one from the U.S. Preventative Services Task Force, where you give five different levels of evidence. One is, clearly, there is good evidence there. You should do this. You should discuss it with your patients. You should go ahead. Level B, which is probably a more common level, the evidence isn't quite that solid, but probably something you should do. Level C, there isn't any evidence that it doesn't harm, but not real strong.

Now most payers, like Blue Cross, will pay for the Level A and the Level B. Level C is the one where you get your medical management people, your medical director, your (indiscernible - voice lowered) nurses to look at it, communicate maybe with the physician and that's one where you could go either way, and it depends on the situation. But there's a Level D where the evidence that the harms outweigh the benefits on things. And then Level I, you just don't have enough.

The next slide from the Preventative Services Task Force Chair there basically says, when there is evidence of benefit, do it. When there is no evidence of benefit or there is harm,

don't do it. If you don't have evidence of benefit, we're spending too much on this, so you shouldn't do it. And then when there is insufficient evidence, that's you use your discretion. That's why physicians get their 12, 15 years of training or whatever it is, to help make those discussions. Next slide.

So initially, the concepts of evidence-based medicine did not deal with issues of cost at all. They were pure. We don't deal with cost issues. Recognition is that's not real life. We all deal with the cost. We decide, do we buy it (indiscernible - voice lowered) or do we buy a lower price? And there are some factors that enter into that decision.

So that led to the concept of comparative effectiveness research. This was a drug that was approved by the FDA for relapsing multiple myeloma, a malignant type process that costs $10,000 a month. Given monthly, it improves survival at a cost of $290,000 by nine months on the (indiscernible - voice lowered). Next slide.

Tarceva, another cancer drug, $4,000 a month, improves survival by 12 days. The next slide, a common diagnosis, rheumatoid arthritis. There is the concept of quality-adjusted life years. This means that life's okay for somebody, and it's a subjective judgment. But if you have rheumatoid arthritis, you might take aspirin. You might take Motrin and Advil, those kinds of drugs. You might take

steroids. There are the disease-modifying, anti-rheumatic drugs, like Methotrexate, which was a cancer drug. Across from that, the (indiscernible - voice lowered), about a little under $5,000 a year. You add some of these newer agents, and the cost goes up $150,000 a year. So if you watch television, you might think everybody with rheumatoid arthritis ought to have this. They're wonderful drugs, but for a small segment of the population. We tend to think, well, if the FDA has approved something, that's good and sound. If CMS has approved something, we should go ahead and use it and maybe for off-label use, too.

This was a study that just came out this week from Canada with their FDA system, and they look at all of the drugs that have been approved through what is their FDA kind of system that we have, and from 1995 to 2010, 24% of the newly-approved drugs were either recalled or problems were found later on.

Vioxx, which has costs Merck billions of dollars after advertising on the television that everybody should have Vioxx for their arthritis, well, the evidence was there of the heart disease right from the beginning. Some of you heard me say before that group health, that was never put on the formulary because the evidence was there. So you can't say, if FDA approves as good, it's safe, if CMS approves it. You need to do your own research. Next slide.

So that was the last one, but why do we need it? Those

were the reasons that we need it. These are a couple things. I referred to this yesterday. Just in my lifetime, annual per capita costs of healthcare in the U.S., in my professional career, went from under $150 a year to over $9,000. Next slide.

This is the inflation cost. The bottom line there, from 2000 to 2010, 27% inflation nationally. Wages went up 36%, health insurance premiums 114%, worker's contribution premiums 147%. Not sustainable. Next slide.

This I mentioned yesterday from the *Washington Post*, 100% of GDP by 2033 on the track that we are, with the increase in healthcare costs compared to overall costs. Next slide.

This talks about the percent of GDP that we're spending. We've heard this from Mark Foster on the lower part there. This was 2010. Yesterday, we heard we're probably spending $10 million now in Alaska on healthcare, half of the well head value (indiscernible - voice lowered) and half of all the wages collected. Next slide.

This is Anchorage, the cost of inflation there. The bottom line -- and this was from 1962 to 2010. Housing up 175%, all items 195%, energy 260%, medical care 419%.

So I don't think we've seen much real understanding and use of evidence-based medicine, but it's out there. I think it's value. I think it's quality. I think it's cost. It's all those things, and we'll talk about it more next year.

Next slide, please, Deb.

To go with the last two items quickly, on Health Information, we have seen some real movement there. Over 500 providers and 17 hospitals registered for the Electronic Health Record Incentive Program. You see the numbers that have been paid and the total that's been paid out. Next slide.

The Meaningful Use rule. Expect to see that be expanded. I think providers are adapting to it. For the most part, I think the rules are useful. So I think that's an area where we've seen some good progress. Next slide.

Just the amount of use that we're seeing as of the end of September, 3,000 (indiscernible - voice lowered) messaging accounts have been created, over 11,000 messages sent. Next slide.

The Medicaid re-enrollment went live. Again, Health Information Technology with the State and the HIE participating in the pilot of lab results. Next slide.

Transparency. We haven't seen a lot of movement yet, but I think considerable discussion about that. I wanted to mention one thing. Initially, as we were looking at the various aspects of healthcare, at least, I had considered acute care to be a spectrum of care. It's from you're in the operating room where you've got an anesthesiologist and a surgeon or four surgeons, depending on whether it's a liver

transplant or a gall bladder operation, and circulating, there is a scrub nurse and all these people to an Intensive Care Unit where your ratio is one or two patients per nurse to a step-down unit to the ward and so on. There is a rehab unit. There are sub-acute hospitals.

My own vision has been that the SNFs component was a part of that acute spectrum of care. I mean, that's from leading health systems, from including (indiscernible - voice lowered) from being on the board and treasurer of a private sector continuing care community from fourplexes as you went in and bought it, if you had enough money to SNFs. And we were going to go ahead with that analysis, but it was rightly pointed out to the Governor's office that we had voted seven-to-one to not go ahead with that analysis. And my faulty recollection being the one was that we had been talking about long-term care and that's what I understood, and when we went back and looked at the transcripts, it was exactly what we had voted, not to do it. Not to look at the SNFs care, I think, partly, because it was felt that there was information available there, but I think we have the information on hospital, on acute care. We have it on physicians. We have it on pharmacy. And I wanted to mention, in my mind, it's still a part of the acute care spectrum, and whether from a health plan standpoint or an administrator standpoint, that was a part of the acute care spectrum that we had. Next slide.

We have the Milliman analysis that we talked about and shared. The payment reform. Very limited activity so far, but some interest in it. As Jeff has mentioned and under some ERISA plans -- are anxious to have their TPAs (indiscernible - voice lowered), often the option for some limited areas for medical tourism. The State, as Becky said yesterday, is thinking about that as a last option. Some physician groups -- - last slide -- are expressing interest in increasing their knowledge about payment reform and various options. A number of institutional leaders have been outspoken, and from what I said at the beginning, Bruce Lamoreaux, for example, from the Providence System, the largest in the state, I thought what he said made so much sense I pasted it up on our wall.

COMMISSIONER ERICKSON: Yes, Keith?

COMMISSIONER CAMPBELL: (Indiscernible - voice lowered) the things here in this slide about what we have taken a look at so far, it seems, to me, there may be a glaring error inasmuch as state and most insurance plans have a dental component and a vision component. Do those need a cursory look? Merely a question.

CHAIR HURLBURT: My own sense is that we can't do everything, so we need to be really selective, and you know, go where the biggest bang for the buck is, and there are smaller components. David was saying yesterday that they're changing the contract with their provider on some of the

vision care services, and there are options out there in doing that, in developing contacted networks, but I don't know that that's such a huge component, but that's just my (indiscernible - voice lowered).

COMMISSIONER ERICKSON: Val?

COMMISSIONER DAVIDSON: I think dental is huge in Alaska in terms of people's limited access to dental, the number of dentists who actually accept Medicaid patients, and the impact that has on the oral health status of people in our state, and I think dental is huge. Access to oral healthcare is huge, and I can tell you that it will cause quite a consternation, and it will sure get interesting quickly politically, if you look at the full range of oral health providers that are currently practicing in Alaska and how that may be different than our friends in the Lower 48 states. Alaska has been a leader in this regard, and it has not necessarily been appreciated by organized dentistry.

CHAIR HURLBURT: (Indiscernible - voice lowered) like going to court.

COMMISSIONER ERICKSON: Any other questions or comments before we move on to the next agenda item? Commissioner and Josh, do you want to come join us at the head of the table?

COMMISSIONER STREUR: Josh is up first, so I'm going to let him cover Patient-Centered Medical Home before we get on to what is or is not happening on federal reform.

MR. APPLEBEE: Good morning. Almost good afternoon, everybody. I know you're really at the end of an agenda that's been really robust yesterday and bringing everything together today. I want to bring up-to-speed on a couple of the projects that we've been working on.

The first I would like to bring up-to-speed on is the Patient-Centered Medical Home Pilot Project. This has been an interesting process. I think one of our biggest challenges has been getting our consultants to have the best grasp of what healthcare is like in Alaska, and we have kind of gone through similar processes where they would come to us with, this is what we think, and our first reaction is no. You don't quite understand. Go back. Talk to some more people, you know, get a better view and then come back, and it seems that, every time I've given an update, it's kind of been that story, and I'm sure that any of you that have worked with outside contractors find this process to be as frustrating as I do.

It was my intention to have our consultants on the phone today, and after going through several volleys back and forth, they just couldn't make this timeframe work because, really, I wanted them to give you an idea of all of the steps that we've basically forced them into, so that they could get a better idea. And so when we get the final project from them, it will be something that we can use.

I'm getting from them, sometime today, a series of reports that we, again, sent them back to talk to different stakeholders at different segments of where our focus is going to be, most recently, behavioral health information. That was one of our last big pushes to them that they need to go back and they need to talk some people with expertise in this area. And so I'm anticipating, from them, a Recipient Utilization and Cost Trends Report, a report on other states and what they're doing with Patient-Centered Medical Homes, the Patient-Centered Medical Home Recognition Model Analysis, and specifically, where we apply standard recommendations.

I'm anticipating getting those this afternoon, and I'll be happy to have them write up a specific update that we can send out to the Health Care Commission in lieu of them actually coming today. We really kind of went back and said, this is an important presentation that I think you need to make, and we just couldn't make it work with travel schedules, and you know, time differences, but I think it will be a good examination of what we've been doing, as a department, to push our contractors to get the best idea of the challenges that we face so that, when they make a recommendation to us, we can actually put to practice and good use. So that's what we've been doing since the last update on the Patient-Centered Medical Home, and I'm really looking forward to that report that I'll be happy to give to Deb and make sure that each of

you get a copy of that.

COMMISSIONER ERICKSON: Are there any questions or comments about the Patient-Centered Medical Home Initiative? Thanks, Josh.

MR. APPLEBEE: More importantly, I've been working with the Director of the Division of Insurance, Bret Kolb, on the Essential Benefits Package. We talked about this a little bit at the last Commission meeting. I wanted to let you know that it was very nice to bring the Division Director onboard and have him engaged in this process.

We found out a lot of interesting things about this process in that what was once a hard deadline of September 30th became a soft deadline to a recommendation to, well, we don't know. If I remember correctly in my last update, I used a couple terms, and I brought my sheet to go over those terms. I think I talked about "soon." I talked about "shortly," and I talked about "later this summer." Well, "later this summer" in an update became "the first couple weeks of October" and now that's been "we don't know." Specifically, we're talking about the Notice of Proposed Rule-Making that covers Essential Health Benefits.

I'm working with the Division Director to draft up a letter letting the Secretary of the Health and Social Services know how frustrated we are, along with several other states, that we don't have the information we need to move forward on

a plan that's going to benefit people in our state. The Secretary told the states, back in December of last year that, regardless of what the Affordable Care Act says -- and it says the Secretary will determine Essential Health Benefits -- she says, well, we can't do this for 50 states. We think it's important that states do that themselves. Okay. How do you want us to do this? Under what framework do you want us to build these things? Well, we're going to get back with you.

I brought some examples of what some states have sent to Secretary Sebelius in regards to this. Wisconsin does not have the necessary information to make an Essential Benefits Benchmark Plan. Without the specific regulations in place, we are unable to choose an option that would best serve Wisconsin consumers. Oklahoma said, I firmly believe our state, not the federal government, is in the best position to determine the healthcare needs of our citizens; however, absent the required documentation, the State of Oklahoma is prevented from undertaking a detailed analysis in choosing Essential Benefits. And you know, Alabama, Florida, Pennsylvania, and so on and so forth. I highlighted a bunch of them, but no need to read them all. They basically say the same thing. We're expected to do something without the tools to do it, and we keep giving -- we are given these not really deadlines, but these promises of delivery, and they keep getting pushed back.

And as I said before, I don't envy this task to the

federal government. The Affordable Care Act is a monstrous piece of legislation with some very interesting timelines set forth, and the people working there are really working very hard. I just think that it's a situation that I don't know if it has a really good resolution because they want to do the right job and they want to the right job for the states, but they keep setting deadlines and then they become soft and then they get passed, and it becomes an issue if they're expecting to deliver on something that we don't have the tools to deliver.

Once that letter gets to be finalized and a public process for determining an Essential Health Benefits Plan get finalized, I'll be happy to, again, share that with anybody here. I'm sure you'll all hear about it because we'll want to get, at least, a couple meetings out there in terms of just information and then to receive stakeholder input on where the State is looking to go in terms of Essential Health Benefits.

UNIDENTIFIED MALE: Shortly.

UNIDENTIFIED MALE: Soon.

MR. APPLEBEE: Any specific questions on Essential Health Benefits?

UNIDENTIFIED MALE: FFE?

MR. APPLEBEE: The Federally-facilitated Exchange. Not to sound like a completely broken record, I looked over my notes and my update to the Commission, and I did -- I went

through my email. I went through several Google searches, and I looked for anything new, and there really isn't anything new. We've gotten some federal guidance in what the federal data hub is going to look like and some of the technical requirements that are going into that, and I think I mentioned that in my last update. But there has been nothing from CMS, CCIIO, or from Health and Social Services specifically regarding the Federally-facilitated Exchange.

There has been a lot of talk about state basic changes and how those processes have been handled in the open and in the public versus the federal government has hired some contractors, but still has yet to tell states anything about the design of the Exchange, how it's going to work, costs. It's really been frustrating, and I think the pushback from the states is becoming greater and greater for them to start releasing some of that information to us. So far, it's been really just kind of a stonewall. And again, it's not that I believe that they're not working. I think they're working incredibly hard, and I think they're trying to put together something that they can put out in the public and defend, and they're just not there yet. So that's -- I wish that I had more on the Federally-facilitated Exchange. I'm really looking forward to what they do come up with in terms of what it's going to look like.

CHAIR HURLBURT: Go ahead, Val.

COMMISSIONER DAVIDSON: On the Federally-facilitated Exchange, they still haven't changed their deadline of November 16. So basically, we have five weeks from today to figure out what they're looking for, or maybe even if we get nothing from them, to be able to figure out what kind of state partnership we want or whether it's going to be completely 100% managed. Or have they changed that date?

MR. APPLEBEE: They haven't mentioned anything about a change in the November 16th date. As far as I know, they're still expecting states to submit a blueprint, if they plan to move forward with a state-based exchange. I know there are states who are looking at doing state-based exchanges that are waiting until the 16th, which kind of really doesn't make much sense because, if you're going to do down the road of a state-based exchange, you really should have been going down that road months ago.

For those states that have decided to move forward with the Federally-facilitated Exchange, that blueprint isn't required, but to the extent that there is going to be any sort of partnership, then that would need to be outlined on the 16th. Any other questions about the Federally-facilitated Exchange?

COMMISSIONER DAVIDSON: I guess I have one more actually. So then -- so I guess we could infer then that, if the State submits something to the CCIIO by the 16th, it's either going

to say we're interested in some kind of partnership there where we will undertake these activities or it will say no, thank you. You manage it all for us or we won't submit a letter, which means they will do everything. Those are our options at this point, right?

MR. APPLEBEE: I think the last two options are basically the same. You don't have to tell the federal government that you -- no, thanks. By not submitting that application, it's really the same thing.

COMMISSIONER DAVIDSON: Yeah.

MR. APPLEBEE: So yes; I think, instead of three options, that would be the two options.

COMMISSIONER DAVIDSON: Yeah. I guess maybe I'll ask more clearly. Are we planning to write a letter or not, do you know at this point?

COMMISSIONER STREUR: We are not.

COMMISSIONER DAVIDSON: Thanks.

MR. APPLEBEE: Specifically moving to the federal reform update, I think one of the questions that everyone wants to know about is Medicaid expansion.

On the 6th of October, we put an RFP on the street to complete a Medicaid (indiscernible - voice lowered). We talked about this RFP being in draft form at the last Commission meeting. We went through the procurement process and got it out on the street. Becky Moore called me

yesterday, and *The Associated Press* reported on it this morning. So (indiscernible - voice lowered) or got their news alerts.

One of the things that Becky didn't put in her report that was part of her interview with me was that we're not alone in doing this study. In fact, we looked at several other studies from states like Wyoming, Pennsylvania, Idaho, Arizona, Nebraska. I mean, this is the crux of trying to make that decision. Without this data and without this type of analysis, it would be very difficult to make a decision, one way or the other. But we're very excited to have the RFP finished and on the street. In fact, it's garnered a lot of attention already, and if they keep the timeline that we've proposed, then we expect to have a report in the Commissioner's hands sometime in the beginning to mid of December.

COMMISSIONER STREUR: He really means the beginning of December. I just want to talk to a couple of things. Josh talked about "shortly," "soon," and "later this summer." Well, there is one more that the Execs have been getting and that's "we'll get back to you on this." We have continued to push and said, well, when is that going to be?

And one of the big problems that, I think, with the whole Medicaid expansion thing is that the speech, right now back East in Washington D.C. and at a conference or a meeting I was

at this past weekend in Boston, is that there is very likely going to be a delay on the Medicaid expansion, not because the Medicaid expansion is fraught with problems, but because of the Health Insurance Exchange and the fact that they don't think that they're going to be able to bring it up.

Some of you have heard that 25 states were on the fence a couple months ago when Josh reported. Right now, it looks like 30 states are saying the Federally-facilitated Exchange is the model that they're going to go to, and Kaiser estimates it could be as high as 35 of the states. Well, it's not a one-size-fits-all that you can bring into a state for a Health Insurance Exchange because it has to be adaptable to that state's insurance regulations, that state's provider system, et cetera, et cetera, et cetera.

And I'm going to say this quietly. They are beginning to realize that, that it isn't quite that easy, that they can't just set one up and expect that it's going to work in 30 or 35 states. Well, a big part of the Health Insurance Exchange was Medicaid expansion and that people would be able to qualify for Medicaid or for premium assistance through the Insurance Exchange, and if that's not up, if that's not available, if that's not operating, the Medicaid expansion is difficult. And so states are starting to push back and say, you know, it's going to fall on our existing systems, our existing eligibility systems and things, and we don't have the

capabilities and we don't have the money, and we don't have this, and we don't have that. You heard that from us in the last report, our annual operating costs and the cost increases that were associated with the Medicaid expansion.

So I'm not betting yet, but I'm of a strong opinion that we're probably looking at, at least, a six-month delay, if not a year's delay, in the Medicaid expansion. The problem with that is that it's in the statute, in the law, in the healthcare law. And how do we deal with that? The Senate and the House are going to go back and take a look at it and say, well, we're going to relax in this area; we're going to change that area. I mean, the danger is, if you open it up -- you open up the bill, the law, it opens up a whole bunch of law, and so there could be a (indiscernible - voice lowered) fight on that one, but I think HHS is particularly oblique right now because they want to get to the election before this starts in talking about challenges that they have.

In the meeting last weekend that was I at, even though it was through the weekend, was very helpful in that these are folks that are on the floor, the folks that are sitting, watching, observing meetings, talking with Congress and the Senate, and most don't believe the law is going to go away, which some would like to see happen, but most believe that the law is going to have to be opened up and that there will be challenges in the budget for particular aspects of the law.

Yeah. You (indiscernible - voice lowered) with the law, but if you don't find it, (indiscernible - voice lowered).

And so I wanted to say to you all that "soon," "shortly," "later this summer," and "we'll get back to you on that" are very much alive and well and are continuing to thrive as standard answers, but I keep harkening back to a statement that, you know, I made some years ago. We've been building healthcare, as we have it today, for close to 80 years, the healthcare system. We've refined it. Some of it was better refinement. Some of it is much worse refinement, but we've been building it this way. And changing the way we do business in any aspect of that healthcare law is not something you're going to do over one, two, or five years. And it's -- I don't think as easy as thought it was going to be, and there have been challenges for quite a while now. Aspects of the law that can go forward are going forward. (Indiscernible - voice lowered), some pro forma, some, you know, basic changes (indiscernible - voice lowered) go forward as (indiscernible - voice lowered) is going to continue to gather traction, but until we address some of the other healthcare issues that have been in place for a lot of years, it's going to be a tough margin to turn.

So questions? That's easy. Thank you. Ward wore you out.

CHAIR HURLBURT: Pat?

COMMISSIONER BRANCO: I did come up with one. You almost got away.

COMMISSIONER STREUR: I'm getting too old to think.

COMMISSIONER BRANCO: I really -- I don't know how much -- let me phrase this the right way. It's complex for those of us in the industry and who focus on this and read it about intensely, how we're going to do the exchanges, how we're going to implement the changes in payer structure, all of this, and you're right. The system we've built, good or bad, is the one that's existed for 80 long years now in which patients have a philosophy of, when I seek care, I go -- I drive this far, I turn left, I walk in the door, and I say, I'm here for care. And changing that model of behavior is going to be very difficult, and I don't think we've even -- any of us have begun the process of educating our patient population of what's going to be in store for them. We talk about it at a high level, and I know you're as worried about it because, in the end, the informed consumer is going to be the one that will help us achieve it. And I just wonder if you had thoughts on the education portion that we're going to be facing one day.

COMMISSIONER STREUR: I think Ward touched on it, on his last slide where he talked about it needs to start from within, and all of you have heard me talking that we need to drive healthcare back into the arms of the primary care

physician, whatever that primary care physician looks like, internal medicine, pediatrician, et cetera. And that's where the education needs to begin, and we can't -- you can't legislate it. You can't mandate it. You can't -- Jeff and I can't stop it by cutting funding for it because it's -- (indiscernible - voice lowered) managed care, the bashing that it took a few years ago. You know, the concept was right. It's just you didn't have all three legs of the stool at the table when you were doing it. So no. This (indiscernible - voice trailed off).

COMMISSIONER DAVIS: So you did give us too long. Take your ticket and run. (Indiscernible - background noise.) Sorry. So I think that -- now that I've recovered full from silence, I just want to make sure that -- I'm not trying to pin you down -- I understood what you said. It sounded -- what I heard was that there is a growing realization that the exchanges for 35 states are complicated enough that they are not going to come up on time; therefore, Medicaid expansion, which should happen at the same time, would be delayed from six to 12 months, and then presumably, subsidies also, which are available through the exchanges, would be delayed. So I mean, it's going to be a -- plus the major 2014, January 1st action would be delayed six to 12 months. So that's kind of the growing murmur that you're hearing. Did I hear that correctly?

COMMISSIONER STREUR: Yes. That's exactly what I was -- once again, (indiscernible - voice lowered) crystal ball (indiscernible - voice lowered) at this point, but I think it's a much clearer crystal ball than what we have up here in Alaska, apparently. And as much time as Josh and I spend on the Internet reading, you know, the speak-of-the-day, spending a couple days with these folks who are there in the trenches talking to folks within HHS as well, saying that, you know, we don't know, and -- but the one movement that I'm seeing from the Feds is that they're moving from this "soon," "shortly," "later this summer," and "we'll get back to you on this" to "we don't know." It's coming up more often, and I think folks are finally -- when it comes to implementing, they're finding that it's not quite as easy as -- you know, deceiving. So.....

COMMISSIONER DAVIS: Thank you.

CHAIR HURLBURT: Valerie?

COMMISSIONER DAVIDSON: So I think that I'm trying to reconcile a couple of things that we said here and also with other -- what Patrick said. I mean, we're all sort of immersed in this incredibly intellectual, exhausting exercise over the last couple of years. I mean, really, it has been one of our greatest intellectual challenges of how do we meet this sea of change in health reform and health delivery on a schedule that the law outlines? And so we have a couple of

new data points.

One is, for state-based exchanges, some states are not going to be ready -- that CCIIO may be willing to, perhaps, move the start date for those states to move forward or is the expectation that those states that haven't met the November 16 deadline for any reason, a variety of reasons -- there just isn't enough time to get it done -- then the expectation is that the Federally-facilitated Exchange will be ready to stand up and start implementing on January 1st of 2014? And I guess -- I think I heard you say that folks are not expecting even the Federally-facilitated Exchange to meet that deadline.

COMMISSIONER STREUR: That's what I said. States that have decided to go ahead with state-based exchanges can bring up their state-based exchange at any time, and they can be enrolling people into it. They can begin testing. They can begin expanding the population that they're enrolling to it.

There is also an option that hasn't been addressed a lot and that's a state-federal partnership. I think what you're going to see with the Federally-facilitated Exchange is that they're going to -- the Feds are going to try to move more toward giving states more rights and more tasks, more charges, more work with regards to the Federally-facilitated Exchange, and you're going to see it blurring between the Federally-facilitated Exchange and the State/Federal Partnership Exchange. At the next meeting, we'll tell you what the

changes are from what we said today, so.....

COMMISSIONER MORGAN: Commissioner, you should said, "we'll get back to you" by the end of the summer maybe if (indiscernible - voice lowered). Use the same words that they're using to you.

COMMISSIONER KELLER: We don't know.

COMMISSIONER STREUR: Thank you.

COMMISSIONER MORGAN: I would like to add we just went through the Meaningful Use part with our guys and set up a hard deadline for Oklahoma/Kansas, and I couple that with the re-enrollment in Medicaid because we've already started doing that. We have probably 409 providers that we're enrolling.

By the way, TRICARE mental health is saying, hey, if Medicaid could do that, we will, too. I just didn't know if you knew that.

But it had a few bumps, but I have to say I've gone through this three other times with three other states, and it was a little bumpy, but I've never seen one go as quickly without as much consternation.

I was in the Lower 48 when we did one in another state, and the whole system collapsed, and they had to restart it the next year. I mean, so usually, everybody is chewing, barking, and beating you up, but on this one, like I said, it wasn't easy for anybody, including their guys, but it did seem to work, and it did seem to get on and get through it, and if you

had a deadline of the end of year, if you were willing to do it as an organization, you could meet it. So I just thought I would add that for the record. I don't think you hear that very much where people try to be nice to you.

COMMISSIONER STREUR: We don't hear it very much, but -- and you know, I'm not going to acknowledge it because tomorrow's another day.

COMMISSIONER ERICKSON: Thank you, Commissioner. Thank you, Josh. Just one other thing I wanted to note for the Commission members, I have been updating the Affordable Care Act PowerPoint overview with notes on things that have happened, and there were lots of updates in the August one. I didn't include one in your notebooks this time because nothing -- while so much happened between June and August, hardly anything has happened, except lots of behind-the-scenes scrolling that we just got a sense of here. So I mean, there were -- nine community health center grants for quality improvement and health center funding were awarded in our state of $55,000 each related to Patient-Centered Medical Home support. So other than that, there wasn't anything. Other than what Commissioner and Josh had to come update us on, there really wasn't much to share. So with our end-of-the-year report, anything that happens over the next few months will include those updates, but if any of you have any questions for me related to the Affordable Care Act updates,

please let me know.

CHAIR HURLBURT: Val?

COMMISSIONER DAVIDSON: I move to adjourn.

COMMISSIONER ERICKSON: We don't have a second yet.

COMMISSIONER BRANCO: Well then, we don't have discussion either.

COMMISSIONER ERICKSON: Do we have a second for adjournment?

COMMISSIONER BRANCO: I just wanted -- our teleconference that we're going to try to set up, I need to ask whether we're going to have that over the (indiscernible - voice lowered)?

COMMISSIONER ERICKSON: Oh, yes.

COMMISSIONER BRANCO: Okay. Just wanted to make sure.

COMMISSIONER ERICKSON: We will, and we'll -- this will be a minor detail, but we'll have the different pass codes for the Commission members to participate, but we'll open it for the public to be able to listen.

COMMISSIONER BRANCO: Second.

COMMISSIONER ERICKSON: Any other discussion? All in favor of adjourning?

COMMISSIONERS IN UNISON: Aye.

COMMISSIONER ERICKSON: Any opposed? Thank you all for your time. Meeting adjourned.

CHAIR HURLBURT: (Indiscernible - background noise) if anybody does have any feedback on this meeting, on process, on

how it went, any suggestions, you can just send it to Deb or to me. I think it's important to end that way.

11:53:58

(Off record)

END OF PROCEEDINGS